Health Financ				u of Form CMS-2552~10
This report payments made	is required by law (42 USC 1395g; 42 CFR 413.20(b)). Faile since the beginning of the cost reporting period being	ure to report can resul deemed overpayments (42	lt in all interim 2 USC 1395g).	FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION NT SUMMARY	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	
	T REPORT STATUS			
Provider	 [X] Electronically filed cost report 		Date: 5/27/20	15 Time: 3:52 pm
use only	2. [] Manually submitted cost report			
	 O] If this is an amended report enter the number of the second of the se	f times the provider ro for low.	esubmitted this co	ost report
Contractor use only	5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for t (4) Reopened (5) Amended	this Provider CCN 12.[IPR Date: Contractor's Vendo [0]If line 5, co number of tim	or Code: 4 Dlumn 1 is 4: Enter nes reopened = 0-9,
PART II - CER	RTIFICATION			
ADMINISTRATIV	ATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THE VE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FO PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A SE VE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	JRTHERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE
	CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER	t(s)		
elect Exper 12/31 prepa	REBY CERTIFY that I have read the above certification startronically filed or manually submitted cost report and the uses prepared by RIVERVIEW HOSPITAL (150059) for the cost/2014 and to the best of my knowledge and belief, this reared from the books and records of the provider in accords the provider in accords of the provider in accords.	e Balance Sheet and Sta st reporting period beg eport and statement are ance with applicable in	tement of Revenue inning 01/01/2014 true, correct, c structions, excep	e and l and ending complete and ot as noted.

Encryption Information ECR: Date: 5/27/2015 Time: 3:52 pm

regulations.

:wa8flueI18MF08DAkHYKY6aEyg740 3HXbs0LPEfX0MkLUWRWX19rZnYkEop ZQ99101IZhOMCYRJ

PI: Date: 5/27/2015 Time: 3:52 pm tlWCjbcmy.MNzRzcMUEOMiV1zomKG0

J0B1a0fkJJ94CxM3sQVYdFS4XxqRCQ

(Signed)

services, and that the services identified in this cost report were provided in compliance with such laws and

Administrator of Provider(s)

Title

Date

		[Títle X	VIII		ŀ	
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	· .
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	155,251	113,177	141,312	-92,812	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	45,805	0		-69,477	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
5.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	O	201,056	113,177	141,312	-162,289	200.00

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

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

19.00 011 61								19.00
					From	1:	To:	
					1. 00)	2.00	
20.00 Cost Reporting Period (mm/dd/yyyy)					01/01/	2014	12/31/2014	20. 00
21.00 Type of Control (see instructions)						9		21. 00
Inpatient PPS Information								
22.00 Does this facility qualify and is					Y		N	22. 00
share hospital adjustment, in acco	rdance with 42 CFR §412.10	06? In co	lumn 1, ∈	enter "Y"				
for yes or "N" for no. Is this fac			2.06(c)(2	2) (Pi ckl e				
amendment hospital?) In column 2,								
22.01 Did this hospital receive interim					Y		Υ	22. 01
period? Enter in column 1, "Y" for								
reporting period occurring prior t								
for no for the portion of the cost	reporting period occurring	ng on or a	fter Octo	ober 1.				
(see instructions)								
22.02 Is this a newly merged hospital th					N		N	22. 02
determined at cost report settleme								
or "N" for no, for the portion of								
in column 2, "Y" for yes or "N" for after October 1.	r no, for the portion of	the cost r	eporting	period on				
22. 03 Did this hospital receive a geogra	nhia raalassifiaatian fra	m urban ta	rural ac	a rocult	N		N	22. 03
of the OMB standards for delineati					IN IN		IN	22.03
in column 1, "Y" for yes or "N" for								
prior to October 1. Enter in colum								
cost reporting period occurring on								
hospital contain at least 100 but								
42 CFR 412.105)? Enter in column 3								
23.00 Which method is used to determine			below? I	n column		3	N	23. 00
1, enter 1 if date of admission, 2								
method of identifying the days in								
used in the prior cost reporting p								
	In-Sta				Out-of	Medi cai d	1 Other	
	Medi ca	aid Medio	caid S	state	State	HMO days	Medicaid	

		Medicaid	Medicaid	State	State	HMO days	Medicaid	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
2	1.00 If this provider is an IPPS hospital, enter the	773	370	0	0	1, 054	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
2	5.00 If this provider is an IRF, enter the in-state	266	71	0	0	0		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-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

care or general surgery. (see instructions)

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)

lealth Financial Systems		I EW HOSPI TAL		ON 45005			In Lie	eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	Prov	nder C	CN: 15005			/01/2014 /31/2014		
								5/27/2015 3:	36 pm
						1	. 00	2.00	
28.00 If this is a Medicare certified li in column 1 and termination date,			erti fi d	ation da	ite				128. 00
29.00 If this is a Medicare certified Lu	ing transplant center,	enter the ce	rti fi ca	ition dat	ein				129. 00
column 1 and termination date, if 30.00 If this is a Medicare certified pa			e certi	fi cati on	1				130. 00
date in column 1 and termination of 31.00 of this is a Medicare certified in			tha car	ti fi cati	on				131. 00
date in column 1 and termination o	date, if applicable, i	n column 2.							
32.00 If this is a Medicare certified is in column 1 and termination date,			erti fi d	ation da	ite				132. 0
33.00 If this is a Medicare certified of	ther transplant center	, enter the c	erti fi d	ation da	ate				133. 00
in column 1 and termination date, 34.00 If this is an organ procurement or			mber ir	n column	1				134. 0
and termination date, if applicabl	e, in column 2.								
40.00 Are there any related organization	n or home office costs	as defined i	n CMS F	Pub. 15-1	,		Υ		140. 00
chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the					sts				
1.00		2. 00					3. 00		
If this facility is part of a chain home office and enter the home of					ne name	and	address	of the	
41. 00 Name:	Contractor's Nam				actor'	s Num	ber:		141. 0
42. 00 Street: 43. 00 Ci ty:	PO Box: State:			Zip C	ode:				142. 00 143. 00
								1.00	
44.00 Are provider based physicians' cos								1.00 Y	144. 0
45.00 If costs for renal services are clonly? Enter "Y" for yes or "N" for		line 74, are	the co	sts for	inpati	ent s	ervi ces	Y	145. 0
					-	1	. 00	2.00	_
46.00 Has the cost allocation methodolog							N	2.00	146. 00
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in		ub. 15-2, § 4	020) If	yes, en	nter				
47.00 Was there a change in the statisti	cal basis? Enter "Y"						N		147. 0
48.00 Was there a change in the order of 49.00 Was there a change to the simplifi					for		N N		148. 0
no.		Part	٨	Part	R	Ti ·	tle V	Title XIX	
		1.0)	2. 00)	3	. 00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '									
55. 00 Hospi tal	N TOT HO TOT CACH CO	N N		N	D. (3C	.0 42	N 3415	N N	155. 0
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N N		N N			N N	N N	156. 00 157. 00
58. 00 SUBPROVI DER		14		14			IN	14	158. 0
59. 00 SNF		N		N			N	N	159. 0
60.00 HOME HEALTH AGENCY 61.00 CMHC		N		N N			N N	N N	160. 00 161. 00
01. 00 Omino				- 14					101.0
Mul ti campus								1.00	
65.00 Is this hospital part of a Multica	ampus hospital that ha	s one or more	campus	ses in di	fferen	t CBS	As?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County		State	Zip C	ode	CBSA	FTE/Campus	
// 0016 line 1/5 i 6	0	1. 00		2. 00	3. 0		4. 00	5.00	2011/
66.00 ffline 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)								0.0	00 166. 0
				· '				1.00	
Health Information Technology (HI	Γ) incentive in the Am	neri can Recove	ry and	Rei nvest	tment A	ct		1.00	
67.00 Is this provider a meaningful user	under Section §1886(n)? Enter "Y	for y	es or "N	l" for	no.	41	Υ	167. 00
68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			(II ne	16/ IS "	ү"), е	nter	tne		0168. 0
69.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y")		CAH (I	ine 105	is "N"), en	ter the	0.	75169. 0

Health Financial Systems	RI VERVI EW HOSPI	TAL	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 150059	Peri od:	Worksheet S-2			
			From 01/01/2014				
			To 12/31/2014	Date/Time Pre 5/27/2015 3:3	pared:		
	Endi ng						
	2.00						
170.00 Enter in columns 1 and 2 the EHR begi	12/31/2014	170. 00					
period respectively (mm/dd/yyyy)							
				1.00			
171.00 If line 167 is "Y", does this provide	er have any days for individ	duals enrolled in secti	on 1876	N	171. 00		
Medicare cost plans reported on Wkst.	S-3, Pt. I, line 2, col. 6	5? Enter "Y" for yes ar	d "N" for no.				
(see instructions)							

34.00	are services furnished at the provider facility under an a	irrangement wrth provider-bas	eu physicians?		34.00		
25 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreements with the n	rovi don bacad		35. 00		
33.00	physicians during the cost reporting period? If yes, see i		i ovi dei -based		35.00		
	phrysicians during the cost reporting period: if yes, see i	HISTI UCTI OHS.	Y/N	Date			
			1, 00	2. 00			
	Home Office Costs						
36. 00	Were home office costs claimed on the cost report?				36.00		
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the home office?			37.00		
	If yes, see instructions.						
38.00 If line 36 is yes , was the fiscal year end of the home office different from that of 3							
the provider? If yes, enter in column 2 the fiscal year end of the home office.							
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, :							
see instructions.							
40. 00	J	home office? If yes, see			40.00		
	i nstructi ons.						
		1.00	0	00	-		
	0 + 0 + 1 + 1 + 0 + 1	1.00	2.	00			
	Cost Report Preparer Contact Information	hu ouasi	AL ECCANIDITAL		14.00		
41.00	Enter the first name, last name and the title/position	MI CHAEL	ALESSANDRI NI		41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
12 00		DLUE AND CO			42.00		
12.00		BLUE AND CO			42.00		
12 00		217 712 7050	MATECCANIDAT ME	DITIEVNDOO COM	43.00		
+3.00		317. 713. 7737	MALLOCANDRI NI ®	JEULANDOU. COM	43.00		
42. 00 43. 00	respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	BLUE AND CO 317. 713. 7959	MALESSANDRI NI @	BLUEANDCO. COM			

Heal th	Financial Systems	RI VERVI EW	H0SPI	TAL		In Lie	eu of Form CMS-	2552-1
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE		Provi der	CCN: 15005	From 01/01/2014	Worksheet S-2 Part II Date/Time Pro 5/27/2015 3:3	epared:
		Part B Date						
		4. 00						
	PS&R Data							
	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)	02/11/2015						16. 00

		Tart D		
		Date		
		4.00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R	02/11/2015		16. 00
	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)			
17.00	Was the cost report prepared using the PS&R			17. 00
	Report for totals and the provider's records			
	for allocation? If either column 1 or 3 is			
	yes, enter the paid-through date in columns			
	2 and 4. (see instructions)			
18. 00				18. 00
	made to PS&R Report data for additional			
	claims that have been billed but are not			
	included on the PS&R Report used to file			
	this cost report? If yes, see instructions.			1.0.00
19. 00	If line 16 or 17 is yes, were adjustments			19. 00
	made to PS&R Report data for corrections of			
	other PS&R Report information? If yes, see instructions.			
20. 00			•	20.00
20.00	made to PS&R Report data for Other? Describe			20.00
	the other adjustments:			
21 00	Was the cost report prepared only using the			21. 00
21.00	provider's records? If yes, see			21.00
	instructions.			
	THE CHARLES ONE			
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title	e/position	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 the cost	report		42. 00
	preparer.			
43.00	Enter the telephone number and email address			43. 00
	report preparer in columns 1 and 2, respective	vel y.		

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | P

					'	0 12/31/2014	5/27/2015 3:3	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	oomponent.	Line Number	110.	or beas	Avai I abl e	Oran nodi S	11 110 1	
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		90				1. 00
	8 exclude Swing Bed, Observation Bed and							
	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 IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						Ō	6. 00
7. 00	Total Adults and Peds. (exclude observation			90	32, 850	0.00	l e	7. 00
7.00	beds) (see instructions)			, ,	1	0.00	Ĭ	7.00
8.00	INTENSIVE CARE UNIT	31. 00		15	5, 475	0.00	0	8. 00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	
14. 00	Total (see instructions)	43.00		105	38, 325	0.00		14. 00
15. 00	CAH visits			100	00,020	0.00	o o	15. 00
16. 00	SUBPROVI DER - I PF						Ĭ	16. 00
17. 00	SUBPROVI DER – I RF	41. 00		24	8, 760	1	0	
18. 00	SUBPROVI DER	11.00		2 1	0,700		Ĭ	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		25	9, 125		0	
20. 00	NURSING FACILITY	11.00		20	7, 120		Ĭ	20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	30.00			•			25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			154				27. 00
28. 00	Observation Bed Days			154			0	28. 00
29. 00	Ambulance Trips						0	29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days (see Histruction)							31.00
31.00	Labor & delivery days (see instructions)			0]			
	, , , , , , , , , , , , , , , , , , ,			0	C	1		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							33. 00
SS. 00	LTCH non-covered days		l		I	1	I	J 33. UU

				'	0 12/31/2014	5/27/2015 3:3	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 221	703	12, 774			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 708	1, 424				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	473	71	_			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	5 004	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	5, 221	703	12, 774			7. 00
0.00	beds) (see instructions)	1, 371	0	2, 762			0.00
8.00	INTENSIVE CARE UNIT	1,3/1	0	2, 762			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00 12. 00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY		0	0			13.00
14. 00	Total (see instructions)	6, 592	703	15, 536	0.00	1, 079. 73	
15. 00	CAH visits	0, 392	703	10, 000	0.00	1,079.73	15. 00
16. 00	SUBPROVI DER - I PF	٩	٩	U			16.00
17. 00	SUBPROVIDER - I RF	3, 630	266	5, 548	0.00	27. 73	
18. 00	SUBPROVI DER	3,030	200	5, 546	0.00	27.73	18.00
19. 00	SKILLED NURSING FACILITY	3, 349	0	4, 820	0.00	0.00	1
20. 00	NURSING FACILITY	3, 347	o _l	4, 020	0.00	0.00	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	l ol	o	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00					0.00	1, 107. 46	
28. 00	Observation Bed Days		92	1, 825			28. 00
29. 00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	o	70	228			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | P

				10	12/31/2014	5/27/2015 3:30	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		C	1, 557	128	3, 810	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			382	344		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF	0. 00	O	1, 557	128	3, 810	14. 00 15. 00 16. 00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER	0. 00	0	301	19	455	17. 00 18. 00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	0. 00					19. 00 20. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0.00					21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 30. 00 31. 00 32. 01 33. 00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150059 Peri od: Worksheet S-3 From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/27/2015 3:36 pm Adj usted Worksheet A Amount Recl assi fi cati Paid Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Salaries in col. 5) Worksheet A-6 3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200. 00 64, 715, 554 2, 733, 933 67, 449, 487 1, 901, 741. 00 35. 47 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Admi ni strati ve Physicians - Part A - Teaching 4.01 0 0.00 0.00 4.01 5.00 Physician-Part B 0.00 0.00 5.00 6.00 Non-physician-Part B 0 0 0.00 0.00 6.00 Interns & residents (in an 21 00 7.00 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and C 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office personnel 0.00 0.00 8.00 44 00 0.00 9 00 SNF 0 00 9 00 10.00 Excluded area salaries (see 23, 353, 739 299, 019 23, 652, 758 519, 687. 00 45.51 10.00 instructions) OTHER WAGES & RELATED COSTS 184, 547 184, 547 1, 321. 00 139. 70 11.00 Contract labor: Direct Patient 11.00 Care 12.00 Contract Labor: Top Level 0 \mathcal{C} 0 0.00 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 315, 277 0 315, 277 1, 671. 00 188. 68 13.00 A - Administrative 14.00 Home office salaries & C 0 0.00 0.00 14.00 0 wage-related costs Home office: Physician Part A 15.00 0 0.00 0.00 15.00 - Administrative 16.00 Home office and Contract 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS Wage-related costs (core) (see 10, 439, 207 0 10, 439, 207 17.00 17.00 instructions) Wage-related costs (other) 0 18.00 18.00 0 (see instructions) 19.00 19 00 Excluded areas 3, 629, 662 0 3, 629, 662 20.00 Non-physician anesthetist Part 20.00 0 21.00 21.00 Non-physician anesthetist Part 0 22.00 Physician Part A -0 22.00 Administrative 22.01 Physician Part A - Teaching С 22.01 23.00 Physician Part B 0 23.00 0 0 24.00 Wage-related costs (RHC/FQHC) O 24 00 25.00 Interns & residents (in an 0 25.00 approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 26.00 4. 00 2, 018, 562 -1, 329, 292 689, 270 15, 129. 00 45. 56 26.00 Administrative & General 260, 699. 00 27.00 7, 468, 772 213, 488 7, 682, 260 29.47 27.00 5.00 28.00 Administrative & General under 557, 336 557, 336 4, 524. 00 123. 20 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 1, 478, 439 56, 815. 00 1, 520, 699 26. 77 30 00 30.00 7 00 42, 260 31.00 Laundry & Linen Service 8.00 23,868 682 24, 550 2, 273. 00 10.80 31.00 32.00 Housekeepi ng 9.00 829, 027 23, 697 852, 724 59, 267. 00 14. 39 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 934, 933 34 00 34.00 Di etarv 10.00 -644, 667 290, 266 17, 392, 00 16, 69 Di etary under contract (see 0.00 35.00 0.00 35.00 instructions) 36.00 615, 852 Cafeteri a 11.00 0 40, 641. 00 15. 15 36.00 615, 852 12.00 0.00 Maintenance of Personnel 37 00 37 00 0 00 38.00 Nursing Administration 13.00 706, 347 20, 190 726, 537 14, 453.00 50. 27 38.00 Central Services and Supply 454, 778 184, 379 639, 157 25, 117. 00 25. 45 39.00 39.00 14.00

15.00

1,889,952

54,023

1, 943, 975

44, 339. 00

43. 84 40. 00

40.00 Pharmacy

Health Financial Systems		HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
HOSPITAL WAGE INDEX INFORMATION					Period: From 01/01/2014 To 12/31/2014		pared:
	Worksheet A Line Number		Reclassificati on of Salaries	, ,		Average Hourly Wage (col. 4 ÷	
		·	(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical Records Library	16. 00	558, 887	15, 975	574, 86	2 27, 110. 00	21. 20	41. 00
42.00 Social Service	17. 00	509, 232	14, 556	523, 78	8 10, 121. 00	51. 75	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

near th	Titianciai Systems		IXI VLIXVI LW	11031 I TAL		III LIC	Su of Form CW3-2	2332-10
HOSPI T	TAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3 Part III	
						To 12/31/2014		nared:
						10 12/31/2014	5/27/2015 3: 36	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		65, 272, 890	2, 733, 933	68, 006, 82	1, 906, 265. 00	35. 68	1.00
	instructions)							
2.00	Excluded area salaries (see		23, 353, 739	299, 019	23, 652, 75	519, 687. 00	45. 51	2.00
	instructions)							
3.00	Subtotal salaries (line 1		41, 919, 151	2, 434, 914	44, 354, 06	5 1, 386, 578. 00	31. 99	3.00
	minus line 2)							
4.00	Subtotal other wages & related		499, 824	0	499, 82	4 2, 992. 00	167. 05	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 439, 207	0	10, 439, 20	7 0.00	23. 54	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		52, 858, 182	2, 434, 914	55, 293, 09	6 1, 389, 570. 00	39. 79	6.00
7.00	Total overhead cost (see		17, 430, 133	-788, 857	16, 641, 27	577, 880. 00	28. 80	7.00
	instructions)							

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150059	Peri od: Worksheet S-3
		From 01/01/2014 Part IV

	To 12/31/2014	Date/Time Prep 5/27/2015 3:30	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 045, 154	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6, 807, 095	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	152, 818	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	52, 426	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	188, 872	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	228, 615	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	4, 362, 862	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	65, 970	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	71, 333	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13, 975, 145	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems	RI VERVI EW HOSPI	TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150059	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Pre 5/27/2015 3:3	pared:
	Cost Center Description				Contract Labor 1.00		
	PART V - Contract Labor and Benefit Cost				1.00	2.00	
	Hospital and Hospital-Based Component Identifica	ati on:					
1.00	Total facility's contract labor and benefit cos				0	0	1. 00
2.00	Hospi tal				0	0	2. 00
3.00	Subprovi der - IPF						3. 00
4.00	Subprovi der - 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	0.00
9.00	Hospital-Based NF						9. 00
10.00	Hospi tal -Based OLTC						10.00
11. 00	Hospital-Based HHA						11. 00
12. 00	Separately Certified ASC						12. 00
13. 00	Hospi tal -Based Hospi ce						13. 00
14. 00	Hospital-Based Health Clinic RHC						14. 00
15. 00	Hospital-Based Health Clinic FQHC						15. 00
16. 00	Hospi tal -Based-CMHC						16. 00
17. 00	Renal Dialysis				0	0	
18. 00	0ther				0	0	18. 00

Health Financial Systems RIVERVIEW	HOSPI TAI		In lie	eu of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		CCN: 150059	Peri od:	Worksheet S-7	
			From 01/01/2014		
			To 12/31/2014		
				5/27/2015 3:3	
	Group	SNF Days	Swing Bed SNF		
	1.00		Days	col. 2 + 3)	
10.00	1.00	2. 00	3. 00	4.00	10.00
69. 00	PE2		0 0		
70. 00	PE1		0 0		
71. 00	PD2		0 0		1
72. 00	PD1		2 0	2	
73. 00	PC2		0 0	0	
74. 00	PC1		7	7	
75. 00	PB2		0	0	
76. 00	PB1		0	0	
77. 00	PA2		0	0	
78. 00	PA1		0	0	
199. 00	AAA		0		199. 00
200. 00 TOTAL		3, 3			200. 00
			CBSA at	CBSA on/after	
			Beginning of	October 1 of	
			Cost Reporting		
			Peri od	Reporting	
				Period (if	
			1.00	applicable)	
lane acompage			1. 00	2. 00	
SNF SERVI CES	1 16	1 6 1111	0.4000	0,000	004 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA			26900	26900	201. 00
in effect at the beginning of the cost reporting period. Er	nter in column	2, the code			
in effect on or after October 1 of the cost reporting period	od (ir appiicad		Percentage	Associ ated	
		Expenses	Percentage	with Direct	
				Patient Care	
				and Related	
				Expenses?	
		1.00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, No. 1	49 Δυσυς† 4 - 2				
payments beginning 10/01/2003. Congress expected this incre					
expenses. For lines 202 through 207: Enter in column 1 the					
column 2 the percentage of total expenses for each category					
line 7, column 3. In column 3, enter "Y" for yes or "N" for					
with direct patient care and related expenses for each cate					
202. 00 Staffing	3- / (0 0.00		202. 00
203.00 Recruitment			0.00		203. 00
204.00 Retention of employees			0.00		204.00
205. 00 Trai ni ng			0.00		205. 00
206. 00 OTHER (SPECIFY)			0.00		206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2, 456, 0			207. 00
		, , , , , , ,	1	1	

	Financial Systems	RI VERVI EW HOSPI				eu of Form CMS-2			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der	CCN: 150059	Peri od:	Worksheet S-1	0		
					From 01/01/2014 To 12/31/2014		nared:		
					10 12/31/2014	5/27/2015 3: 3			
					·				
						1. 00			
	Uncompensated and indigent care cost computati								
1.00	Cost to charge ratio (Worksheet C, Part I line	e 202 column 3 div	ided by li	ne 202 colum	n 8)	0. 341663	1. 00		
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid					3, 054, 756	2. 00		
3. 00	Did you receive DSH or supplemental payments i					Y	3. 00		
4.00	If line 3 is "yes", does line 2 include all DS	1.1	1 2	from Medicai	d'?	Y	4. 00		
5.00	If line 4 is "no", then enter DSH or supplemen	ntai payments from	medicai d			0	5. 00		
6.00	Medicaid charges					22, 698, 035	6. 00 7. 00		
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for N	Andinaid program (lina 7 min	us sum af Li	noo 2 and E. if	7, 755, 079 4, 700, 323			
8.00	<pre> < zero then enter zero)</pre>	neurcaru program (iiie / IIIiii	us suili 01 11	iles 2 and 5, 11	4, 700, 323	0.00		
	State Children's Health Insurance Program (SCH	HP) (see instructi	ons for e	ach Line)					
9.00	Net revenue from stand-alone SCHIP) (555 11.51.451.	01.0 . 0. 0	40.1 11110)		0	9.00		
10.00	Stand-alone SCHIP charges					0			
11. 00	Stand-alone SCHIP cost (line 1 times line 10)					0			
12. 00	Difference between net revenue and costs for s	stand-alone SCHLP	(line 11 m	inus line 9;	if < zero then	0	12.00		
	enter zero)		`						
	Other state or local government indigent care	program (see insti	ructions f	or each line)				
13.00	Net revenue from state or local indigent care					l .	13.00		
14. 00	Charges for patients covered under state or lo	ocal indigent care	program (Not included	in lines 6 or	0	14. 00		
45.00	10)						45.00		
15. 00	State or local indigent care program cost (lir				15! !	0			
16. 00	Difference between net revenue and costs for s 13; if < zero then enter zero)	state or rocal ind	igent care	program (II	ne 15 minus iine	0	16. 00		
	Uncompensated care (see instructions for each	Line)							
17. 00	Private grants, donations, or endowment income		ndi ng char	ity care		0	17. 00		
18. 00						0			
19. 00	Total unreimbursed cost for Medicaid, SCHIP a				ms (sum of lines	4, 700, 323	19. 00		
	8, 12 and 16)								
				Uni nsured	Insured	Total (col. 1			
				patients	pati ents	+ col . 2)			
20.00	T-+-1 : -: +: -1 -b1:+:£+:+-	Con about the con-	(-+ £	1.00	2. 00 81	3.00	20.00		
20. 00	Total initial obligation of patients approved charges excluding non-reimbursable cost center			3, 957, 4	81	3, 957, 481	20. 00		
21. 00	Cost of initial obligation of patients approve			1, 352, 1	25 C	1, 352, 125	21 00		
21.00	times line 20)	ou for charry car	e (i i iie i	1,002,1	20	1,002,120	21.00		
22. 00	Partial payment by patients approved for chari	ty care			0 0	0	22. 00		
23.00	Cost of charity care (line 21 minus line 22)			1, 352, 1	25 C	1, 352, 125	23. 00		
						1.00			
24. 00	Does the amount in line 20 column 2 include ch			nd a Length	of stay limit	N	24. 00		
25 00	imposed on patients covered by Medicaid or oth			oanom! - ! -	+b af at !!-!!	0	25. 00		
25. 00									
26.00	26.00 Total bad debt expense for the entire hospital complex (see instructions) 10,560,570 2 27.00 Medicare bad debts for the entire hospital complex (see instructions) 151,536 2								
28. 00	Non-Medicare and non-reimbursable Medicare bac		,	s line 27)		151, 536 10, 409, 034			
29. 00	Cost of non-Medicare and non-reimbursable Medi	, ,		,	28)	3, 556, 382			
30. 00	Cost of uncompensated care (line 23 column 3 g		chac (Title	i times illi	20)	4, 908, 507			
	Total unreimbursed and uncompensated care cost	,	ne 30)			9, 608, 830			
2 20	1		/			1, 222, 000			

Health Financial Systems	RI VERVI EW HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE			1	Period: From 01/01/2014 Fo 12/31/2014	Worksheet A Date/Time Pre 5/27/2015 3:3	pared:
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	·
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		40 (40 040	40 (40 04)	400 000	40 404 005	4 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	2, 018, 562	12, 619, 218 6, 359, 503	12, 619, 218 8, 378, 06		12, 496, 925 7, 620, 330	1. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	7, 468, 772	17, 298, 447	24, 767, 21		24, 100, 297	5.00
7. 00 00700 OPERATION OF PLANT	1, 478, 439	4, 427, 914	5, 906, 35		5, 951, 254	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	23, 868	324, 131	347, 99		348, 724	8. 00
9. 00 00900 HOUSEKEEPI NG	829, 027	644, 148			1, 498, 353	
10. 00 01000 DI ETARY	934, 933	1, 563, 630			732, 697	
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0 706, 347	0 104, 035	810, 38:	1, 645, 835 2 21, 452	1, 645, 835 831, 834	
14. 00 01400 CENTRAL SERVI CES & SUPPLY	454, 778	13, 235, 126			14, 372, 341	
15. 00 01500 PHARMACY	1, 889, 952	8, 190, 531	10, 080, 48		10, 137, 882	
16.00 01600 MEDICAL RECORDS & LIBRARY	558, 887	675, 962	1, 234, 84		1, 251, 822	16. 00
17. 00 01700 SOCI AL SERVI CE	509, 232	231, 257	740, 48	9 15, 466	755, 955	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	/ OF7 40/	722 204	4 700 00	720 242	7 520 225	20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	6, 057, 486 1, 781, 506	733, 396 196, 243	6, 790, 88: 1, 977, 74 ⁹		7, 529, 225 2, 109, 218	
41. 00 04100 SUBPROVI DER - RF	1, 119, 964	937, 966		·	2, 091, 944	
43. 00 04300 NURSERY	0	0	, ,	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	2, 172, 521	2, 172, 52	1 -37, 108	2, 135, 413	44. 00
ANCI LLARY SERVI CE COST CENTERS	4 500 050	/ 05/ 400	0.007.50	044 050	7 575 407	
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 530, 059	6, 856, 480	8, 386, 53	-811, 353 0	7, 575, 186 0	50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 535, 933	773, 137			2, 369, 817	
55. 00 05500 RADI OLOGY-THERAPEUTI C	359, 335	437, 555	796, 890		807, 719	
57. 00 05700 CT SCAN	222, 575	36, 043	258, 61		265, 378	57.00
57. 01 03630 ULTRA SOUND	149, 506	18, 290				
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	158, 205	29, 925	188, 130		192, 935	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	718, 031 2, 245, 828	305, 518 2, 719, 092	1, 023, 54 ¹ 4, 964, 92		1, 045, 390 5, 089, 722	59. 00 60. 00
60. 01 06000 LABORATORY	2, 243, 626	2, 719, 092 0	4, 904, 920) 124, 802	5, 069, 722	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	618, 456	618, 45	6 0	618, 456	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	923, 258	158, 699			1, 187, 359	
66. 00 06600 PHYSI CAL THERAPY	3, 578, 798	1, 400, 757	4, 979, 55	108, 691	5, 088, 246	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0	1		0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	601, 488	74, 185	675, 67	125, 634	801, 307	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 130, 572	1, 130, 57	2 0	1, 130, 572	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	074 05	0	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY	0	274, 350	274, 350		274, 350	74. 00 76. 00
76. 01 03140 CARDI AC REHAB	652, 759	129, 724	782, 48	19, 825		
76. 02 03070 WOMEN' S CENTER	318, 933	53, 970				
76. 03 03330 ENDOSCOPY	413, 800	61, 934	475, 73	12, 576	488, 310	76. 03
OUTPATIENT SERVICE COST CENTERS	1 107 5/7	FFF 7F0	1 (02 22)	- 14 505	1 (70 740	00.00
90. 00 09000 CLI NI C 90. 01 09001 OUTPATI ENT	1, 137, 567 340, 093	555, 758 433, 710				
91. 00 09100 EMERGENCY	1, 763, 858	682, 667	2, 446, 52			
91. 01 09101 SHORT STAY	0	0	(0	0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	FF (40	10 /71	/0.21	1 (00	71 000	05 00
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	55, 648	13, 671	69, 31	9 1, 690	71, 009	95.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	42, 537, 427	86, 478, 521	129, 015, 94	-53, 944	128, 962, 004	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	91, 677	157, 277			251, 739	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	20, 682, 100	12, 917, 575				
192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	158, 118 820, 966	11, 846 177, 072	169, 96, 998, 03		174, 766 1, 007, 675	
192. 03 19206 HOME HEALTH PARTNERSHIP	820, 966	177,072				192. 02
192. 04 19207 WESTFI ELD SCHOOLS	172, 076	37, 184	209, 26	1		
192. 05 19203 PRACTI CE MANAGEMENT	253, 190	-338, 984	-85, 79	7, 687	-78, 107	192. 05
192. 06 19204 MOB - NOBLESVILLE SQUARE	0	347, 489			347, 489	
192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	148, 958			148, 958	
193. 00 19300 NONPALD WORKERS 194. 00 07950 WORKMED		0				193. 00 194. 00
194. 01 07951 MEALS ON WHEELS	0	0		148, 425		
200. 00 TOTAL (SUM OF LINES 118-199)	64, 715, 554	99, 937, 007	164, 652, 56			
	· ·					

Provider CCN: 150059

| Peri od: | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 3:36 pm

			5/27/2015	5 3: 36 pm
Cost Center Description	(See A-8) F	Net Expenses for Allocation	0,2,720.6	у от риг
GENERAL SERVICE COST CENTERS	6.00	7. 00		
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT	-347	12, 496, 578		1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-34, 224	7, 586, 106		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-8, 177, 701	15, 922, 596		5. 00
7.00 OO700 OPERATION OF PLANT	-53, 498	5, 897, 756		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	348, 724		8. 00
9. 00 00900 HOUSEKEEPI NG	0	1, 498, 353		9. 00
10. 00 01000 DI ETARY	0	732, 697		10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	-626, 526 0	1, 019, 309 831, 834		11. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY		14, 372, 341		14. 00
15. 00 01500 PHARMACY	-3, 600	10, 134, 282		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-2, 335	1, 249, 487		16. 00
17. 00 01700 SOCIAL SERVICE	0	755, 955		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-554, 375	6, 974, 850		30. 00
31. 00 03100 INTENSI VE CARE UNI T	-35, 697	2, 073, 521		31.00
41. 00 04100 SUBPROVI DER - I RF	0	2, 091, 944		41.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	-125, 211	2, 010, 202		43. 00 44. 00
ANCILLARY SERVICE COST CENTERS	-125, 211	2,010,202		44.00
50. 00 05000 OPERATI NG ROOM	-2, 404, 715	5, 170, 471		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	О		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-455	2, 369, 362		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	807, 719		55. 00
57. 00 05700 CT SCAN	0	265, 378		57. 00
57. 01 03630 ULTRA SOUND	0	172, 336		57. 01
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	170 022	192, 935		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	-170, 833 -80, 254	874, 557 5, 009, 468		59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	-80, 234	0		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		618, 456		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	o	0		64. 00
65. 00 06500 RESPIRATORY THERAPY	-35, 697	1, 151, 662		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	5, 088, 246		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	801, 307		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 130, 572		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 130, 372		73. 00
74. 00 07400 RENAL DI ALYSI S	o	274, 350		74.00
76. 00 03020 OTHER ANCILLARY	o	0		76. 00
76. 01 03140 CARDI AC REHAB	0	802, 308		76. 01
76. 02 03070 WOMEN' S CENTER	-400	382, 189		76. 02
76. 03 03330 ENDOSCOPY	0	488, 310		76. 03
OUTPATIENT SERVICE COST CENTERS	120 202	1 550 250		00.00
90. 00 09000 CLI NI C 90. 01 09001 OUTPATI ENT	-128, 382 0	1, 550, 358 790, 132		90. 00
91. 00 09100 EMERGENCY		2, 520, 094		91. 00
91. 01 09101 SHORT STAY		0		91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1		92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95. 00 09500 AMBULANCE SERVI CES	-5, 096	65, 913		95. 00
SPECIAL PURPOSE COST CENTERS				
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-12, 439, 346	116, 522, 658		118. 00
NONREI MBURSABLE COST CENTERS		251 720		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	251, 739 33, 475, 057		190. 00 192. 00
192. 01 19201 FOUNDATION		174, 766		192. 00
192. 02 19202 CLI NI CS		1, 007, 675		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP		69		192. 03
192. 04 19207 WESTFIELD SCHOOLS		214, 486		192. 04
192.05 19203 PRACTICE MANAGEMENT	O	-78, 107		192. 05
192.06 19204 MOB - NOBLESVILLE SQUARE	0	347, 489		192. 06
192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	148, 958		192. 08
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 WORKMED 194.01 07951 MEALS ON WHEELS	0	140 425		194. 00 194. 01
200.00 TOTAL (SUM OF LINES 118-199)	-12, 439, 346	148, 425 152, 213, 215		200. 00
		.02,2.0,2.0		1200.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 5/27/2015 3:36 pm Provider CCN: 150059

					5/27/2015 3: 36	pm د
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	11. 00	615, 852	1, 029, 983		1.00
	0		615, 852	1, 029, 983		
	B - MEALS ON WHEELS					
1.00	MEALS ON WHEELS	194. 01	5 <u>5, 5</u> 39	<u>92, 8</u> 86		1.00
	0		55, 539	92, 886		
	C - INSURANCE RECLASS					
1.00	ADMI NI STRATI VE & GENERAL	500	0	12 <u>2, 2</u> 93		1.00
	0		0	122, 293		
	D - MED SUPPLY RECLASS					
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	483, 982		1.00
2.00	CARDIAC CATHETERIZATION	59. 00	0	34		2.00
3.00	ENDOSCOPY	76. 03	0	9		3.00
4.00	ENDOSCOPY					4.00
5.00						5.00
6.00		0.00	o	0		6.00
7.00		0.00	0	0		7.00
				484, 025		
	E - RSMA RECLASS	<u>'</u>	- 1			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	654, 638		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	171, 380	13, 264		2. 00
3.00	OPERATING ROOM	50.00	2, 562, 553	185, 707		3.00
		+-	2, 733, 933	853, 609		
	F - PHYSICIAN PROFESSIONAL FEE	FS	2,,00,,00	000,007		
1.00	ADULTS & PEDIATRICS	30.00	0	554, 375		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	ol	14, 100		2. 00
3.00	ELECTROCARDI OLOGY	69. 00	o	112, 500		3. 00
4. 00	EMERGENCY	91.00	o	20, 000		4. 00
5. 00	INTENSIVE CARE UNIT	31.00	Ö	77, 363		5. 00
6. 00	OPERATING ROOM	50.00	0	22, 750		6. 00
7. 00	LABORATORY	60.00	o	56, 595		7. 00
8. 00	RESPIRATORY THERAPY	I	0			8. 00
	1	65.00	-1	77, 363		
9.00	OUTPATIENT	90. 01	0	6, 000		9. 00
10. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	•	75, 000		10. 00
	U DONING DECLACE		0	1, 016, 046		
1.00	G - BONUS RECLASS ADMINISTRATIVE & GENERAL	5. 00	213, 488	13, 343		1. 00
2. 00	OPERATION OF PLANT	7. 00	42, 260	2, 641		2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	682	43		3. 00
	1					
4.00	HOUSEKEEPI NG DI ETARY	9.00	23, 697	1, 481		4. 00
5.00	l l	10.00	26, 724	1, 670		5. 00
6.00	NURSING ADMINISTRATION	13.00	20, 190	1, 262		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	12, 999	812		7. 00
8.00	PHARMACY	15.00	54, 023	3, 376		8. 00
9.00	MEDICAL RECORDS & LIBRARY	16.00	15, 975	998		9. 00
10.00	SOCI AL SERVI CE	17. 00	14, 556	910		10.00
11. 00	ADULTS & PEDIATRICS	30.00	173, 148	10, 822		11. 00
12. 00	INTENSIVE CARE UNIT	31.00	50, 923	3, 183		12. 00
13. 00	SUBPROVI DER - I RF	41. 00	32, 013	2, 001		13. 00
14. 00	OPERATING ROOM	50.00	4, 968	311		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	43, 903	2, 744		15. 00
16. 00	RADI OLOGY-THERAPEUTI C	55. 00	10, 271	642		16. 00
17. 00	CT SCAN	57. 00	6, 362	398		17. 00
18. 00	ULTRA SOUND	57. 01	4, 273	267		18. 00
19.00	MAGNETIC RESONANCE IMAGING	58. 00	4, 522	283		19. 00
	(MRI)					
20. 00	CARDI AC CATHETERI ZATI ON	59. 00	20, 524	1, 283		20. 00
21.00	LABORATORY	60.00	64, 195	4, 012		21. 00
22.00	RESPI RATORY THERAPY	65. 00	26, 390	1, 649		22. 00
23.00	PHYSI CAL THERAPY	66. 00	102, 297	6, 394		23. 00
24.00	ELECTROCARDI OLOGY	69. 00	17, 193	1, 075		24.00
25.00	CARDI AC REHAB	76. 01	18, 659	1, 166		25.00
26.00	WOMEN'S CENTER	76. 02	9, 116	570		26.00
27.00	ENDOSCOPY	76. 03	11, 828	739		27.00
28.00	CLINIC	90.00	32, 507	2, 032		28.00
29.00	OUTPATI ENT	90. 01	9, 721	608		29.00
30. 00	EMERGENCY	91.00	50, 418	3, 151		30. 00
31. 00	AMBULANCE SERVICES	95. 00	1, 591	99		31. 00
32. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	2, 621	164		32. 00
	CANTEEN	. ,	2, 52 1	.51		00
33. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	181, 511	11, 344		33. 00
34. 00	FOUNDATION	192. 01	4, 520	282		34. 00
35. 00	CLINICS	192. 02	9, 070	567		35. 00
36. 00	WESTFIELD SCHOOLS	192. 04	4, 919	307		36. 00
	1	.,2.01	., , , , ,	307	I	

Heal th	Financial Systems		RI VERVI EW	HOSPI TA	۸L			In Lie	u of Form CMS-2552-10
RECLASS	SIFICATIONS			Pr	rovi der	CCN:	150059	Period: From 01/01/2014	Worksheet A-6
								To 12/31/2014	Date/Time Prepared: 5/27/2015 3:36 pm
		Increases							
	Cost Center	Li ne #	Salary	Othe	er				

		Increases			
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	
37.00	PRACTI CE MANAGEMENT	192. 05	7, 235	452	37. 00
	TOTALS — — — — —		1, 329, 292	83, 081	
500.00	Grand Total: Increases		4, 734, 616	3, 681, 923	500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 5/27/2015 3:36 pm Provider CCN: 150059

					1	5/27/2015 3	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6. 00 A - CAFETERI A RECLASS	7. 00	8. 00	9. 00	10. 00		
1. 00	DI ETARY	10.00	615, 852	1, 029, 983	0		1.00
1.00	0		615, 852	1, 029, 983			1.00
	B - MEALS ON WHEELS		010, 002	1,027,700			
1.00	DI ETARY	10.00	55, 539	92, 886	0		1.00
	0		55, 539	92, 886			
	C - INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	122, 293	12		1. 00
	FIXT — — — —	+					
	O D - MED SUPPLY RECLASS		U	122, 293			
1. 00	SKILLED NURSING FACILITY	44.00	o	37, 108	O		1.00
2. 00	RADI OLOGY-THERAPEUTI C	55.00	Ö	84			2. 00
3.00	ELECTROCARDI OLOGY	69. 00	ol	5, 134			3. 00
4.00	CLINIC	90.00	o	49, 124			4. 00
5.00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	392, 473	0		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	2			6. 00
7.00	OPERATING ROOM	<u>50.</u> 00	•	100			7. 00
	0		0	484, 025			
1 00	E - RSMA RECLASS OPERATING ROOM	50.00	0	2 507 542	O		1 00
1. 00 2. 00	DERATTING ROOM	0.00	0	3, 587, 542 0	1		1. 00 2. 00
3. 00		0.00	Ö	0	0		3. 00
0.00				3, 587, 542	<u> </u>		0.00
	F - PHYSICIAN PROFESSIONAL FE	ES	- '	., ,			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 016, 046	0		1. 00
2.00		0. 00	0	0	0		2. 00
3.00		0. 00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5. 00		0.00	0	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0	0		6. 00 7. 00
8. 00		0.00	0	0	0		8. 00
9. 00		0.00	ő	0	0		9. 00
10.00		0.00	Ö	0	0		10. 00
	0			1, 016, 046			
	G - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 329, 292	83, 081	1		1. 00
2.00		0.00	0	0			2.00
3. 00 4. 00		0. 00 0. 00	0	0	0		3. 00 4. 00
5. 00		0.00	0	0	0		5. 00
6. 00		0.00	Ö	0	0		6. 00
7. 00		0.00	ō	0	0		7. 00
8.00		0.00	О	0	0		8. 00
9.00		0.00	0	0	0		9. 00
10.00		0.00	0	0			10. 00
11. 00		0.00	0	0	١		11.00
12.00		0.00	0	0			12.00
13. 00 14. 00		0. 00 0. 00	0	0			13. 00 14. 00
15. 00		0.00	0	0			15. 00
16. 00		0.00	o	0			16. 00
17. 00		0.00	ō	0			17. 00
18. 00		0.00	o	0			18. 00
19.00		0.00	O	0	0		19. 00
20.00		0.00	0	0	0		20. 00
21. 00		0. 00	0	0			21. 00
22. 00		0.00	0	0			22. 00
23. 00		0.00	0	0			23. 00
24. 00		0. 00 0. 00	0	0			24. 00
25. 00 26. 00		0.00	0	0			25. 00 26. 00
27. 00		0.00	0	0			27. 00
28. 00		0.00	o	0			28. 00
29. 00		0.00	o	0			29. 00
30. 00		0.00	Ö	0			30.00
31.00		0.00	o	0			31.00
32.00		0.00	О	0			32. 00
33. 00		0.00	0	0	1		33. 00
34.00		0.00	0	0			34.00
35. 00		0.00	0	0			35. 00
36. 00 37. 00		0. 00 0. 00	0	0			36. 00 37. 00
57.00	l	0.00	니 니		ı U		1 37.00

						 5/27/2015 3:3	36 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	TOTALS		1, 329, 292	83, 081			
500.00	Grand Total: Decreases		2, 000, 683	6, 415, 856			500.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 150059 Pe	eriod: Worksheet A-7

RECONC	ECONCILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2014 To 12/31/2014		pared:
				Acqui si ti ons	S		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 814, 610	6, 102, 774		0 6, 102, 774		1. 00
2.00	Land Improvements	2, 491, 524	133, 875		0 133, 875	0	2. 00
3.00	Buildings and Fixtures	101, 789, 134	11, 425, 517		0 11, 425, 517	9, 032, 886	3. 00
4.00	Building Improvements	0	0	1	0	0	4. 00
5.00	Fi xed Equipment	34, 518, 797	2, 470, 535		0 2, 470, 535	35, 775	5. 00
6.00	Movable Equipment	72, 517, 731	8, 068, 751		0 8, 068, 751	18, 218, 382	6. 00
7.00	HIT designated Assets	0	0)	0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	221, 131, 796	28, 201, 452		0 28, 201, 452	27, 287, 043	8. 00
9.00	Reconciling Items	O	0)	0 0	0	9. 00
10.00	Total (line 8 minus line 9)	221, 131, 796	28, 201, 452		0 28, 201, 452	27, 287, 043	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	15, 917, 384	0)			1. 00
2.00	Land Improvements	2, 625, 399	0				2. 00
3.00	Buildings and Fixtures	104, 181, 765	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	36, 953, 557	0				5. 00
6.00	Movable Equipment	62, 368, 100	0)			6. 00
7.00	HIT designated Assets	O	0				7. 00
8.00	Subtotal (sum of lines 1-7)	222, 046, 205	O)			8. 00
9.00	Reconciling Items	О	0				9. 00
10.00	Total (line 8 minus line 9)	222, 046, 205	0				10. 00

Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7		
				From 01/01/2014 To 12/31/2014		nared:	
				10 12/31/2014	5/27/2015 3:3		
		Sl	IMMARY OF CAPI	TAL			
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
	·			instructions)	instructions)		
	9. 00	10.00	11. 00	12.00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00 NEW CAP REL COSTS-BLDG & FLXT	10, 462, 802	0	1, 882, 42	0 273, 996	0	1. 00	
3.00 Total (sum of lines 1-2)	10, 462, 802	0	1, 882, 42	0 273, 996	0	3. 00	
	SUMMARY OF	F CAPITAL					
Cost Center Description	Other	Total (1) (sum					
	Capi tal -Rel ate	of cols. 9					
	d Costs (see	through 14)					
	instructions)						
	14. 00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	12, 619, 218				1. 00	
3.00 Total (sum of lines 1-2)	0	12, 619, 218				3. 00	

Health Financial	Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-255			
RECONCILIATION OF	CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 Fo 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/27/2015 3:36	pared:	
		COME	PUTATION OF RAT	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		
	RECONCILIATION OF CAPITAL COSTS CE	ENTERS		Г				
	L COSTS-BLDG & FLXT	0	0		1.000000	0	1. 00 3. 00	
3.00 Total (sum	of lines 1-2)	ALLOCA	O O O 1.000000 O ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost	Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6, 00	7.00	8.00	9. 00	10.00		
PART III -	RECONCILIATION OF CAPITAL COSTS CE	ENTERS						
1.00 NEW CAP RE	L COSTS-BLDG & FLXT	0	0		10, 462, 802	0	1.00	
3.00 Total (sum	of lines 1-2)	0	0		10, 462, 802	0	3. 00	
			SL	JMMARY OF CAPI	TAL			
Cost	Center Description	Interest	Insurance (see instructions)	,	Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11. 00	12. 00	13. 00	14. 00	15. 00		
	RECONCILIATION OF CAPITAL COSTS CE							
	L COSTS-BLDG & FIXT of lines 1–2)	1, 882, 073 1, 882, 073			0 0	12, 496, 578 12, 496, 578		

Health Financial Systems
ADJUSTMENTS TO EXPENSES

				T	o 12/31/2014		
				Expense Classification on To/From Which the Amount is		5/27/2015 3: 3	o pm
	Cost Center Description	Basi s/Code (2)	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - NEW CAP		0	NEW CAP REL COSTS-BLDG &	1.00		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		0		0. 00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0. 00	О	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 21)		J		0.00		7,00
8. 00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	О	
10. 00	Provider-based physician adjustment	A-8-2	-2, 151, 264			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-376, 080			О	12. 00
13. 00	Laundry and linen service		0 (0)	OAFETER! A	0.00		
	Cafeteria-employees and guests Rental of quarters to employee		-626, 526 0	CAFETERI A	11. 00 0. 00	0	
16. 00	and others Sale of medical and surgical		0		0.00	О	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	О	18. 00
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vendi ng machi nes		0		0. 00	0	
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	О	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 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 -		0	*** Cost Center Deleted ***	114. 00		25. 00
04.00	physicians' compensation (chapter 21)			NEW OAR REL COOTS RIDG A	4.00		
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2. 00	0	27. 00
1	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00
	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) 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 Depreciation and Interest		0		0.00	О	32. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150059 Peri od: Worksheet A-8 From 01/01/2014
To 12/31/2014 Date/Time Prepared:

					12/31/2014	Date/lime Pre	
				Expense Classification on	Worksheet A	372772013 3.3	о ріп
				To/From Which the Amount is			
		D 1 (0 1 (0)					
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
33. 00	OTHER REVENUES ->HOSPITAL	1. 00 B	2.00	3.00 ADMI NI STRATI VE & GENERAL	4. 00 5. 00	5. 00	33. 00
33.00	OUTPATIENT	В	-2,810	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33. 01	OTHER REV MEDICAL REPORT	В	_2 335	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 01
33. 02	OTHER REV RADIOLOGY FILM	B	•	RADI OLOGY-DI AGNOSTI C	54.00		
33. 03	OTHER REVENUES-OTHER	B		ADMINISTRATIVE & GENERAL	5. 00		33. 03
00.00	REV-FI TNESS		1, 100	TRANSPORT VE & GENERALE	0.00	Ĭ	00.00
33. 04	OTHER REVENUES ->PURCHASE	В	-17, 686	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
	DI SCOUNTS						
33. 05	OTHER REV ->VHA DIVIDENDS:	В	-55, 850	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
	OTHER						
33. 06	EDUCATION OTHER REVENUE	В	-550	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 06
33. 07	NON-OP EXPENSE INVESTMENT FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	EMPLOYEE HEALTH/INF CONT -	В	-2, 358	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 08
	OTHER REV	_				_	
33. 09	PHARMACY -> OTHER REVENUE	В	•	PHARMACY	15. 00		33. 09
34. 00	RADI OLOGY-OTHER REVENUE-CDS	В	-420	RADI OLOGY-DI AGNOSTI C	54.00	0	34. 00
27 00	FOR LEGA	D	F 00/	AMBUL ANCE CEDVI CEC	05.00		27.00
36. 00	AMBULANCE ->OTHER REVENUE	В	•	AMBULANCE SERVICES	95.00		36.00
38. 00 39. 00	LABORATORY -> OTHER REVENUE EMPLOYEE WELLNESS- OTHER	B B	•	LABORATORY EMPLOYEE BENEFITS DEPARTMENT	60. 00 4. 00		38. 00 39. 00
39.00	REVENUE	D	-17, 440	EMPLOTEE BENEFITS DEPARTMENT	4.00	0	39.00
40. 00	PR/MARKETING- OTHER REVENUE	В	-1 735	ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
41. 00	PHYSICIAN BILLING -> OTHER	В	•	ADMINISTRATIVE & GENERAL	5. 00		41. 00
11.00	REVENUE		000	TRANSPORT VE & GENERALE	0.00	Ĭ	11.00
42. 00	205 CONNER STREET- > RENTAL	В	-21.072	ADMINISTRATIVE & GENERAL	5. 00	0	42. 00
	INCOME		•				
44.00	MISCELLANEOUS INTEREST INCOME	В	-39, 887	ADMINISTRATIVE & GENERAL	5. 00	0	44.00
45. 01	INTEREST INCOME - BOND FUNDS	В	-347	NEW CAP REL COSTS-BLDG &	1.00	11	45. 01
				FIXT			
45. 03	RENTAL INCOME - TCU	В		SKILLED NURSING FACILITY	44.00	0	
45. 06	COMMUNITY RELATIONS	A		ADMINISTRATIVE & GENERAL	5. 00		45. 06
45. 07	COMMUNITY RELATIONS BENEFITS	A	•	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 07
45. 08	CRNA	A	-675, 000	OPERATING ROOM	50.00	0	45. 08
45. 10	PHYSICIAN RECRUITMENT	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	45. 10
45. 11	THA LOBBYING EXPENSE	A	•	ADMINISTRATIVE & GENERAL	5. 00		45. 11
45. 12	HAF EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00		45. 12
45. 13	ENGINEERING - ENERGY REBATES	В		OPERATION OF PLANT	7. 00		45. 13
45. 14	SCHOOL FITNESS CONTRACT -	В	-126, 299	CLINIC	90. 00	0	45. 14
	OTHER REV						
45. 15	COMM HEALTH CLINIC - OTHER	В	-2, 083	CLINIC	90. 00	0	45. 15
/E 1/	GRANT REV	D D	105	EMDLOVEE DENEELTS DEDARTMENT	4 00		1E 14
45. 16	HUMAN RESOURCES-OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00		
45. 18	OTHER REVENUES-DONATED EQUI PMENT	A	-218,841	ADMINISTRATIVE & GENERAL	5. 00	0	45. 18
45. 19	ENGINEERING - OTHER REVENUE	В	10 570	OPERATION OF PLANT	7. 00	0	45. 19
45. 19 45. 20	WOMEN'S CTR> -OTHER	B B	•	WOMEN'S CENTER	7. 00 76. 02		45. 19
45. 20	REVENUE-SILVER R	ا	-400	WOWLIN 3 CLINIER	70.02		45.20
50. 00	TOTAL (sum of lines 1 thru 49)		-12, 439, 346				50. 00
55. 66	(Transfer to Worksheet A,		12, 437, 340				00.00
	column 6, line 200.)						
(4) 5							

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).
- 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.

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.

3.00

4.00

5.00

0

3, 981, 977

0

3, 605, 897

·			Related Organization(s) and/or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	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:

0.00

- 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.
- 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

3.00

4.00

5.00

Heal th	Financial Syste	ems	RI VERVI EW HOSPI TAL					In Lieu of Form CMS-2552-1			
	ENT OF COSTS OF	SERVICES FROM	RELATED ORG	ANIZATIONS AND	HOME	Provi der	CCN:	150059	Peri od: From 01/01/201	Worksheet A-	8-1
OFFICE	C0515								To 12/31/201		epared: 36 pm
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REQUIR	ED AS A RESULT	T OF TRANS	SACTIONS W	/ITH R	ELATED (ORGANIZATIONS OR	CLAIMED	
	HOME OFFICE CO	STS:									
1.00	-376, 080	0									1.00
2.00	0	0									2.00
3.00	0	0									3.00
4.00	0	0									4.00
5.00	-376, 080	-									5. 00
* The	amounts on line	es 1-4 (and sub	scripts as a	appropriate) a	are transf	erred in	detai l	to Wor	ksheet A, columi	n 6, lines as	•
									ganization or ho		whi ch
has not	been posted to	o Worksheet A,	col umns 1 ar	nd/or 2, the a	amount all	owable sh	oul d l	oe indic	ated in column 4	4 of this part.	
	Related Orga	ani zati on(s)								•	

nas not	been posted to norrestice n,	cordinate transfer 2, the dispart arrowable should be that cated the cordinate terms part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
В	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	
TI C			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		6. 00
7.00		7. 00
8.00		8. 00 9. 00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

							Го 12/31/2014	Date/Time Pro 5/27/2015 3:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi ona	I Prov	i der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Compo	nent		ider Component	
				'	· ·			Hours	
	1. 00	2. 00	3. 00	4.00	5.	00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	1, 027	1, 0	27	0	177, 200	0	1. 00
2.00	50.00 OPERATING ROOM		1, 353, 635	1, 353, 6	35	0	208, 000	0	2. 00
3.00	59. 00 CARDI AC CATHETERI ZATI ON		170, 833		33	0	225, 300	0	3. 00
4.00	30.00 ADULTS & PEDIATRICS		554, 375	554, 3	75	0	208, 000	0	4. 00
5.00	31.00 INTENSIVE CARE UNIT		35, 697	35, 6	97	0	177, 200	0	5. 00
6.00	65. 00 RESPI RATORY THERAPY		35, 697	35, 6	97	0	177, 200	0	6. 00
7.00	0. 00		0		0	0	0	0	7. 00
8.00	0. 00		0		0	0	0	0	8. 00
9. 00	0. 00		0		0	0	0	0	9. 00
10.00	0. 00		0		0	0	0	0	10.00
200.00			2, 151, 264			0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE				Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted R			Component	of Malpractice	
				Limit	Conti		Share of col.	Insurance	
					Educa		12		
	1. 00	2.00	8. 00	9. 00	12.		13.00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0	1	0	0			
2.00	50. 00 OPERATI NG ROOM		0	1	0	0	0		
3.00	59. 00 CARDI AC CATHETERI ZATI ON		0		0	0	0	0	0.00
4.00	30. 00 ADULTS & PEDIATRICS		0		0	0	0	0	
5.00	31. 00 I NTENSI VE CARE UNI T		0		0	0	0	0	0.00
6.00	65. 00 RESPI RATORY THERAPY		0		0	0	0	0	0.00
7.00	0.00		0		0	0	0	0	7. 00
8.00	0.00		0		0	0	0	0	8. 00
9.00	0.00		0		0	0	0	0	7.00
10.00	0. 00		0		0	0	0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RC	E RO	<u> </u>	Adjustment	0	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Disall		Adjustment		
		ruentifiei	Share of col.	LIIIII	DI Sai i	owance			
			14						
	1. 00	2.00	15. 00	16. 00	17.	00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	0		0	0			1. 00
2.00		OPERATING ROOM	0		0	0	1, 353, 635		2. 00
3.00	59. 00	CARDIAC CATHETERIZATION	0		0	0	170, 833		3. 00
4.00	30.00	ADULTS & PEDIATRICS	0		0	0	554, 375		4. 00
5.00	31.00	INTENSIVE CARE UNIT	0		0	0	35, 697		5. 00
6.00	65. 00	RESPI RATORY THERAPY	0		0	0	35, 697		6. 00
7.00	0. 00		0		0	0	0		7. 00
8.00	0. 00		0		O	0	0		8. 00
9.00	0. 00		0		O	0	0		9. 00
10.00	0.00		0		0	0	0		10.00
200.00			0		0	0	2, 151, 264		200.00

| Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150059

			pared:
CAPITAL		5/27/2015 3: 36	o piii
Cost Center Description Net Expenses NEW BLDG & EMPLOYEE Subt	total	ADMI NI STRATI VE	
for Cost FIXT BENEFITS	totai	& GENERAL	
Allocation DEPARTMENT			
(from Wkst A col. 7)			
0 1.00 4.00	4A	5. 00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 12,496,578 12,496,578			1. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 7,586,106 62,261 7,648,367			4. 00
	837, 948	17, 837, 948	5. 00
7. 00 00700 OPERATI ON OF PLANT 5, 897, 756 4, 578, 368 174, 219 10, 8. 00 00800 LAUNDRY & LI NEN SERVI CE 348, 724 50, 251 2, 813	650, 343 401, 788	1, 413, 301 53, 317	7. 00 8. 00
	627, 734	216, 000	9. 00
10. 00 01000 DI ETARY 732, 697 76, 862 33, 254	842, 813	111, 841	10.00
11. 00 01100 CAFETERI A 1, 019, 309 156, 085 70, 555 1, 13. 00 01300 NURSI NG ADMI NI STRATI ON 831, 834 0 83, 236	245, 949 915, 070	165, 337 121, 430	11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 14, 372, 341 94, 585 73, 225 14,	540, 151	1, 929, 478	14. 00
	507, 568	1, 394, 354	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 1, 249, 487 78, 385 65, 859 1, 17. 00 01700 SOCI AL SERVI CE 755, 955 41, 719 60, 008	393, 731 857, 682	184, 948 113, 814	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0077 002	1107011	00
	630, 902 649, 607	1, 278, 021	30. 00 31. 00
	564, 504	351, 603 340, 310	41. 00
43. 00 04300 NURSERY 0 0 0	0	0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY 2, 010, 202 235, 004 0 2, ANCI LLARY SERVI CE COST CENTERS	245, 206	297, 939	44. 00
	360, 080	843, 983	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0	0	0	52. 00
	868, 138 030, 372	380, 602 136, 730	54. 00 55. 00
57. 00 05700 CT SCAN 265, 378 0 26, 228	291, 606	38, 696	57. 00
57. 01 03630 ULTRA SOUND 172, 336 0 17, 618	189, 954	25, 207	57. 01
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 192, 935 0 18, 643 59. 00 05900 CARDIAC CATHETERIZATION 874, 557 73, 104 84, 613 1,	211, 578 032, 274	28, 076 136, 983	58. 00 59. 00
	586, 235	741, 293	60.00
60. 01 06001 BLOOD LABORATORY	0	0	60. 01
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 618, 456 95, 779 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	714, 235	94, 779 0	63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY 1, 151, 662 46, 823 108, 796 1,	307, 281	173, 476	65. 00
	509, 971	731, 173	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	0	67. 00 68. 00
	144, 160	151, 830	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 130, 572	0 150, 027	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0	0	150, 027	73. 00
74. 00 07400 RENAL DI ALYSI S 274, 350 13, 483 0	287, 833	38, 195	
76. 00 03020 OTHER ANCI LLARY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 879, 229	0 116, 674	
76. 02 03070 WOMEN' S CENTER 382, 189 206, 615 37, 583	626, 387	83, 122	76. 02
76. 03 03330 ENDOSCOPY 488, 310 64, 242 48, 762	601, 314	79, 794	76. 03
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 1,550,358 0 134,050 1,	684, 408	223, 521	90. 00
90. 01 09001 0UTPATI ENT 790, 132 87, 501 40, 076	917, 709	121, 780	90. 01
91. 00 09100 EMERGENCY 2,520,094 406,832 207,853 3, 91. 01 09101 SHORT STAY 0 0 0	134, 779	415, 985 0	91. 00 91. 01
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0	O	92. 00
OTHER REIMBURSABLE COST CENTERS			
95. 00 09500 AMBULANCE SERVI CES 65, 913 0 6, 558 SPECI AL PURPOSE COST CENTERS	72, 471	9, 617	95. 00
	491, 582	12, 693, 236	118. 00
NONREI MBURSABLE COST CENTERS	700	50 707	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 251, 739 120, 257 10, 803 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 33, 475, 057 257, 856 2, 390, 221 36,	382, 799 123, 134	50, 797 4, 793, 486	
192. 01 19201 FOUNDATI ON 174, 766 81, 737 18, 633	275, 136	36, 511	
	102, 768	146, 337	
192. 03 19206 HOME HEALTH PARTNERSHI P 69 0 0 192. 04 19207 WESTFI ELD SCHOOLS 214, 486 0 20, 277	69 234, 763	9 31, 153	192. 03 192. 04
192. 05 19203 PRACTI CE MANAGEMENT -78, 107 0 29, 836	-48, 271	0	192. 05
192. 06 19204 MOB - NOBLESVI LLE SQUARE 347, 489 0 0 192. 08 19205 RI VERVI EW MEDI CAL ARTS 148, 958 0 0	347, 489 148, 958	46, 112 19, 767	
192. 08 19205 REVERVIEW MEDICAL ARTS 148, 958 0 0 0 193. 00 193. 00 1930 NONPALD WORKERS 0 0 0	140, 958		192. 08 193. 00
194. 00 07950 WORKMED 0 0 0	o	0	194. 00
194. 01 07951 MEALS ON WHEELS 148, 425 0 6, 363	154, 788	20, 540	194. 01

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014		nared·
				12/01/2011	5/27/2015 3:3	
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	for Cost	FLXT	BENEFITS		& GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1. 00	4.00	4A	5. 00	
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118-201)	152, 213, 215	12, 496, 578	7, 648, 36	7 152, 213, 215	17, 837, 948	202. 00

Provi der CCN: 150059

					To	12/31/2014	Date/Time Pre 5/27/2015 3:3	
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, piii
			PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	11.00	
		AL SERVICE COST CENTERS						
1. 00 4. 00	1	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5.00		ADMINISTRATIVE & GENERAL						5.00
7. 00		OPERATION OF PLANT	12, 063, 644					7. 00
8.00		LAUNDRY & LINEN SERVICE	88, 878		1			8. 00
9.00	1	HOUSEKEEPI NG	56, 048		,	1 004 402		9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	135, 944 276, 064	0		1, 094, 483 0	1, 741, 740	10. 00 11. 00
13. 00		NURSI NG ADMI NI STRATI ON	0	Ö		0	27, 739	
14.00		CENTRAL SERVICES & SUPPLY	167, 291	4, 089	0	0	48, 206	14. 00
15.00	1	PHARMACY	266, 318	0		0	85, 098	1
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	138, 638 73, 788	0		0	52, 031 19, 425	1
17.00		I ENT ROUTINE SERVICE COST CENTERS	70,700		<u> </u>		17, 120	17.00
30. 00	1	ADULTS & PEDIATRICS	3, 435, 194			535, 631	382, 753	1
31.00		INTENSIVE CARE UNIT SUBPROVIDER - IRF	647, 608			77, 323	98, 464	1
41. 00 43. 00		NURSERY	602, 383	42, 501 0	1	258, 734 0	73, 512 0	1
44. 00		SKILLED NURSING FACILITY	415, 645	39, 453		222, 795	ő	
	_	LARY SERVICE COST CENTERS						
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	1, 273, 748	28, 532 0	·	0	155, 219 0	1
54. 00		RADI OLOGY-DI AGNOSTI C	562, 053	31, 855		0	80, 536	
55. 00	05500	RADI OLOGY-THERAPEUTI C	318, 909	4, 401		0	21, 273	1
57. 00	1	CT_SCAN	0	0	1	0	12, 013	
57. 01 58. 00		ULTRA SOUND MAGNETIC RESONANCE IMAGING (MRI)	0	0	0 1, 943	0	4, 537 9, 166	1
59. 00	1	CARDI AC CATHETERI ZATI ON	129, 297	14, 036		0	36, 708	1
60.00	06000	LABORATORY	552, 038	0	67, 988	0	151, 829	60. 00
60. 01		BLOOD LABORATORY	0	0	_	0	0	
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	169, 402	0	0	0	0	
65. 00	1	RESPI RATORY THERAPY	82, 815	Ö	_	0	52, 223	1
66. 00	06600	PHYSI CAL THERAPY	0	4, 587		0	132, 022	
67. 00	1	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	481, 035	4, 669	67, 988	0	0 34, 810	68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	461, 033	4, 009	07, 488	0	34,810	1
72. 00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	1
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74. 00 76. 00		RENAL DIALYSIS OTHER ANCILLARY	23, 847	0	0	0	0	
76. 01		CARDI AC REHAB	0	401	_	0	34, 529	
76. 02		WOMEN'S CENTER	365, 436			0	25, 275	1
76. 03	-	ENDOSCOPY TIENT SERVICE COST CENTERS	113, 623	24, 265	0	0	23, 897	76. 03
90. 00		CLINIC	0	736	0	0	34, 453	90.00
90. 01	1	OUTPATI ENT	154, 761	14, 779		0	21, 928	90. 01
91.00		EMERGENCY	719, 554	73, 427	1	0	92, 735	
91. 01 92. 00	1	SHORT STAY OBSERVATION BEDS (NON-DISTINCT PART)	O	0	0	0	0	91. 01 92. 00
72.00		REIMBURSABLE COST CENTERS						72.00
95. 00	09500	AMBULANCE SERVICES	0	0	0	0	4, 673	95. 00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	11, 250, 317	500, 702	1, 752, 151	1, 094, 483	1, 715, 054	110 00
110.00		IMBURSABLE COST CENTERS	11, 250, 317	500, 702	[1, 752, 151]	1, 094, 463	1, 715, 054	1116.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212, 696			0		190. 00
		PHYSICIANS' PRIVATE OFFICES	456, 065		102, 953	0		192.00
		FOUNDATION CLINICS	144, 566	193	38, 850	0	11, 205	192. 01 192. 02
	1	HOME HEALTH PARTNERSHIP	0	0		0		192. 02
		WESTFIELD SCHOOLS	0	0	0	0	0	192. 04
		PRACTI CE MANAGEMENT	0	178	1	0		192. 05
		MOB - NOBLESVILLE SQUARE RIVERVIEW MEDICAL ARTS	0	0	0	0		192. 06 192. 08
		NONPAID WORKERS		0		0		193. 00
194.00	07950	WORKMED	0	0	O	0	0	194. 00
		MEALS ON WHEELS	0	0	0	0	7, 034	194. 01
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers	0	<u> </u>	0	Ω	n	200. 00 201. 00
202.00	1	TOTAL (sum lines 118-201)	12, 063, 644	543, 983	1, 899, 782	1, 094, 483	l .	
			·		"			

Provider CCN: 150059

			T	0 12/31/2014	Date/Time Prep 5/27/2015 3:30	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	5 p
	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
	13. 00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 066, 182	47 700 045				13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	16, 689, 215 0	12, 301, 901			14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY		0	12, 301, 301	1, 779, 061		16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	1, 064, 709	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(20, 200			F00 000	004 054	00.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	630, 282 162, 141	0	0	593, 020 104, 140	831, 354 65, 043	30. 00 31. 00
41. 00 04100 SUBPROVI DER - RF	121, 052	0	0	104, 140	91, 061	41. 00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44. 00 04400 SKILLED NURSING FACILITY	0	0	0	2, 893	77, 251	44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	0	O	0	613, 271	0	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0	0	013, 271	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	O	0	11, 571	0	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	23, 142	0	55.00
57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND	0	0	0	0	0	57. 00 57. 01
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	Ö	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	31, 821	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	63. 00 64. 00
65. 00 06500 RESPIRATORY THERAPY	0	Ö	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	170, 674	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	0	63, 641	0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16, 689, 215	0	03, 041	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	12, 301, 901	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY	0	0	0	0	0	74. 00 76. 00
76. 00 03020 OTHER ANCITELARY 76. 01 03140 CARDI AC REHAB		0	0	0	0	76. 00 76. 01
76. 02 03070 WOMEN' S CENTER	0	0	0	0	0	76. 02
76. 03 03330 ENDOSCOPY	0	0	0	0	0	76. 03
90. 00 O9000 CLINIC		٥	0	0	0	90. 00
90. 01 09001 0UTPATI ENT		0	0	0	0	90. 00
91. 00 09100 EMERGENCY	152, 707	0	0	153, 317	0	91.00
91. 01 09101 SHORT STAY	0	0	0	0	0	91. 01
92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS		- 1				
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 066, 182	16, 689, 215	12, 301, 901	1, 767, 490	1, 064, 709	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		0	0	0		192. 00
192. 01 19201 FOUNDATI ON	0	0	0	0	0	192. 01
192. 02 19202 CLI NI CS	0	0	0	11, 571		192. 02
192.03 19206 HOME HEALTH PARTNERSHIP 192.04 19207 WESTFIELD SCHOOLS	0	0	0	0		192. 03 192. 04
192.05 19203 PRACTICE MANAGEMENT	0	0	0	0		192. 04
192. 06 19204 MOB - NOBLESVILLE SQUARE		Ö	0	Ö		192. 06
192.08 19205 RIVERVIEW MEDICAL ARTS		O	0	0		192. 08
193. 00 19300 NONPALD WORKERS 194. 00 07950 WORKMED	0	0	0	0		193. 00 194. 00
194.00 07950 WORKMED 194.01 07951 MEALS ON WHEELS		0	0	0		194. 00 194. 01
200.00 Cross Foot Adjustments		Ĭ	0	J		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	1, 066, 182	16, 689, 215	12, 301, 901	1, 779, 061	1, 064, 709	202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015 3:36 pm	Provi der CCN: 150059

			'`	5/27/2015 3:	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS		,			
1.00 O0100 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					7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCIAL SERVICE					17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	40.005.470		10 005 (70		
30. 00 03000 ADULTS & PEDI ATRI CS	18, 095, 673	0	18, 095, 673		30.00
31. 00 03100 INTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - IRF	4, 290, 862 4, 216, 436	0	4, 290, 862		31. 00 41. 00
43. 00 04300 NURSERY	4, 210, 430	o	4, 216, 436 0		43.00
44. 00 04400 SKI LLED NURSING FACILITY	3, 409, 963	0	3, 409, 963		44. 00
ANCILLARY SERVICE COST CENTERS	0, 10,, 700	<u> </u>	07 1077 700		
50. 00 05000 OPERATI NG ROOM	9, 511, 820	0	9, 511, 820		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0	0		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 965, 835	0	3, 965, 835		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 544, 540	0	1, 544, 540		55. 00
57. 00 05700 CT SCAN	342, 315	0	342, 315		57. 00
57.01 03630 ULTRA SOUND 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	219, 698	0	219, 698		57. 01
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	250, 763 1, 349, 298	ol Ol	250, 763 1, 349, 298		58. 00 59. 00
60. 00 06000 LABORATORY	7, 131, 204		7, 131, 204		60.00
60. 01 06001 BLOOD LABORATORY	7, 131, 204	o	7, 131, 204		60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	978, 416	Ö	978, 416		63.00
64.00 06400 INTRAVENOUS THERAPY	O	0	0		64.00
65. 00 06500 RESPI RATORY THERAPY	1, 621, 623	0	1, 621, 623		65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 556, 197	0	6, 556, 197		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0 1 040 122	0	1 040 122		68. 00
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 948, 133 16, 689, 215	0	1, 948, 133 16, 689, 215		69. 00 71. 00
72. 00 07100 IMPL. DEV. CHARGED TO PATTENTS	1, 280, 599	o	1, 280, 599		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	12, 301, 901	0	12, 301, 901		73. 00
74. 00 07400 RENAL DI ALYSI S	349, 875	Ö	349, 875		74. 00
76.00 03020 OTHER ANCILLARY	o	0	0		76. 00
76. 01 03140 CARDI AC REHAB	1, 069, 683	0	1, 069, 683		76. 01
76. 02 03070 WOMEN' S CENTER	1, 145, 668	0	1, 145, 668		76. 02
76. 03 03330 ENDOSCOPY	842, 893	0	842, 893		76. 03
90. 00 OOOOO CLINIC	1 042 110	ما	1 042 110		
90. 00 09000 CLI NI C 90. 01 09001 0UTPATI ENT	1, 943, 118 1, 254, 267	0	1, 943, 118 1, 254, 267		90. 00 90. 01
91. 00 09100 EMERGENCY	4, 907, 618	ol Ol	4, 907, 618		91.00
91. 01 09101 SHORT STAY	4, 707, 010	o	4, 907, 010		91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		o	J		92.00
OTHER REIMBURSABLE COST CENTERS		-1			
95. 00 09500 AMBULANCE SERVICES	86, 761	0	86, 761		95. 00
SPECIAL PURPOSE COST CENTERS	,				
118.00 SUBTOTALS (SUM OF LINES 1-117)	107, 304, 374	0	107, 304, 374		118. 00
NONREI MBURSABLE COST CENTERS			//0.5/7		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	660, 567	0	660, 567		190. 00 192. 00
192. 00 19200 PHTSTCTAINS PREVAILE OFFICES	41, 518, 548 467, 418	0	41, 518, 548 467, 418		192. 00
192. 02 19202 CLI NI CS	1, 299, 719	0	1, 299, 719		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	78	ő	78		192. 02
192. 04 19207 WESTFIELD SCHOOLS	265, 916	ő	265, 916		192. 04
192.05 19203 PRACTICE MANAGEMENT	-48, 093	o	-48, 093		192. 05
192.06 19204 MOB - NOBLESVILLE SQUARE	393, 601	o	393, 601		192. 06
192.08 19205 RIVERVIEW MEDICAL ARTS	168, 725	O	168, 725		192. 08
193. 00 19300 NONPAI D WORKERS	0	0	0		193. 00
194. 00 07950 WORKMED	100 340	0	100 340		194. 00
194.01 07951 MEALS ON WHEELS 200.00 Cross Foot Adjustments	182, 362	0	182, 362		194. 01 200. 00
201.00 Negative Cost Centers	0	0	0		200.00
	<u>,</u> 9	<u> </u>	0		1-01.00

Heal th Finar	ncial Systems	RI VERVI EW	RI VERVI EW HOSPI TAL			In Lieu of Form CMS-2552-1		
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der		Peri od: From 01/01/2014 To 12/31/2014			
	Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments					
		24. 00	25. 00	26.00				
202. 00	TOTAL (sum lines 118-201)	152, 213, 215	0	152, 213, 21	15		202.00	

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150059

Cost Center Description						To	12/31/2014	Date/Time Prep 5/27/2015 3:30	
Control Cont									•
CERNARUL SERVICE COST CENTERS			Cost Center Description	Di rectly		Subtotal	EMPLOYEE	ADMI NI STRATI VE	
					FLXT			& GENERAL	
CHERAN SERVICE COST CENTERS 1 0 0 00000 10 000000 10 000000 10 000000 10 000000 10 000000 10 000000 10 000000 10 000000 10 000000 10 000000 10 000000 10 0000000 10 00000000				Related Costs					
1.00		GENER	AL SERVICE COST CENTERS	0	1.00	2A	4. 00	5. 00	
5.00 DIOSCOL ARMINI STRATT HY A CEMBEAL 0 1, 035, 234 7, 168 1, 025, 244 7, 168 1, 024, 207 7, 00 8 00 DOSCOL (LARMORY & LINETY SERVICE) 0 4, 577, 306 4, 577, 308 1, 235 3, 116 8, 00 10 0 DOSCOL (LARMORY & LINETY SERVICE) 0 7, 602 7,	1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						
7,00 00 00000 [PRANTIO IO PLANT 0 4,578, 368 1,199 22,503 7,00 00 000000 [BUSSEEP] MIG 0 50,251 52,51 23,311 8,00 0, 00 000000 [BUSSEEP] MIG 0 7,00 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				1 042 402	
B.DO DOBODO LAIMBREY & LITHEN STRVICE			•						
10.00 01000 DIETARY	8.00			0		50, 251	23	3, 116	8. 00
11.00 01100 CAFETERIA				0					
13.00 01300 MIRSING AGMINISTIATION 0 0 678 7,096 12,797 14.00 13.00 01300 PIRASANCY 0 70,858 70,858 50,60 112,797 14.00 13.00 01300 PIRASANCY 0 70,858 70,858 10,808 16.00 16.				0					
15.00 01500 HABMACY 0 150.775 105.775 1.814 81.486 15.00 10.00 1	13.00	01300	NURSING ADMINISTRATION	0	0	0		7, 096	
16.00 16:00 MEDICAL RECORDS & LIBRARY 0 78,385 78,385 536 10,808 16.00				0		·			
IMPAIL ENT ROUTINE SERVICE COST CENTERS 1, 942, 239 1, 942, 239 1, 942, 239 1, 942, 239 3, 913 0, 90 300, 00 3000 QUITS & PEDIA TRICS S 0 1, 942, 239 1, 942, 239 1, 942, 239 3, 913 0, 943 31, 00 310, 00 310, 00 340, 584 340,				0					
30.00	17. 00			0	41, 719	41, 719	489	6, 651	17. 00
31.00 03100 INTERSIVE CARE UNIT 0 366, 154 340, 556 1,775 19,888 41 00 041	30.00			1 0	1 942 239	1 0/12 239	5 813	74 688	30 00
43.00 0300 NURSERY 0 235,004 0 17,412 44.00		03100	INTENSIVE CARE UNIT	0					
44.00 0400 SKILLED MURSING FACILITY 0 225,004 235,004 235,004 317,412 44,005 340,000				0			•		
MICHELARY SERVICE COST CENTERS 0.00 0.000 0.000 0.000 0.000 0.0				0					
52 00 55200 BELIVERY ROOM & LABOR ROOM	44. 00				233, 004	233, 004	0	17, 412	44.00
54. 00 05400 RADIOLOCY-DIAGNOSTIC 0 317, 782 317, 782 1, 474 22, 242 54. 00 575. 00 05500 RADIOLOCY-THERAPPUTIC 0 180, 309 345 7, 791 55. 00 570, 00				0		1	·		
55.00 05500 RADIOLOGY-THERAPEUTIC 0 180, 309 180, 309 245 7, 991 55.00 57.00 057		1	•	0					
57.01 03630 ULTRA SOUND 0 0 0 144 1.473 57.01				Ö					
58.00 05800 MACHETIC RESONANCE IMAGINO (MRI) 0 0 152 1.641 58.00		1	•	0	0	0			
59.00 05900 CARDIA C CATHETERIZATION 0 73, 104 6.69 8, 005 59, 00				0	0	0			
60.00 06.000 BLOOD LABORATORY 0 0 0 0 0 5.539 63.00				Ö	73, 104	73, 104			
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 95.779 95.779 0 5.539 63. 00 64.00 0640 0 0700			•	0					
64. 00 06400 INTRAVENOUS THERAPY				0	1	-			
66.00 06600 PhYSI CAL THERAPY 0 0 0 3,434 42,730 66.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 69.00 68.00 69.				0	0	0	0		
67.00 06700 06700 0600 0 0 0 0 0 0 0		1	l .	0	46, 823	_			
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00				0	0	0			
17. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00		06800	SPEECH PATHOLOGY	0	Ō	Ō	0		
12 00 07200 MPL DEV CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0				0		1	577		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00					1	I - 1	0		
76. 00 03020 OTHER ANCILLARY 0 0 0 0 0 76. 00	73. 00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 01 03140 CARDI AC REHAB 0 0 0 0 6.26 6.818 76. 01				0	13, 483		0		
76. 02 03070 00MEN''S CENTER 0 206,615 206,615 306 4,858 76. 02 3030 ENDOSCOPY 0 64,242 64,242 397 4,663 76. 03					0	0	-		
OUTPAT1 ENT SERVICE COST CENTERS 90.00 0 0 0 0 0 1,092 13,063 90.00 90.01 09001 0UTPAT1 ENT 0 87,501 87,501 326 7,117 90.01 91.00 9100 EMERGENCY 0 406,832 406,832 406,832 1,693 24,310 91.00 91.01 99101 SHORT STAY 0 0 0 0 0 0 0 91.01 92.00 99200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 53 562 92.00 99500 AMBULANCE SERVI CES 0 0 0 0 53 562 95.00 99500 AMBULANCE SERVI CES 0 0 0 2,936,728 41,348 741,793 118.00 990.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 120,257 120,257 88 2,969 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 257,856 257,856 19,439 280,082 192.00 192.01 19201 FOUNDATI ON 0 81,737 81,737 152 2,134 192.01 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0 0 0 1192.03 192.04 192.07 WESTFI ELD SCHOOLS 0 0 0 0 0 243 0 192.05 192.08 192.05 192.08 PRACTI CE MANAGEMENT 0 0 0 0 0 0 2,695 192.06 192.08 192.08 192.08 192.00 19300 NONPAL DE WORKERS 0 0 0 0 0 0 0 1,155 192.08 193.00 19300 NONPAL DE WORKERS 0 0 0 0 0 0 0 194.00 194.00 194.00 19750 WERKED 0 0 0 0 0 0 0 194.00 194.00 194.00 19750 WERKED 0 0 0 0 0 0 194.00 194.00 194.00 19750 WERKED 0 0 0 0 0 0 194.00 194.00 19750 WERKED 0 0 0 0 0 0 0 0 194.00 194.00 194.00 19500 NORMED 0 0 0 0 0 0 0 0 0	76. 02	03070	WOMEN'S CENTER	0			306	4, 858	76. 02
90. 00 09000 CLINIC 0 0 0 0 1,092 13,063 90.00 90.01 09001 0JTPATIENT 0 87,501 87,501 326 7,117 90.01 91.00 91.00 91.01 91.00 91.00 91.01 91.00 91.00 92.00 0BERGENCY 0 406,832 406,832 1,693 24,310 91.00 91.01 92.00 0 0 0 0 0 0 0 92.00 95.00 9	76. 03			0	64, 242	64, 242	397	4, 663	76. 03
91. 00 09100 EMERGENCY 0 406, 832 406, 832 1, 693 24, 310 91. 00 91. 01 991. 01 SHORT STAY 0 0 0 0 0 0 91. 01 92. 00 00 00 00 00 91. 01 92. 00 00 00 00 00 00 92. 00 00 00 00 00 00 00 00	90. 00			0	0	O	1, 092	13, 063	90. 00
91. 01 09101 SHORT STAY 0 0 0 0 0 0 0 91. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 07 07 07 07 07 07 93. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 08 09500 AMBULANCE SERVI CES 0 0 0 0 53 562 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 53 562 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 18. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 12, 036, 728 12, 036, 728 41, 348 741, 793 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 120, 257 120, 257 88 2, 969 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 257, 856 257, 856 19, 439 280, 082 192. 00 192. 01 19201 FOUNDATION 0 81, 737 81, 737 152 2, 134 192. 01 192. 02 19202 CLI NI CS 0 0 0 0 774 8, 552 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 0 0 0 0 0 1 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 0 0 0 0 243 0 192. 05 192. 05 19203 PRACTI CE MANAGEMENT 0 0 0 0 2, 695 192. 06 192. 08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 0 1, 155 192. 08 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 194. 00 07950 WORKMED 0 0 0 0 0 194. 00 07951 MEALS ON WHEELS 0 0 0 0 0 194. 01 07951 MEALS ON WHEELS 0 0 0 0 0 194. 01 07951 MEALS ON WHEELS 0 0 0 0 0 194. 01 07951 MEALS ON WHEELS 0 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 194. 01 07951 MEALS ON WHEELS 0 0 0 0 195. 00 0 0 0 0 196. 00 0 0 0 0 196. 00 0 0 0 196. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0 0 0 197. 00 0				0					
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0				0	406, 832		1, 693		
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 53 562 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 12,036,728 12,036,728 41,348 741,793 118. 00 NONREI MBURSABLE COST CENTERS		1	i e		Ĭ		0		
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) O 12,036,728 12,036,728 41,348 741,793 118.00	05.00							=	
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 12, 036, 728 12, 036, 728 41, 348 741, 793 118. 00	95. 00			0	0	0	53	562	95. 00
190. 00	118. 00			0	12, 036, 728	12, 036, 728	41, 348	741, 793	118. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 257, 856 19, 439 280, 082 192.00 192.01 19201 FOUNDATI ON 0 81, 737 81, 737 152 2, 134 192.01 192.02 19202 CLI NI CS 0 0 0 0 774 8, 552 192.02 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0 0 0 165 1, 821 192.03 192.04 19207 WESTFI ELD SCHOOLS 0 0 0 0 0 165 1, 821 192.04 192.05 19203 PRACTI CE MANAGEMENT 0 0 0 0 243 0 192.05 192.06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 0 2, 695 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 0 1, 155 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193.00 194.00 194.01 07951 MEALS ON WHEELS	400.00				100.057	100 057		0.040	
192. 01 19201 FOUNDATION 0 81, 737 81, 737 152 2, 134 192. 01 192. 02 19202 CLI NI CS 0 0 0 774 8, 552 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 0 0 0 0 0 165 1, 821 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 0 0 0 0 165 1, 821 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 0 0 0 0 243 0 192. 05 192. 08 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 0 2, 695 192. 06 192. 08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 0 2, 695 192. 08 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 194. 01 07951 MEALS ON WHEELS				0					
192. 03		1	l .	0					
192. 04				0	0	0			
192.05 19203 PRACTI CE MANAGEMENT 0 0 0 243 0 192.05 192.06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 2,695 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 1,155 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.01 07951 MEALS ON WHEELS 0 0 0 52 1, 200 194.01		1	l .	0	0	0			
192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 1, 155 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 52 1, 200 194.01	192. 05	19203	PRACTICE MANAGEMENT	0	0	0		0	192. 05
193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 52 1, 200 194.01				0	0	0	0		
194. 00 07950 WORKMED 0 0 0 0 194. 00 194. 00 194. 00 194. 01 07951 MEALS ON WHEELS 0 0 0 52 1, 200 194. 01				0	0	0	0		
	194.00	07950	WORKMED	0	o o	o o	0	0	194. 00
200.00 ₁ 0.055 F001 Aujustilients			ł .	0	0	0	52		
	200.00	יו	Toross root Aujustillerits	1	I	ı U		l	200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 1500		From 01/01/2014		narod:
				10 12/31/2014	Date/Time Pre 5/27/2015 3:3	6 pm
		CAPITAL RELATED COSTS				
Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	Assigned New	FLXT		BENEFITS	& GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 00	
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	12, 496, 578	12, 496, 57	8 62, 261	1, 042, 402	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | Part II | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: | Provider CCN: 150059

			10) 12/31/2014	Date/lime Pre 5/27/2015 3:3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	0.00	10.00	44.00	
GENERAL SERVICE COST CENTERS	7.00	8. 00	9. 00	10.00	11. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT				I		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT	4, 662, 380	l e				7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	34, 350	1	1			8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	21, 662	0	/:-	124 244		9. 00 10. 00
11. 00 01100 CAFETERI A	52, 540 106, 694	0	1, 912	136, 346 0	274, 928	11.00
13. 00 01300 NURSING ADMINISTRATION	0	Ö	68	o	4, 379	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	64, 655	659		Ō	7, 609	14. 00
15. 00 01500 PHARMACY	102, 927	0	1, 707	o	13, 433	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	53, 581	0	341	0	8, 213	16. 00
17. 00 01700 SOCIAL SERVICE	28, 518	0	0	0	3, 066	17. 00
30.00 O3000 ADULTS & PEDIATRICS	1, 327, 640	27, 501	21, 371	66, 726	60, 416	30.00
31. 00 03100 NTENSI VE CARE UNIT	250, 289		1	9, 633	15, 542	31.00
41. 00 04100 SUBPROVI DER – I RF	232, 810	l	1	32, 232	11, 604	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44.00 O4400 SKILLED NURSING FACILITY	160, 639	6, 363	3, 823	27, 755	0	44. 00
ANCILLARY SERVICE COST CENTERS	100 001			ما	0.4 50.4	
50. 00 05000 OPERATING ROOM	492, 281	4, 602	1	0	24, 501	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	217, 223	0 5, 138		0	0 12, 712	52. 00 54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	123, 252	710	1	0	3, 358	55.00
57. 00 05700 CT SCAN	0	0		ol	1, 896	57.00
57. 01 03630 ULTRA SOUND	0	Ö	Ö	Ö	716	57. 01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	68	o	1, 447	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	49, 971	2, 264	1	0	5, 794	59. 00
60. 00 06000 LABORATORY	213, 353	0	2, 390	0	23, 966	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	65, 471	0	0	0	0	63. 00 64. 00
65. 00 06500 RESPIRATORY THERAPY	32, 006	0	205	0	8, 243	65.00
66. 00 06600 PHYSI CAL THERAPY	32,000	740	1	0	20, 839	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	o	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	О	О	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	185, 911	753	2, 390	o	5, 495	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1	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 74.00 07400 RENAL DIALYSIS	0 217	0	0	0	0	73.00
74. 00 07400 RENAL DI ALTSI 3 76. 00 03020 OTHER ANCI LLARY	9, 217	0	0	0	0	74. 00 76. 00
76. 01 03140 CARDI AC REHAB	0	65	1, 365	0	5, 450	76. 01
76. 02 03070 WOMEN' S CENTER	141, 234	438		o	3, 990	76. 02
76. 03 03330 ENDOSCOPY	43, 913	3, 914		o	3, 772	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1		0	0, .00	
90. 01 09001 0UTPATI ENT	59, 812			0	3, 461	1
91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY	278, 095 0	11, 843	5, 803	0	14, 638 0	91. 00 91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	_	0		ď	0	92.00
OTHER REIMBURSABLE COST CENTERS	·					
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	738	95. 00
SPECIAL PURPOSE COST CENTERS						
118. 00 SUBTOTALS (SUM OF LINES 1-117)	4, 348, 044	80, 759	61, 582	136, 346	270, 716	1118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	82, 203		205	ol	1 222	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	176, 261	6, 921		0		192.00
192. 01 19201 FOUNDATION	55, 872		0,010	ő		192. 01
192. 02 19202 CLI NI CS	0	31	1, 365	0		192. 02
192.03 19206 HOME HEALTH PARTNERSHIP	0	0	О	О	0	192. 03
192.04 19207 WESTFIELD SCHOOLS	0	0	0	0		192. 04
192. 05 19203 PRACTI CE MANAGEMENT	0	29	0	0		192. 05
192.06 19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192. 06
192. 08 19205 RIVERVIEW MEDICAL ARTS 193. 00 19300 NONPAID WORKERS	0		0	0		192. 08 193. 00
193.00 19300 NONPALD WORKERS 194.00 07950 WORKMED	0			0		193.00
194. 01 07951 MEALS ON WHEELS	0		n	ol Ol		194. 00
200.00 Cross Foot Adjustments				Ĭ	., . 10	200. 00
201.00 Negative Cost Centers	0	0	0	o		201. 00
202.00 TOTAL (sum lines 118-201)	4, 662, 380	87, 740	66, 770	136, 346	274, 928	202. 00

Provider CCN: 150059

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | Part II | Part II | Prepared: | Part II | Prepared: | Part II | Prepared: |

				11	0 12/31/2014	Date/lime Pre 5/27/2015 3:3	
Cost Cen	ter Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	<u>Б</u>
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		13.00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	
GENERAL SERVIC	E COST CENTERS	13.00	14.00	13.00	10.00	17.00	
	REL COSTS-BLDG & FIXT						1.00
	BENEFITS DEPARTMENT						4. 00
	RATIVE & GENERAL						5. 00
7. 00 00700 OPERATI 0							7. 00
	& LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEE	PING						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI	۸						10. 00 11. 00
	A ADMI NI STRATI ON	12, 221					13.00
	SERVICES & SUPPLY	12, 221	280, 863				14. 00
15. 00 01500 PHARMACY			0	351, 942			15. 00
1 1	RECORDS & LIBRARY	0	0		151, 864		16. 00
17.00 01700 SOCIAL S	ERVI CE	0	0	0	0	80, 443	17. 00
	TINE SERVICE COST CENTERS						
30. 00 03000 ADULTS &		7, 224	0		50, 621	62, 812	30. 00
31. 00 03100 I NTENSI V		1, 859	0	0	8, 890		31.00
41. 00 04100 SUBPROVI 43. 00 04300 NURSERY	DER - IRF	1, 388	0		0	6, 880	41.00
	NURSING FACILITY		0	0	247	0 5, 837	43. 00 44. 00
	I CE COST CENTERS	J U	0	<u> </u>	247	5, 657	44.00
50. 00 05000 OPERATI N		O	0	0	52, 350	0	50.00
	ROOM & LABOR ROOM	o	0		0	0	52. 00
54. 00 05400 RADI OLOG		0	0	0	988	0	54.00
55. 00 05500 RADI OLOG	Y-THERAPEUTI C	0	0	0	1, 975	0	55. 00
57. 00 05700 CT SCAN		0	0	0	0	0	57. 00
57. 01 03630 ULTRA S0		0	0	0	0	0	57. 01
	RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
	CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATO 60. 01 06001 BLOOD LA		0	0		2, 716	0	60. 00 60. 01
	ORING, PROCESSING & TRANS.		0		0	0	63. 00
64. 00 06400 I NTRAVEN			0		0	0	64. 00
65. 00 06500 RESPIRAT			0	ő	0	Ö	65. 00
66. 00 06600 PHYSI CAL		O	0	ő	14, 569	Ö	66. 00
67. 00 06700 OCCUPATI		0	0	o	0	0	67. 00
68.00 06800 SPEECH P	ATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROC	ARDI OLOGY	0	0	0	5, 433	0	69. 00
1 1	SUPPLIES CHARGED TO PATIENTS	0	280, 863	0	0	0	71. 00
	V. CHARGED TO PATIENT	0	0	0	0	0	72.00
	ARGED TO PATIENTS	0	0	351, 942	0	0	73.00
74. 00 07400 RENAL DI 76. 00 03020 OTHER AN		0	0		0	0	74. 00 76. 00
76. 01 03140 CARDI AC			0		0		76. 00
76. 02 03070 WOMEN' S			0	0	0	ĺ	76. 02
76. 03 03330 ENDOSCOP			0	ő	0	Ö	76. 03
	RVICE COST CENTERS	· -1.		,			
90. 00 09000 CLI NI C		0	0	0	0	0	90. 00
90. 01 09001 0UTPATI E		0	0	0	0	0	90. 01
91. 00 09100 EMERGENC		1, 750	0	0	13, 087	0	91.00
91. 01 09101 SHORT ST		0	0	0	0	0	91. 01
	ION BEDS (NON-DISTINCT PART)						92. 00
95. 00 09500 AMBULANC	SABLE COST CENTERS	0	0	0	0	0	95. 00
	E COST CENTERS	l d		<u> </u>		0	95.00
	S (SUM OF LINES 1-117)	12, 221	280, 863	351, 942	150, 876	80, 443	118 00
	E COST CENTERS	12, 221	200, 003	331, 742	130, 070	00, 443	1110.00
	OWER, COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
192. 00 19200 PHYSI CI A		o	0		0		192. 00
192. 01 19201 FOUNDATI		0	0	o	0		192. 01
192. 02 19202 CLI NI CS		0	0	0	988	0	192. 02
192.03 19206 HOME HEA	LTH PARTNERSHIP	0	0	0	0		192. 03
192. 04 19207 WESTFI EL		0	0	0	0	l e	192. 04
192. 05 19203 PRACTI CE		0	0	0	0	l e	192. 05
192.06 19204 MOB - NO		0	0	0	0	l e	192. 06
192. 08 19205 RI VERVI E		0	0] 0	0	l e	192. 08
193. 00 19300 NONPALD 194. 00 07950 WORKMED	CX3ANDW		0		0		193. 00 194. 00
194. 00 07950 WORKMED 194. 01 07951 MEALS ON	WHEELS		0		0	l e	194. 00
1 1	ot Adjustments	"	Ü		U		200. 00
1 1	Cost Centers	0	Ω	n	n	n	201.00
, ,	um lines 118-201)	12, 221	280, 863	351, 942	151, 864	l e	
	·	· '			· · · · · · · · · · · · · · · · · · ·	·	-

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150059

			Τ̈́	o 12/31/2014 Date/Time Pre 5/27/2015 3:3	
Cost Center Description	Subtotal	Intern &	Total	372772013 3. 0	Jo pili
		Residents Cost			
		& Post Stepdown			
		Adjustments			
CENEDAL CEDALCE COCT CENTEDO	24. 00	25. 00	26. 00		
1. 00 OO100 NEW CAP REL COSTS-BLDG & FLXT					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
17. 00 01700 SOCIAL SERVICE					17. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	3, 647, 051 689, 295	0	3, 647, 051 689, 295		30.00
41. 00 04100 SUBPROVI DER - I RF	657, 617		657, 617		41.00
43. 00 04300 NURSERY	0		C		43. 00
44.00 O4400 SKILLED NURSING FACILITY	457, 080	0	457, 080		44. 00
ANCI LLARY SERVI CE COST CENTERS	1 255 270	O	1 255 270	1	E0 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 355, 378		1, 355, 378 0		50. 00 52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	578, 651	l o	578, 651		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	318, 281	0	318, 281		55. 00
57. 00 05700 CT SCAN	4, 371	0	4, 371		57.00
57.01 03630 ULTRA SOUND 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 332 3, 308		2, 332 3, 308		57. 01 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	139, 827	0	139, 827		59. 00
60. 00 06000 LABORATORY	600, 020	0	600, 020		60.00
60. 01 06001 BLOOD LABORATORY	1// 700	0	1// 700		60. 01 63. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	166, 789		166, 789 0		64. 00
65. 00 06500 RESPIRATORY THERAPY	98, 301	0	98, 301		65. 00
66. 00 06600 PHYSI CAL THERAPY	82, 585		82, 585		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		C		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 481, 406	1 -1	481, 406	'	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	280, 863	1	280, 863		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 768	1	8, 768		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	351, 942		351, 942		73. 00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY	24, 932		24, 932		74. 00 76. 00
76. 01 03140 CARDI AC REHAB	14, 324		14, 324	1	76. 01
76. 02 03070 WOMEN' S CENTER	358, 943	1 _1	358, 943	3	76. 02
76. 03 03330 ENDOSCOPY	120, 901	0	120, 901		76. 03
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	19, 712	ام	19, 712		90. 00
90. 01 09001 OUTPATI ENT	161, 420		161, 420		90. 01
91. 00 09100 EMERGENCY	758, 051	0	758, 051		91. 00
91. 01 09101 SHORT STAY	0	1 -1	C)	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0			92. 00
95. 00 09500 AMBULANCE SERVICES	1, 353	0	1, 353	3	95. 00
SPECIAL PURPOSE COST CENTERS					
118. 00 SUBTOTALS (SUM OF LINES 1-117)	11, 383, 501	0	11, 383, 501		118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	207, 055		207, 055	5	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	744, 177	1	744, 177		192. 00
192. 01 19201 FOUNDATI ON	141, 664		141, 664		192. 01
192. 02 19202 CLI NI CS	11, 710	0	11, 710		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFIELD SCHOOLS	1, 986	0	ا 1, 986		192. 03 192. 04
192. 05 19203 PRACTICE MANAGEMENT	272		272		192. 05
192. 06 19204 MOB - NOBLESVILLE SQUARE	2, 695		2, 695		192. 06
192.08 19205 RIVERVIEW MEDICAL ARTS	1, 155	0	1, 155		192. 08
193. 00 19300 NONPALD WORKERS	0	0	C		193. 00
194. 00 07950 WORKMED 194. 01 07951 MEALS ON WHEELS	2, 362		2, 362		194. 00 194. 01
200.00 Cross Foot Adjustments	0		2, 002		200. 00
201.00 Negative Cost Centers	0	o	C	p	201. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
					5/27/2015 3:3	
Cost Center Description	Subtotal	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments				
	24.00	25.00	26.00			
202.00 TOTAL (sum Lines 118-201)	12, 496, 578	0	12, 496, 57	'8		202.00

	Financial Systems ALLOCATION - STATISTICAL BASIS	RI VERVI EW F		CCN: 150059 P	In Lie Period:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/27/2015 3:3	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SOUARE FEET)	
	CENEDAL CEDVICE COCT CENTEDS	1.00	4. 00	5A	5. 00	7. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	492, 145					1.00
4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	00400 NEW CAP REL COSIS-BLDG & FIXI 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 143 2, 452 40, 770 180, 307 1, 979 1, 248 3, 027 6, 147 0 3, 725 5, 930 3, 087 1, 643	66, 760, 217 7, 682, 260 1, 520, 699 24, 550 852, 724 290, 266 615, 852 726, 537 639, 157 1, 943, 975 574, 862 523, 788	-17, 837, 948	10, 650, 343 401, 788 1, 627, 734 842, 813 1, 245, 949 915, 070 14, 540, 151 10, 507, 568 1, 393, 731	268, 616 1, 979 1, 248 3, 027 6, 147 0 3, 725 5, 930 3, 087 1, 643	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 31. 00 41. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSIVE CARE UNIT 04100 SUBPROVIDER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACILITY ANCILLARY SERVICE COST CENTERS	76, 490 14, 420 13, 413 0 9, 255	6, 230, 634 1, 832, 429 1, 151, 977 0	C C	2, 649, 607 2, 564, 504 0	76, 490 14, 420 13, 413 0 9, 255	31. 00 41. 00 43. 00
50. 00	05000 OPERATI NG ROOM	28, 362	4, 097, 580	С	6, 360, 080	28, 362	50.00
52. 00 54. 00 55. 00 57. 01 58. 00 59. 00 60. 01 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 72. 00 74. 00 74. 00 76. 01 76. 02 76. 03		28, 362 0 12, 515 7, 101 0 0 0 2, 879 12, 292 0 3, 772 0 1, 844 0 0 0 10, 711 0 0 0 531 0 0 8, 137 2, 530	4, 097, 580 0 1, 579, 836 369, 606 228, 937 153, 779 162, 727 738, 555 2, 310, 023 0 0 949, 648 3, 681, 095 0 0 618, 681 0 0 0 671, 418 328, 049 425, 628 1, 170, 074 349, 814 1, 814, 276		0 2, 868, 138 1, 030, 372 291, 606 189, 954 211, 578 1, 032, 274 5, 586, 235 0 714, 235 0 1, 307, 281 5, 509, 971 0 0 1, 144, 160 0 1, 130, 572 0 287, 833 0 879, 229 626, 387 601, 314	0 531 0 0 8, 137 2, 530 0 3, 446	52. 00 54. 00 55. 00 57. 01 58. 00 59. 00 60. 01 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 02 76. 03
92. 00 95. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		57, 239		72, 471	0	92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	NONREI MBURSABLE COST CENTERS	474, 035	44, 316, 675			250, 506	1
192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 192. 06 193. 00 194. 00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES 0 19201 FOUNDATION 0 19202 CLINICS 0 19206 HOME HEALTH PARTNERSHIP 0 19207 WESTFIELD SCHOOLS 0 19203 PRACTICE MANAGEMENT 0 19204 MOB - NOBLESVILLE SQUARE 0 19205 RIVERVIEW MEDICAL ARTS 0 19300 NONPAID WORKERS 0 107950 WORKMED 0 107951 MEALS ON WHEELS	4, 736 10, 155 3, 219 0 0 0 0 0 0 0 0	94, 298 20, 863, 611 162, 638 830, 036 0 176, 995 260, 425 0 0 0 55, 539	48, 271 C	36, 123, 134 275, 136 1, 102, 768 69 234, 763 0 347, 489 148, 958 0 0	10, 155 3, 219 0 0 0 0 0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 192. 06 192. 08 193. 00 194. 01

Health Fina	ncial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der	CCN: 150059	Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 3:3	
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliati	on ADMI NI STRATI VE	OPERATION OF	
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		,	SALARI ES)			ĺ	
		1.00	4. 00	5A	5. 00	7. 00	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	12, 496, 578	7, 648, 367		17, 837, 948	12, 063, 644	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	25. 392065	0. 114565		0. 132700	44. 910370	203. 00
204.00	Cost to be allocated (per Wkst. B,		62, 261		1, 042, 402	4, 662, 380	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000933		0. 007755	17. 357045	205. 00
	11)						

COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
	Cost Contar Decemintion	LAUNDDY 0	HOUSEKEEDING	DIETADY	CAFFTEDIA	5/27/2015 3:3	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS	CAFETERIA (MAN	NURSI NG ADMI NI STRATI ON	
		(POUNDS OF	SERVI CE)	SERVED)	HOURS)		
		LAUNDRY)				(DI RECT	
		8.00	9. 00	10.00	11.00	NRSI NG HRS) 13.00	
	GENERAL SERVICE COST CENTERS	0.00	7. 00	10.00	11.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00 5. 00	OO4OO						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	73, 174					8. 00
9. 00	00900 HOUSEKEEPI NG	0	978				9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	2 28	82, 196			10.00
13.00	01300 NURSI NG ADMI NI STRATI ON		20		1	337, 350	
14. 00	01400 CENTRAL SERVICES & SUPPLY	550	0	d	25, 117	0	14. 00
15. 00	01500 PHARMACY	0	25		44, 339	0	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	5	C	, -	0	16. 00 17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0		10, 121	0	17.00
30.00	03000 ADULTS & PEDIATRICS	22, 936	313	40, 226	199, 427	199, 427	30.00
31. 00	03100 I NTENSI VE CARE UNI T	5, 347	49			51, 303	1
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	5, 717	63 0			38, 302	1
44. 00	04400 SKI LLED NURSING FACILITY	5, 307	56	1	· ·	0	
00	ANCILLARY SERVICE COST CENTERS	0,007		107702			
50. 00	05000 OPERATING ROOM	3, 838	122		1	0	
52. 00 54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC	0 4, 285	0	1		0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	592	16 5			0	55. 00
57. 00	05700 CT SCAN	0	0	d		0	l
57. 01	03630 ULTRA SOUND	0	0	C	2, 364	0	57. 01
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 1, 888	1	0	4, 776 19, 126	0	58. 00 59. 00
60.00	06000 LABORATORY	1,000	35		79, 108	0	60.00
60. 01	06001 BLOOD LABORATORY	O	0	d		0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0 27, 210	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	617	3		68, 788	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	d	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	628	35	0	18, 137	0 1	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENT		0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	07400 RENAL DIALYSIS	0	0	C	0	0	
	03020 OTHER ANCI LLARY	0	0	0	17 001	0	
76. 01	03140 CARDI AC REHAB 03070 WOMEN' S CENTER	54 365	20 22		1	0	
76. 03	03330 ENDOSCOPY	3, 264	0			0	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLI NI C 09001 OUTPATI ENT	99 1, 988	0 12		1	0	
91.00	09100 EMERGENCY	9, 877	85	•		_	
91. 01	09101 SHORT STAY	0	0	1		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	0	0	C	2, 435	0	95. 00
93.00	SPECIAL PURPOSE COST CENTERS	l o	0	1	2, 433	0	95.00
118.00		67, 352	902	82, 196	893, 600	337, 350	118. 00
	NONREI MBURSABLE COST CENTERS			I -		_	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 5, 772	3 53		1		190. 00 192. 00
	19201 FOUNDATION	0,772	0				192. 01
	19202 CLI NI CS	26	20	C		0	192. 02
	19206 HOME HEALTH PARTNERSHIP	0	0	C	0		192. 03
	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT	24	0	0	0		192. 04 192. 05
	19204 MOB - NOBLESVILLE SQUARE	0	0	Ö	Ö		192. 06
192. 08	19205 RIVERVIEW MEDICAL ARTS	0	0	C	0	0	192. 08
	19300 NONPALD WORKERS	0	0	C	0		193. 00
	07950 WORKMED 07951 MEALS ON WHEELS	0	0		0 3, 665		194. 00 194. 01
200.00			U		3,000		200. 00
201.00							201. 00
<u></u>							

Health Fin	ancial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOC	CATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014		pared: 6 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(HOURS OF	(MEALS	(MAN	ADMI NI STRATI ON	
		(POUNDS OF	SERVI CE)	SERVED)	HOURS)		
		LAUNDRY)				(DI RECT	
						NRSING HRS)	
		8. 00	9. 00	10.00	11.00	13.00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	543, 983	1, 899, 782	1, 094, 48	3 1, 741, 740	1, 066, 182	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	7. 434102	1, 942. 517382	13. 31552	6 1. 919264	3. 160462	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)	87, 740	66, 770	136, 34	6 274, 928	12, 221	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 199060	68. 271984	1. 65879	0. 302950	0. 036226	205. 00

					rom 01/01/2014 o 12/31/2014	Date/Time Prepared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	5/27/2015 3:36 pm
		SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	(TIME	
		(COSTED REQUIS.)		(TIME SPENT)	SPENT)	
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16.00	17. 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 5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					8. 00 9. 00
10. 00	1 I					10.00
11.00	· ·					11.00
13. 00 14. 00	· ·	100				13. 00 14. 00
15. 00		0	100			15. 00
16. 00 17. 00		0	0			16. 00 17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			005	4.454	20.00
30. 00 31. 00	· ·	0	0			30. 00 31. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	455	41. 00
43. 00 44. 00	1 I	0	0		0 386	43. 00 44. 00
	ANCILLARY SERVICE COST CENTERS	-1				
50. 00 52. 00	1 I	0	0		1	50. 00 52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	Ö	0	4	o	54.00
55. 00 57. 00	1 I	0	0	8 0		55. 00 57. 00
57. 01	1 1	0	0	1	_	57. 01
58. 00 59. 00		0	0	0		58. 00 59. 00
60.00	1 I	0	0	11	0	60.00
60. 01	1	0	0	0		60. 01
63. 00 64. 00	· ·	0	0	0	_	63. 00 64. 00
65. 00	· ·	0	0	0		65. 00
66. 00 67. 00	· ·	0	0	59 0		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0		68. 00
69. 00 71. 00		100	0	22		69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72. 00
73. 00 74. 00	1	0	100 0		0	73. 00 74. 00
76. 00	03020 OTHER ANCILLARY	Ö	0	0		76. 00
	03140 CARDI AC REHAB 03070 WOMEN' S CENTER	0	0	0		76. 01 76. 02
76. 03	03330 ENDOSCOPY	O	0			76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0	Ιο	O	90.00
90. 01	09001 OUTPATI ENT	0	0	ő		90. 01
91. 00 91. 01	1	0	0	53 0	1	91. 00 91. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				J	92. 00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0	0	0	O	95. 00
	SPECIAL PURPOSE COST CENTERS					
118. 00	O SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	100	100	611	5, 320	118. 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
	0 19200 PHYSICIANS' PRIVATE OFFICES 1 19201 FOUNDATION	0	0	0	0	192. 00 192. 01
192. 02	2 19202 CLI NI CS	o	0	4	0	192. 02
	3 19206 HOME HEALTH PARTNERSHIP 4 19207 WESTFIELD SCHOOLS	0	0	0	0	192. 03 192. 04
192.05	5 19203 PRACTICE MANAGEMENT	0	0	0	0	192. 05
	6 19204 MOB - NOBLESVILLE SQUARE 8 19205 RIVERVIEW MEDICAL ARTS	0	0	0	0	192. 06 192. 08
193.00	0 19300 NONPALD WORKERS	Ö	Ö	0	o	193. 00
	0 07950 WORKMED 1 07951 MEALS ON WHEELS	0	0	0	0	194. 00 194. 01
200.00	O Cross Foot Adjustments		0	ĺ		200. 00
201.00	0 Negative Cost Centers	1				201. 00

Heal th Fina	ncial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 3:3	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(COSTED	RECORDS &			
		SUPPLY	REQUIS.)	LI BRARY	(TIME		
		(COSTED		(TIME	SPENT)		
		REQUIS.)		SPENT)			
		14.00	15. 00	16.00	17. 00		
202.00	Cost to be allocated (per Wkst. B,	16, 689, 215	12, 301, 901	1, 779, 06	1 1, 064, 709		202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	166, 892. 150000	123, 019. 010000	2, 892. 78211	4 200. 133271		203. 00
204.00	Cost to be allocated (per Wkst. B,	280, 863	351, 942	151, 86	4 80, 443		204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	2, 808. 630000	3, 519. 420000	246. 93333	3 15. 120865		205. 00
	11)						
·		,		•			•

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150059	Period: Worksheet C

From 01/01/2014 To 12/31/2014 Part I Date/Time Prepared: 5/27/2015 3:36 pm Title XVIII Hospi tal PPS Costs Therapy Limit Cost Center Description Total Cost Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 18, 095, 673 18, 095, 673 18, 095, 673 03100 INTENSIVE CARE UNIT 4, 290, 862 4, 290, 862 0 4, 290, 862 31.00 31.00 04100 SUBPROVI DER - I RF 0 41.00 4, 216, 436 4, 216, 436 4, 216, 436 41.00 04300 NURSERY 43.00 0 43.00 0 04400 SKILLED NURSING FACILITY 44.00 3, 409, 963 3, 409, 963 3, 409, 963 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 511, 820 9, 511, 820 9, 511, 820 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 965, 835 3, 965, 835 3, 965, 835 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 544, 540 1, 544, 540 0 0 0 1, 544, 540 55.00 05700 CT SCAN 342, 315 342, 315 57.00 342.315 57.00 219, 698 03630 ULTRA SOUND 219, 698 57.01 219, 698 57.01 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 250, 763 250, 763 250, 763 58.00 05900 CARDIAC CATHETERIZATION 1, 349, 298 1, 349, 298 1, 349, 298 59.00 0 59.00 06000 LABORATORY 60 00 7, 131, 204 7, 131, 204 7, 131, 204 60 00 60.01 06001 BLOOD LABORATORY 0 Ω Ω 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 978, 416 978, 416 978, 416 63.00 63.00 0 0 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 0 1, 621, 623 1, 621, 623 1, 621, 623 06500 RESPIRATORY THERAPY 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 6, 556, 197 6, 556, 197 6, 556, 197 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 68 00 0 1, 948, 133 69.00 06900 ELECTROCARDI OLOGY 1, 948, 133 1, 948, 133 69.00 16, 689, 215 16, 689, 215 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16, 689, 215 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 280, 599 1, 280, 599 1, 280, 599 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 12, 301, 901 12 301 901 12, 301, 901 73 00 74.00 07400 RENAL DIALYSIS 349, 875 349, 875 349, 875 74.00 03020 OTHER ANCILLARY 76.00 76.00 0 76.01 03140 CARDI AC REHAB 1,069,683 1,069,683 1,069,683 76.01 76.02 03070 WOMEN'S CENTER 1, 145, 668 1, 145, 668 1, 145, 668 76 02 76.03 03330 ENDOSCOPY 842, 893 842, 893 842, 893 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 943, 118 1, 943, 118 0 1, 943, 118 90.00 09001 OUTPATI ENT 0 90.01 1, 254, 267 1, 254, 267 1, 254, 267 90.01 91.00 09100 EMERGENCY 4, 907, 618 4, 907, 618 0 4, 907, 618 91.00 91.01 09101 SHORT STAY 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 262, 106 2, 262, 106 2, 262, 106 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 86, 761 86, 761 86, 761 95.00 200.00 Subtotal (see instructions) 109, 566, 480 109, 566, 480 o 109, 566, 480 200. 00 2, 262, 106 201. 00 2, 262, 106 2, 262, 106 201.00 Less Observation Beds 202.00 Total (see instructions) 107, 304, 374 107, 304, 374 107, 304, 374 202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2014	Part
To 12/31/2014	Date/Time Prepared:
5/27/2015 3:36 pm	Provider CCN: 150059

						5/27/2015 3:3	6 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	'	+ col. 7)	Ratio	Inpati ent	
				ĺ		Rati o	
		6.00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	' ' '		•			
30.00	03000 ADULTS & PEDIATRICS	24, 491, 005		24, 491, 00	5		30.00
31.00	03100 INTENSIVE CARE UNIT	5, 895, 771		5, 895, 77	1		31.00
41.00	04100 SUBPROVI DER - I RF	5, 747, 163		5, 747, 16			41.00
43. 00	04300 NURSERY	0			2		43. 00
44. 00	04400 SKILLED NURSING FACILITY	2, 456, 021		2, 456, 02	1		44. 00
00	ANCI LLARY SERVI CE COST CENTERS	27 1007 02 1		27 1007 02	•		
50. 00	05000 OPERATING ROOM	19, 324, 249	22, 838, 848	42, 163, 09	7 0. 225596	0. 000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 678, 736	12, 364, 856			0. 000000	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	168, 591	5, 268, 430			0. 000000	
57. 00	05700 CT SCAN	1, 637, 085	7, 988, 294			0.000000	•
57. 00	03630 ULTRA SOUND	271, 615	2, 150, 702			0.000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	357, 048	3, 085, 796			0.000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 662, 545	7, 929, 162			0.000000	1
60.00	06000 LABORATORY					0.000000	
	06001 BLOOD LABORATORY	10, 793, 232	25, 531, 470	1			1
60. 01 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1 054 210	0 40F 044		0. 000000 4 0. 589672	0.000000	1
		1, 054, 210	605, 044	1, 659, 25		0.000000	
64. 00	06400 I NTRAVENOUS THERAPY	4 070 047	001 007	F 0/1 07	0.000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	4, 870, 847	991, 027			0.000000	
66.00	06600 PHYSI CAL THERAPY	7, 476, 718	9, 977, 651	1		0.000000	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0.000000	0.000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0.000000	0.000000	1
69. 00	06900 ELECTROCARDI OLOGY	1, 849, 487	7, 843, 806			0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 521, 441	19, 075, 896			0. 000000	•
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 595, 222	2, 726, 120			0. 000000	l
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 767, 395	9, 664, 215			0. 000000	
74. 00	07400 RENAL DI ALYSI S	414, 926	2, 860	1		0. 000000	1
76. 00	03020 OTHER ANCI LLARY	0	0		0.000000	0. 000000	1
76. 01	03140 CARDI AC REHAB	324, 525	2, 633, 058			0. 000000	1
76. 02	03070 WOMEN' S CENTER	8, 613	4, 055, 284			0. 000000	1
76. 03	03330 ENDOSCOPY	912, 493	4, 884, 464	5, 796, 95	7 0. 145403	0.000000	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	4, 048	3, 799, 418	3, 803, 46		0.000000	1
90. 01	09001 OUTPATI ENT	179, 109	3, 978, 413	4, 157, 52	0. 301686	0. 000000	90. 01
91. 00	09100 EMERGENCY	2, 947, 880	18, 383, 279	21, 331, 15	9 0. 230068	0.000000	91.00
91. 01	09101 SHORT STAY	0	0		0.000000	0.000000	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	557, 582	2, 319, 575	2, 877, 15	7 0. 786230	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	95. 00
200.00	Subtotal (see instructions)	135, 967, 557	178, 097, 668	314, 065, 22	5		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	135, 967, 557	178, 097, 668	314, 065, 22	5		202. 00
					*		

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150059	Peri od: Worksheet C From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

<u> </u>				12, 51, 251	5/27/2015 3:3	36 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30. 00
	03100 INTENSIVE CARE UNIT					31. 00
	04100 SUBPROVI DER - I RF					41. 00
	04300 NURSERY					43. 00
	04400 SKILLED NURSING FACILITY					44. 00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM	0. 225596				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 282395				54. 00
1	05500 RADI OLOGY-THERAPEUTI C	0. 284078				55. 00
	05700 CT SCAN	0. 035564				57. 00
	03630 ULTRA SOUND	0. 090697				57. 01
1	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 072836				58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 107158				59.00
	06000 LABORATORY	0. 196318				60.00
1	06001 BLOOD LABORATORY	0.000000				60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 589672				63.00
	06400 INTRAVENOUS THERAPY	0.000000				64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 276639 0. 375619				65. 00 66. 00
	06700 OCCUPATIONAL THERAPY	0. 000000				67. 00
	06800 SPEECH PATHOLOGY	0. 000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 200977				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 382804				71.00
1	07200 IMPL. DEV. CHARGED TO PATIENT	0. 296343				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 574007				73. 00
	07400 RENAL DIALYSIS	0. 837450				74.00
	03020 OTHER ANCILLARY	0. 000000				76.00
	03140 CARDI AC REHAB	0. 361675				76. 01
	03070 WOMEN' S CENTER	0. 281914				76. 02
	03330 ENDOSCOPY	0. 145403				76. 03
	OUTPATIENT SERVICE COST CENTERS					1
	09000 CLI NI C	0. 510881				90.00
	09001 OUTPATI ENT	0. 301686				90. 01
91. 00	09100 EMERGENCY	0. 230068				91. 00
	09101 SHORT STAY	0. 000000				91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 786230				92. 00
_	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	0. 000000				95. 00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201. 00
202. 00	Total (see instructions)					202. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150059	Peri od: Worksheet C

From 01/01/2014 To 12/31/2014 Part I Date/Time Prepared: 5/27/2015 3:36 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 18, 095, 673 18, 095, 673 18, 095, 673 03100 INTENSIVE CARE UNIT 4, 290, 862 4, 290, 862 0 4, 290, 862 31.00 31.00 04100 SUBPROVI DER - I RF 0 41.00 4, 216, 436 4, 216, 436 4, 216, 436 41.00 04300 NURSERY 43.00 0 43.00 0 04400 SKILLED NURSING FACILITY 44.00 3, 409, 963 3, 409, 963 3, 409, 963 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 511, 820 9, 511, 820 9, 511, 820 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 965, 835 3, 965, 835 3, 965, 835 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 544, 540 1, 544, 540 0 0 0 1, 544, 540 55.00 05700 CT SCAN 342, 315 342, 315 57.00 342.315 57.00 219, 698 03630 ULTRA SOUND 219, 698 57.01 219, 698 57.01 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 250, 763 250, 763 250, 763 58.00 05900 CARDIAC CATHETERIZATION 1, 349, 298 1, 349, 298 1, 349, 298 59.00 0 59.00 06000 LABORATORY 60 00 7, 131, 204 7, 131, 204 7, 131, 204 60 00 60.01 06001 BLOOD LABORATORY 0 Ω Ω 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 978, 416 978, 416 978, 416 63.00 63.00 0 0 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 0 1, 621, 623 1, 621, 623 1, 621, 623 06500 RESPIRATORY THERAPY 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 6, 556, 197 0 6, 556, 197 6, 556, 197 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 68 00 0 0 1, 948, 133 69.00 06900 ELECTROCARDI OLOGY 1, 948, 133 1, 948, 133 69.00 16, 689, 215 16, 689, 215 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16, 689, 215 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 280, 599 1, 280, 599 1, 280, 599 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 12, 301, 901 12 301 901 12, 301, 901 73 00 74.00 07400 RENAL DIALYSIS 349, 875 349, 875 349, 875 74.00 03020 OTHER ANCILLARY 0 76.00 76.00 76.01 03140 CARDI AC REHAB 1,069,683 1,069,683 1,069,683 76.01 76.02 03070 WOMEN'S CENTER 1, 145, 668 1, 145, 668 1, 145, 668 76 02 76.03 03330 ENDOSCOPY 842, 893 842, 893 842, 893 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 943, 118 1, 943, 118 0 1, 943, 118 90.00 1, 254, 267 09001 OUTPATI ENT 0 90.01 1, 254, 267 1, 254, 267 90.01 91.00 09100 EMERGENCY 4, 907, 618 4, 907, 618 0 4, 907, 618 91.00 91.01 09101 SHORT STAY 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 262, 106 2, 262, 106 2, 262, 106 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 86, 761 86, 761 86, 761 95.00 200.00 Subtotal (see instructions) 109, 566, 480 109, 566, 480 o 109, 566, 480 200. 00 2, 262, 106 201. 00 2, 262, 106 2, 262, 106 201.00 Less Observation Beds

107, 304, 374

107, 304, 374

107, 304, 374 202. 00

202.00

Total (see instructions)

| Period: | Worksheet C | From 01/01/2014 | Part | Date/Time Prepared: | 5/27/2015 3:36 pm Provi der CCN: 150059

						5/27/2015 3:3	6 pm
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	24, 491, 005		24, 491, 00	5		30. 00
31.00	03100 INTENSIVE CARE UNIT	5, 895, 771		5, 895, 77	1		31.00
41.00	04100 SUBPROVI DER - I RF	5, 747, 163		5, 747, 16	3		41.00
43.00	04300 NURSERY	0			O		43.00
44.00	04400 SKILLED NURSING FACILITY	2, 456, 021		2, 456, 02	1		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	19, 324, 249	22, 838, 848	42, 163, 09	7 0. 225596	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 678, 736	12, 364, 856	14, 043, 59	0. 282395	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	168, 591	5, 268, 430	5, 437, 02	0. 284078	0.000000	55. 00
57.00	05700 CT SCAN	1, 637, 085	7, 988, 294	9, 625, 37	9 0. 035564	0.000000	57. 00
57. 01	03630 ULTRA SOUND	271, 615	2, 150, 702	2, 422, 31	7 0. 090697	0.000000	57. 01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	357, 048	3, 085, 796	3, 442, 84	0. 072836	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 662, 545	7, 929, 162	12, 591, 70	7 0. 107158	0.000000	59. 00
60.00	06000 LABORATORY	10, 793, 232	25, 531, 470	36, 324, 70	0. 196318	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0.000000	0.000000	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 054, 210	605, 044	1, 659, 25	0. 589672	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0.000000	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	4, 870, 847	991, 027	5, 861, 87	0. 276639	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	7, 476, 718	9, 977, 651	17, 454, 36	9 0. 375619	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0.000000	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0.000000	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 849, 487	7, 843, 806	9, 693, 29	0. 200977	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 521, 441	19, 075, 896	43, 597, 33	7 0. 382804	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 595, 222	2, 726, 120	4, 321, 34	0. 296343	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 767, 395	9, 664, 215	21, 431, 61	0. 574007	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	414, 926	2, 860	417, 78	6 0. 837450	0. 000000	74. 00
76.00	03020 OTHER ANCI LLARY	0	0		0.000000	0. 000000	76. 00
76. 01	03140 CARDI AC REHAB	324, 525	2, 633, 058	2, 957, 58		0. 000000	
76. 02	03070 WOMEN' S CENTER	8, 613	4, 055, 284			0. 000000	76. 02
76. 03	03330 ENDOSCOPY	912, 493	4, 884, 464	5, 796, 95	7 0. 145403	0. 000000	76. 03
	OUTPATIENT SERVICE COST CENTERS	,	., ,				
90.00	09000 CLI NI C	4, 048	3, 799, 418	3, 803, 46	6 0. 510881	0.000000	90.00
90. 01	09001 OUTPATI ENT	179, 109	3, 978, 413			0. 000000	
91.00	09100 EMERGENCY	2, 947, 880	18, 383, 279	21, 331, 15	9 0. 230068	0. 000000	91.00
91. 01	09101 SHORT STAY	0	0		0.000000	0. 000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	557, 582	2, 319, 575	2, 877, 15		0. 000000	
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	0	0		0.000000	0. 000000	95. 00
200.00	1	135, 967, 557	178, 097, 668	314, 065, 22			200. 00
201.00				' '			201.00
202.00	1 1	135, 967, 557	178, 097, 668	314, 065, 22	5		202.00
				' '	T .	•	

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150059	From 01/01/2014	Worksheet C Part I Date/Time Prepared:

Cost Center Description	31	
Ratio 11.00	31	
11. 00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00	3	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	3	
30. 00	3	
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	3	
41. 00 04100 SUBPROVI DER - RF		30. 00
	4	31. 00
		41. 00
43. 00 04300 NURSERY		43. 00
44. 00 O4400 SKILLED NURSING FACILITY	4	44. 00
ANCILLARY SERVICE COST CENTERS	_	
50. 00 05000 OPERATING ROOM 0. 00000		50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 00000		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 00000		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C		55. 00
57. 00 05700 CT SCAN 0. 00000	I I	57. 00
57. 01 03630 ULTRA SOUND		57. 01
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0. 00000	I I	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00000	I I	59. 00
60. 00 06000 LABORATORY	I I	60. 00
60. 01 06001 BLOOD LABORATORY		60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	l l	63. 00
64. 00 06400 INTRAVENOUS THERAPY	· ·	64. 00
65. 00 06500 RESPI RATORY THERAPY	· ·	65. 00
66. 00 06600 PHYSI CAL THERAPY	· ·	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	· ·	67. 00
68. 00 06800 SPEECH PATHOLOGY	l l	68. 00 69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 00000	I I	71. 00
72. 00 07200 MPL. DEV. CHARGED TO PATIENT 0. 00000	I I	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 00000	I I	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S 0. 00000	I I	74. 00
76. 00 03020 OTHER ANCI LLARY 0. 00000		76. 00
76. 01 03140 CARDI AC REHAB	I I	76. 00 76. 01
76. 02 03070 WOMEN' S CENTER		76. 02
76. 03 03330 ENDOSCOPY 0. 00000		76. 03
OUTPATIENT SERVICE COST CENTERS		, 0, 00
90. 00 09000 CLI NI C 0. 00000	90	90. 00
90. 01 09001 0UTPATI ENT		90. 01
91. 00 09100 EMERGENCY		91. 00
91. 01 09101 SHORT STAY	I I	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 00000		92. 00
OTHER REIMBURSABLE COST CENTERS		
95. 00 09500 AMBULANCE SERVI CES 0. 00000	99	95. 00
200.00 Subtotal (see instructions)	I I	00.00
201.00 Less Observation Beds	20	00 .10
202.00 Total (see instructions)	20:	02. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 3:3	pared: 6 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 647, 051		-, ,			
31.00 INTENSIVE CARE UNIT	689, 295		689, 29	5 2, 762	249. 56	31. 00
41. 00 SUBPROVI DER - I RF	657, 617	0	657, 61	7 5, 548	118. 53	41. 00
43. 00 NURSERY	0			0 0	0.00	43.00
44.00 SKILLED NURSING FACILITY	457, 080		457, 08	0 4, 820	94. 83	44.00
200.00 Total (lines 30-199)	5, 451, 043		5, 451, 04	3 27, 729		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, 221	1, 304, 310				30. 00
31.00 INTENSIVE CARE UNIT	1, 371	342, 147				31.00
41. 00 SUBPROVI DER - I RF	3, 630	430, 264				41.00
43. 00 NURSERY	0	0)			43.00
44.00 SKILLED NURSING FACILITY	3, 349	317, 586	,			44. 00
200.00 Total (lines 30-199)	13, 571	2, 394, 307	1			200. 00

358, 943

120, 901

19, 712

161, 420

758, 051

455, 912

6, 387, 017

4, 063, 897

5, 796, 957

3, 803, 466

4, 157, 522

21, 331, 159

2, 877, 157

275, 475, 265

0.088325

0.020856

0.005183

0.038826

0.035537

0.000000

0.158459

3, 250

2.994

127, 087

1, 638, 223

38, 933, 577

41, 963

287

875

16

0

0 92.00

763, 150 200. 00

4, 934

58, 218

76.02

76.03

90 00

90.01

91.00

91.01

95 00

76.01

76.02

76.03

90 00

90.01

91.01

92.00

95.00

200.00

03070 WOMEN'S CENTER

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

03330 ENDOSCOPY

09001 OUTPATI ENT

09101 SHORT STAY

09000 CLI NI C

91. 00 09100 EMERGENCY

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der	CCN: 150059	Peri od:	Worksheet D		
				From 01/01/2014			
				To 12/31/2014	Date/Time Pre 5/27/2015 3:3		
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs		
		Cost	Medi cal	Adjustment	(sum of cols.		
			Education Cos		1 through 3,		
					minus col. 4)		
	1.00	2. 00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0	0		
31. 00 03100 I NTENSI VE CARE UNI T	0	0	1	0	0	31.00	
41. 00 04100 SUBPROVI DER - I RF	0	0	1	0	0	41. 00	
43. 00 04300 NURSERY	0	0	1	0	0	43. 00	
44.00 04400 SKILLED NURSING FACILITY	0	0	1	0	0	44. 00	
200.00 Total (lines 30-199)	0	0		0	0	200. 00	
Cost Center Description		Per Diem (col.	Inpatient	I npati ent			
	Days	5 ÷ col . 6)	Program Days				
				Pass-Through			
				Cost (col. 7 x			
	6. 00	7. 00	8.00	col . 8) 9.00			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00			
30. 00 03000 ADULTS & PEDIATRICS	14, 599	0.00	5, 22	21 0		30.00	
31. 00 03100 NTENSI VE CARE UNI T	2, 762					31.00	
41. 00 04100 SUBPROVI DER - RF	5, 548					41.00	
43. 00 04300 NURSERY	3, 340	0.00		0 0		43.00	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	4, 820		1	-		44. 00	
200.00 Total (lines 30-199)	27, 729		13, 57			200.00	
200.00 [10101 (111163 30-177)	21,127	I	13,5	0	i	1200.00	

	Financial Systems	RI VERVI EW				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	S Provi der	CCN: 150059	Peri od: From 01/01/2014	Worksheet D Part IV	
TTIKOOG	11 60313				To 12/31/2014		
			Ti +I	e XVIII	Hospi tal	PPS	о рііі
	Cost Center Description	Non Physician				Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0	0	54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	()	0	0	55. 00
	05700 CT SCAN	0	C)	0 0	0	57. 00
57. 01	03630 ULTRA SOUND	0	C)	0 0	0	57. 01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C)	0 0	0	59. 00
60.00	06000 LABORATORY	0	C)	0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C		0 0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0			0 0	0	74. 00
76.00	03020 OTHER ANCI LLARY	0			0 0	0	76. 00
76. 01	03140 CARDI AC REHAB	0	l		0 0	0	76. 01
76. 02	03070 WOMEN'S CENTER	0			0 0	0	76. 02
	03330 ENDOSCOPY	0	ď		0 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	•					1
90.00	09000 CLI NI C	0	C)	0 0	0	90. 00
90 01	09001 OUTPATI ENT	1	1	d .		ĺ	90 01

0

0

91. 00 0

91. 01 92. 00

95.00

0 200. 00

0 90.01

0

0

90. 01 09001 OUTPATI ENT

91. 01 09101 SHORT STAY

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

91. 00 09100 EMERGENCY

200.00

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER' THROUGH COSTS	RIVERVIEW /ICE OTHER PAS:			In Lie Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 3:3	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	$\mbox{col}.$ 2, $$ 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0				8, 758, 529	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0.0000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				905, 447	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	-, ,			136, 583	
57. 00 05700 CT SCAN	0	9, 625, 379			819, 822	
57. 01 03630 ULTRA SOUND	0	_,,			112, 390	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				137, 832	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				1, 243, 103	
60. 00 06000 LABORATORY	0				4, 758, 129	
60. 01 06001 BL00D LABORATORY	0	-	0.00000		0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	.,,			338, 587	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	-	0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0		l .		2, 583, 938	
66. 00 06600 PHYSI CAL THERAPY	0	17, 454, 369	0.00000		848, 519	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0				0	67.00
68. 00 06800 SPEECH PATHOLOGY	0		0.0000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		1		953, 107	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1		9, 869, 681	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		1		780, 978	
73.00 07300 DRUGS CHARGED TO PATIENTS	0		1		4, 531, 129	
74. 00 07400 RENAL DI ALYSI S	0	417, 786			164, 177	74.00
76. 00 03020 OTHER ANCILLARY	0	0	0.0000		0	76. 00
76. 01 03140 CARDI AC REHAB	0		1		178, 109	
76. 02 03070 WOMEN' S CENTER	0				3, 250	
76. 03 03330 ENDOSCOPY	0	5, 796, 957	0.00000	0.00000	41, 963	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0		1			
90. 01 09001 OUTPATI ENT	0				127, 087	90. 01
91. 00 09100 EMERGENCY	0				1, 638, 223	
91. 01 09101 SHORT STAY	0		0.0000		0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 877, 157	0.00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	275, 475, 265	1	1	38, 933, 577	1000 00

Health Financial Systems	S	RI VE	RVIEW HOSP	I TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIE THROUGH COSTS	ENT/OUTPATIENT ANCILLAR	Y SERVICE OTHE	R PASS	Provi der CCN	: 150059	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

Title XVIII				10	12/31/2014	5/27/2015 3:3	
Program Program Program Program Charges Program Charges Program Prog			Ti tl	e XVIII	Hospi tal		
Pass-Through Costs (col. 8 x col. 10)	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
ANCILLARY SERVICE COST CENTERS 11.00 12.00 13.00	·	Program	Program	Program Program			
ANCILLARY SERVICE COST CENTERS 11.00 12.00 13.00		Pass-Through	Charges	Pass-Through			
ANCILLARY SERVICE COST CENTERS		Costs (col. 8	Ü	Costs (col. 9			
ANCILLARY SERVICE COST CENTERS S0 00 05000 DEPENTAING ROOM S0 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		x col. 10)		x col. 12)			
50.00 05000 05000 05000 0520		11.00	12.00	13. 00			
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52. 00	ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 3, 524, 656 0 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 57. 00 05700 CT SCAN 0 2, 712, 975 0 57. 00 57. 00 57. 01 03630 ULTRA SOUND 0 366, 344 0 57. 01 58. 00 58. 00 58. 00 58. 00 59. 00 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 00 60. 01 60. 00	50.00 05000 OPERATING ROOM	0	4, 763, 884	0			50.00
55. 00 05500 RADIO LOGY-THERAPEUTIC 0 2, 012, 224 0 55. 00 57. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 68. 00	52.00 05200 DELIVERY ROOM & LABOR ROOM	O	0	0			52. 00
57. 00 05700 CT SCAN 0 2,719,975 0 57. 00 57. 01 03630 ULTRA SOUND 0 366,344 0 57. 01 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 909,956 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 3,373,081 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 63. 00 05300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 243,211 0 0 64. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 891,054 0 0 65. 00 66. 00 06500 RESPI RATORY THERAPY 0 0 0 0 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 4,707,418 0 71. 00 72. 00 07200 DRUISC CHARGED TO PATI ENTS 0 2,222,717 0 73. 00 74. 00 07300 DRUISC CHARGED TO PATI ENTS 0 2,222,717 0 73. 00 76. 00 03000 DRUISC CHARGED TO PATI ENTS 0 2,222,717 0 73. 00 76. 00 03000 DRUISC CHARGED TO PATI ENTS 0 2,222,717 0 73. 00 76. 00 03000 DRUISC CHARGED TO PATI ENTS 0 2,222,717 0 73. 00 76. 00 03000 DRUISC CHARGED TO PATI ENTS 0 2,222,717 0 73. 00 76. 00 03000 DRUISC CHARGED TO PATI ENTS 0 2,222,717 0 74. 00 76. 01 03140 CARDI AC REHAB 0 1,104,341 0 76. 01 76. 02 03070 WOMEN' S CENTER 0 296,304 0 76. 02 00 09000 CLINIC 0 1,937,628 0 90. 01 90. 01 90010 OUTPATI ENT 0 92. 00 91. 00 90. 01 90010 OUTPATI ENT STAY 0 0 0 91. 01 90. 01 90010 OUTPATI ENT STAY 0 0 0 91. 01 90. 01 09000 OUTPATI ENT STAY 0 0 0 91. 01 90. 00 09000 OUTPATI ENT STAY 0 0 0 91. 01 90. 00 09000 OUTPATI ENT STAY 0 0 0 91. 01 90. 00 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	3, 524, 656	0			54.00
57. 01 03630 ULTRA SOUND 0 366, 344 0 57. 01 58. 00 05800 MARNETI C RESONANCE I MAGI NG (MRI) 0 909, 956 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 3, 373, 081 0 59. 00 60. 00 06000 LABORATORY 0 2, 839, 920 0 0 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 243, 211 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65. 00 05500 RESPI RATORY THERAPY 0 891, 054 0 0 66. 00 06600 PHYSI CAL THERAPY 0 891, 054 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MBUIL ALS ELECTROCARDI OLOGY 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 4, 707, 418 0 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 4, 707, 418 0 72. 00 74. 00 07400 RENAL DI LALYSI S 0 0 0 0 76. 01 03140 CARDI AC REHAB 0 1, 104, 341 0 76. 01 76. 01 03140 CARDI AC REHAB 0 1, 104, 341 0 76. 01 76. 02 03070 WOMEN'S CENTER 0 296, 304 0 76. 02 76. 02 03070 WOMEN'S CENTER 0 296, 304 0 76. 02 79. 00 09000 CLIRC SERVICE COST CENTERS 0 0 0 90. 01 09010 SHORT STAY 0 0 0 0 90. 01 09010 SHORT STAY 0 0 0 0 90. 01 09010 SHORT STAY 0 0 0 0 90. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0 90. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0 90. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0 90. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0 90. 00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0	55. 00 05500 RADI OLOGY-THERAPEUTI C	O	2, 012, 224	0			55. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 999,956 0 58.00	57. 00 05700 CT SCAN	o	2, 719, 975	0			57.00
59, 00 05900 CARDI AC CATHETERIZATION 0 3, 373, 081 0 0 0 0 0 0 0 0 0	57. 01 03630 ULTRA SOUND	O	366, 344	0			57. 01
60. 00 06000 LABORATORY 0 2,839,920 0 60. 00 60. 01 60. 00 60. 01 60. 00	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	O	909, 956	0			58. 00
60. 00 06000 LABORATORY 0 2, 839, 920 0 0 0 0 0 0 0 0 0		o	3, 373, 081	O			59.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 243, 211 0 0 64. 00 64. 00 64. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67	60. 00 06000 LABORATORY	o					60.00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 65.00 65.00 RESPI RATORY THERAPY 0 891.054 0 65.00 66.00 66.00 06600 PHYSI CAL THERAPY 0 420 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 66.00	60. 01 06001 BLOOD LABORATORY	o	0	0			60. 01
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	243, 211	0			63.00
66. 00	64. 00 06400 I NTRAVENOUS THERAPY	o	0	0			64.00
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 68.00 68.00 6800 SPECCH PATHOLOGY 0 0 0 0 68.00 69.00 6900 ELECTROCARDIOLOGY 0 1, 983, 852 0 69.00 69.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 4, 707, 418 0 71.00 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 992, 668 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 2, 222, 717 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00 76.00 03020 OTHER ANCILLARY 0 0 0 0 0 76.00 76.00 03020 OTHER ANCILLARY 0 0 0 0 0 76.00 76.00 03020 OTHER ANCILLARY 0 0 1, 104, 341 0 76.01 03140 CARDIA CARDIA CREHAB 0 1, 104, 341 0 76.01 03330 ENDOSCOPY 0 154, 806 0 76.03 03330 ENDOSCOPY 0 154, 806 0 76.03 000 000 CLINIC 0 0 0000 CLINIC 0 0 0000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	o	891, 054	0			65.00
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 68. 00 68. 00 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 68. 00 69. 0	66. 00 06600 PHYSI CAL THERAPY	ol	420	o			66, 00
69. 00 06900 ELECTROCARDI OLOGY 0 1, 983, 852 0 69. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00	· · · · · · · · · · · · · · · · · · ·	o	0	o			67. 00
69. 00 06900 ELECTROCARDI OLOGY 0 1, 983, 852 0 69. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00	68. 00 06800 SPEECH PATHOLOGY	o	0	o			68. 00
71. 00		o	1, 983, 852	o			69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 992, 668 0 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00		o					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2,222,717 0 0 73. 00 74. 00 74. 00 74. 00 74. 00 76. 00 0 0 0 0 0 0 0 0 0		o					72. 00
74. 00		o					
76. 00 03020 OTHER ANCI LLARY 0 0 0 0 76. 00 76. 01 03140 CARDI AC REHAB 0 1,104, 341 0 76. 01 76. 02 03070 WOMEN'S CENTER 0 296, 304 0 76. 02 76. 03 0330 ENDOSCOPY 0 154, 806 0 76. 03 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 1,037, 628 0 90. 01 90. 01 09001 OUTPATI ENT 0 820, 179 0 90. 01 91. 01 09101 SHORT STAY 0 97. 01 91. 01 09101 SHORT STAY 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 795, 869 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES		o		o			
76. 01		o	0	o			
76. 02 76. 03 03070 WOMEN'S CENTER 0 296, 304 0 154, 806 0 76. 02 76. 03 0000 CLI NI C 00000 CLI NI C 00000 CLI NI C 00000 CUPATIENT 00000 09100 EMERGENCY 010000 09100 EMERGENCY 010000 09101 SHORT STAY 01000 09101 SHORT STAY 0100 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 795. 00 071HER REI MBURSABLE COST CENTERS 0 296, 304 0 154, 806 0 76. 02 76. 02 76. 02 76. 03 76. 02 76. 02 76. 02 76. 02 76. 03 76. 02 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 02 76. 03 76. 03 76. 02 76. 03 7		o	1. 104. 341	0			
76. 03 03330 ENDOSCOPY 0 154,806 0 76. 03 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 1,037,628 0 90. 00 90. 01 09001 OUTPATI ENT 0 820,179 0 90. 01 91. 00 09100 EMERGENCY 0 3,089,130 0 91. 00 91. 01 09101 SHORT STAY 0 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 795,869 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES		o					
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 1, 037, 628 0 90. 00 90. 01 09001 0UTPATI ENT 0 820, 179 0 90. 01 91. 00 09100 EMERGENCY 0 3, 089, 130 0 91. 00 91. 01 09101 SHORT STAY 0 0 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 795, 869 0 95. 00 09500 AMBULANCE SERVI CES 95. 00		o					
90. 00 09000 CLINIC 0 1, 037, 628 0 90. 00 90. 01		-1					1
90. 01 09001 0UTPATIENT		0	1, 037, 628	0			90.00
91. 01 09101 SHORT STAY 0 0 0 0 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 01 09001 OUTPATI ENT	o					90. 01
91. 01 09101 SHORT STAY 0 0 0 0 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00							
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 795, 869 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00		1	0				
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	· · · · · · · · · · · · · · · · · · ·	1	795, 869	0			
95. 00 09500 AMBULANCE SERVICES 95. 00		-1	.,				1
							95. 00
200:00	200.00 Total (lines 50-199)	o	38, 849, 637	0			200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150059	Peri od:	Worksheet D	
					From 01/01/2014	Part V	
					To 12/31/2014	Date/Time Pre	
						5/27/2015 3:3	6 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 225596	4, 763, 884		0	1, 074, 713	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000) c		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 282395	3, 524, 656	,	0	995, 345	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 284078	2, 012, 224		0 0	571, 629	55. 00
57.00	05700 CT SCAN	0. 035564			0	96, 733	57.00
57. 01	03630 ULTRA SOUND	0. 090697			0	33, 226	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 072836			0 267	66, 278	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 107158			0 0	361, 453	
60.00	06000 LABORATORY	0. 196318		•	0 0	557, 527	1
60. 00	06001 BL00D LABORATORY	0. 000000			0 0	0 337, 327	1
			1	•	0 0		1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 589672		l		143, 415	1
64.00	06400 NTRAVENOUS THERAPY	0.000000		1	0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 276639			0	246, 500	1
66. 00	06600 PHYSI CAL THERAPY	0. 375619			0	158	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000		1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	l control of the cont	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 200977			0	398, 709	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 382804		1	0 1, 297	1, 802, 018	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 296343	992, 668	3	0	294, 170	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 574007	2, 222, 717	'	0 10, 319	1, 275, 855	73. 00
74.00	07400 RENAL DIALYSIS	0. 837450) c		0	0	74.00
76.00	03020 OTHER ANCI LLARY	0. 000000) c		0	0	76. 00
76. 01	03140 CARDI AC REHAB	0. 361675	1, 104, 341		0	399, 413	76. 01
76. 02	03070 WOMEN' S CENTER	0. 281914	296, 304		0 0	83, 532	76. 02
76. 03	03330 ENDOSCOPY	0. 145403	154, 806		0	22, 509	76. 03
	OUTPATIENT SERVICE COST CENTERS		•	•			1
90.00	09000 CLI NI C	0. 510881	1, 037, 628	3	0 77	530, 104	90.00
90. 01	09001 OUTPATI ENT	0. 301686			0 2, 089	247, 437	90. 01
91.00	09100 EMERGENCY	0. 230068			0	710, 710	1
91. 01	09101 SHORT STAY	0. 000000		•	o o	0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 786230		1		625, 736	1
72.00	OTHER REIMBURSABLE COST CENTERS	0.700230	775,007	'	0	023, 730	72.00
95. 00	09500 AMBULANCE SERVICES	0. 000000	J		0		95. 00
200.00		0.000000	38, 849, 637	1	0 14, 049	10, 537, 170	
200.00	,		30, 047, 037		14, 049	10, 557, 170	200.00
201.00	Only Charges			'	٥		201.00
202.00			38, 849, 637	,	0 14, 049	10, 537, 170	202 00
202.00	inet sharges (Trile 200 17 Trile 201)	I	30, 047, 037	1	0 17,047	10, 337, 170	1202.00

Health Financial Systems RIVERVIEW APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST RI VERVI EW HOSPI TAL

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2014	Part V
To 12/31/2014	Date/Time Prepared:
5/27/2015 3:36 pm	Provider CCN: 150059

					12, 21, 221	5/27/2015 3:3	6 pm
			Ti tl	e XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0)			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
57.00	05700 CT SCAN	0	0				57. 00
57. 01	03630 ULTRA SOUND	0	0				57. 01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	19				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0)			59. 00
60.00	06000 LABORATORY	0	0				60. 00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0)			63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPIRATORY THERAPY	0	l o)			65. 00
66.00	06600 PHYSI CAL THERAPY	0	l o)			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0)			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	,			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	496				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	5, 923				73. 00
74. 00	07400 RENAL DIALYSIS	0	0	1			74. 00
76. 00	03020 OTHER ANCI LLARY	0	0	1			76. 00
76. 01	03140 CARDI AC REHAB	0	0	1			76. 01
76. 02	03070 WOMEN'S CENTER	0	Ö				76. 02
76. 03	03330 ENDOSCOPY	0	ĺ				76. 03
70.00	OUTPATIENT SERVICE COST CENTERS			1			70.00
90. 00	09000 CLINIC	0	39				90.00
90. 01	09001 OUTPATI ENT	0	630				90. 01
91. 00	09100 EMERGENCY	0	0				91.00
91. 01	09101 SHORT STAY	0	Ö	1			91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 00
7Z. UU	OTHER REIMBURSABLE COST CENTERS			1			72.00
95. 00	09500 AMBULANCE SERVICES	0					95. 00
200.00	1		7, 107				200. 00
200.00			, 107	1			200.00
201.00	Only Charges						201.00
202.00		0	7, 107				202. 00
202.00	The charges (Title 200 +/ - Title 201)	1	1 ,, 107	I			1202.00

	Financial Systems	RI VERVI EW	HOSPI TAL	-		In Lie	eu of Form CMS-:	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Pro	ovi der	CCN: 150059	Peri od: From 01/01/2014	Worksheet D Part II	
			Cor	mponent	CCN: 15T059	To 12/31/2014	Date/Time Pre 5/27/2015 3:3	pared: 6 pm
				Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
			(from Wk			Program	(column 3 x	
		(from Wkst. B,			(col . 1 ÷ col	. Charges	column 4)	
		Part II, col. 26)	8)		2)			
		1.00	2.0)O	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.0	,	3.00	4.00	3.00	
50.00	05000 OPERATI NG ROOM	1, 355, 378	42.1	63, 097	0. 03214	16 84, 928	2, 730	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0			0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	578, 651	14.0)43, 592			2, 804	
55. 00	05500 RADI OLOGY-THERAPEUTI C	318, 281		37, 021	0. 05854		1, 657	1
57. 00	05700 CT SCAN	4, 371		25, 379			29	
57. 01	03630 ULTRA SOUND	2, 332		22, 317			5	57. 01
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 308	1	42, 844			22	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	139, 827		91, 707			282	
60.00	06000 LABORATORY	600, 020		324, 702			10, 542	1
60. 01	06001 BLOOD LABORATORY	0	1	. 0			0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	166, 789	1, 6	59, 254	0. 10052	14, 817	1, 489	63.00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0. 00000	00	0	64. 00
65.00	06500 RESPI RATORY THERAPY	98, 301	5, 8	861, 874	0. 0167	70 414, 535	6, 952	65. 00
66.00	06600 PHYSI CAL THERAPY	82, 585	17, 4	54, 369	0. 00473	3, 028, 151	14, 326	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0.00000	00	0	67.00
68.00	06800 SPEECH PATHOLOGY	0		0	0.00000	00	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	481, 406	9, 6	93, 293	0. 04966	54 51, 750	2, 570	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	280, 863	43, 5	97, 337	0. 00644	12 381, 029	2, 455	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8, 768	4, 3	321, 342	0. 00202		25	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	351, 942		31, 610			11, 750	
74.00	07400 RENAL DIALYSIS	24, 932	4	17, 786			6, 486	
76. 00	03020 OTHER ANCILLARY	0	1	0	0.0000		0	1
76. 01	03140 CARDI AC REHAB	14, 324		57, 583			47	76. 01
76. 02	03070 WOMEN'S CENTER	358, 943		63, 897			4	76. 02
76. 03	03330 ENDOSCOPY	120, 901	5, 7	96, 957	0. 0208!	1, 074	22	76. 03
	OUTPATIENT SERVICE COST CENTERS							1
90. 00	09000 CLI NI C	19, 712		303, 466			0	
90. 01	09001 OUTPATI ENT	161, 420		57, 522			l	1
91.00	09100 EMERGENCY	758, 051		31, 159			1, 789	
91. 01	09101 SHORT STAY	0		0	0.0000		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	լ 2,8	377, 157	0.00000	00 0	0	92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES							05 00
95. 00 200. 00	l	5, 931, 105	275 4	75, 265		5, 741, 779	66 500	95. 00 200. 00
200.00		J, 731, 103	y 275,4	1, 3, 200	I	5, 141, 119	1 00, 390	1200.00

APP0R	Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RIVERVIEW HOS RVICE OTHER PASS		CCN: 150059	Peri od:	u of Form CMS-2 Worksheet D	
THROUG	GH COSTS		Componen-	t CCN: 15T059	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/27/2015 3:3	
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician Nur	sing School	Allied Healt		Total Cost	
		Anesthetist Cost			Medical Education Cost	(sum of col 1	
		COST			Educati on Cost	4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	C		0 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C)	0 0	0	55. 00
57. 00	05700 CT SCAN	0	C)	0 0	0	57.00
57. 01	03630 ULTRA SOUND	0	C)	0 0	0	57. 01
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00	06000 LABORATORY	0	C		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C		0 0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	C	1	0 0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C	1	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	1	0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	C	1	0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY		C	1	0 0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		C	1	0 0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS			•		0	73.00
74. 00	07400 RENAL DIALYSIS		C	1		0	74.00
76. 00	03020 OTHER ANCILLARY					0	76.00
76. 01	03140 CARDI AC REHAB					0	76. 00
76. 02	1		C	1		0	76. 02
	03330 ENDOSCOPY		C			0	76. 02
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0 0		70.00
90. 00	09000 CLI NI C	0	C		ol ol	0	90.00
90. 01	09001 OUTPATI ENT		Ċ		ol ol	0	90. 01
91. 00	09100 EMERGENCY	l ol	C		o o	0	91.00
91. 01	09101 SHORT STAY	o	C		o o	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	C		o o	0	92.00
	OTHER REIMBURSABLE COST CENTERS	1		•			1
95. 00	09500 AMBULANCE SERVICES						95.00
200. 00	Total (lines 50-199)	o	C	ol .	0 0	0	200. 00

Health Financial Systems RIVERVIEW HOSPI APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS				CCN: 150059	Peri od:	u of Form CMS-2552-10 Worksheet D	
			5 Provider	CCN: 150059	From 01/01/2014		
THROUGH COSTS				t CCN: 15T059	To 12/31/2014	Date/Time Prepared: 5/27/2015 3:36 pm	
			e XVIII	Subprovi der – I RF	PPS		
	Cost Center Description	Total	Total Charges			I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0				84, 928	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	.,			68, 052	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	-,,			28, 313	
57.00	05700 CT SCAN	0	7,020,07			63, 947	
57. 01	03630 ULTRA SOUND	0	_, .==,			5, 701	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				23, 338	
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0. 00000		25, 398	59. 00
60.00	06000 LABORATORY	0	36, 324, 702			638, 239	
60. 01	06001 BLOOD LABORATORY	0	1	0.0000		0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 659, 254			14, 817	63.00
64.00	06400 I NTRAVENOUS THERAPY	0) (0. 00000		0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	5, 861, 874			414, 535	65.00
66.00	06600 PHYSI CAL THERAPY	0	17, 454, 369			3, 028, 151	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0) (0.00000	0. 000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0) (0.00000	0. 000000	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	9, 693, 293	0. 00000	0. 000000	51, 750	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43, 597, 337	0. 00000	0. 000000	381, 029	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	4, 321, 342	0. 00000	0. 000000	12, 508	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21, 431, 610	0. 00000	0. 000000	715, 500	73.00
74.00	07400 RENAL DIALYSIS	0	417, 786	0. 00000	0. 000000	108, 691	74.00
76.00	03020 OTHER ANCI LLARY	0)	0. 00000	0. 000000	0	76.00
76. 01	03140 CARDI AC REHAB	0	2, 957, 583	0. 00000	0. 000000	9, 781	76. 01
76. 02	03070 WOMEN' S CENTER	0	4, 063, 897	0. 00000	0. 000000	47	76. 02
76. 03	03330 ENDOSCOPY	0	5, 796, 957	0. 00000	0. 000000	1, 074	76. 03
	OUTPATIENT SERVICE COST CENTERS	·					
90.00	09000 CLI NI C	0	3, 803, 466	0.00000	0. 000000	61	90.00
90. 01	09001 OUTPATI ENT	0			0. 000000	15, 565	90. 01
91.00	09100 EMERGENCY	0				50, 354	1
91. 01	09101 SHORT STAY	0				0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	l ·	1		0	
	OTHER REIMBURSABLE COST CENTERS		, , , , , , ,				1
95. 00	09500 AMBULANCE SERVI CES						95. 00
	Total (lines 50-199)	0	275, 475, 265	1		5, 741, 779	

Health Financial Systems RIVERVIEW HOSPI			TAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETHROUGH COSTS	ERVICE OTHER PASS	6			Peri od: From 01/01/2014 To 12/31/2014			
			Title XVIII		Subprovi der - I RF	PPS		
Cost Center Description	Inpatient Program Pass-Through	P C	tpatient rogram harges	Outpatient Program Pass-Through				

					IRF					
Cost Center Description		I npati ent	Outpati ent	Outpati ent						
		Program	Program	Program						
		Pass-Through	Charges	Pass-Through						
		Costs (col. 8		Costs (col. 9)					
		x col. 10)		x col. 12)						
		11. 00	12. 00	13.00						
	ANCILLARY SERVICE COST CENTERS									
50.00	05000 OPERATI NG ROOM	0	0)	O		50.00			
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	O		52. 00			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	O		54. 00			
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0)	O		55. 00			
57.00	05700 CT SCAN	0	0)	O		57.00			
57. 01	03630 ULTRA SOUND	0	0)	O		57. 01			
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	O		58. 00			
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0)	O		59. 00			
60.00	06000 LABORATORY	0	0		O		60.00			
60. 01	06001 BLOOD LABORATORY	0	0		O		60. 01			
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		O		63.00			
64.00	06400 I NTRAVENOUS THERAPY	o	0)	O		64.00			
65.00	06500 RESPI RATORY THERAPY	o	0)	O		65. 00			
66.00	06600 PHYSI CAL THERAPY	o	0)	O		66.00			
67.00	06700 OCCUPATI ONAL THERAPY	o	0)	O		67.00			
68.00	06800 SPEECH PATHOLOGY	o	0)	O		68. 00			
69.00	06900 ELECTROCARDI OLOGY	o	0)	0		69. 00			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	Ō)	O		71. 00			
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0)	0		72. 00			
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0)	O		73. 00			
74.00	07400 RENAL DIALYSIS	o	0)	O		74.00			
76.00	03020 OTHER ANCILLARY	o	0)	0		76. 00			
76. 01	03140 CARDI AC REHAB	o	0)	0		76. 01			
76. 02	03070 WOMEN' S CENTER	o	0)	0		76. 02			
76. 03	03330 ENDOSCOPY	o	0)	O		76. 03			
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000 CLI NI C	0	0)	O		90.00			
90. 01	09001 OUTPATI ENT	0	0)	O		90. 01			
91.00	09100 EMERGENCY	o	0)	O		91.00			
91. 01	09101 SHORT STAY	o	0)	O		91. 01			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0)	O		92.00			
	OTHER REIMBURSABLE COST CENTERS									
95.00	09500 AMBULANCE SERVICES						95. 00			
200.00	Total (lines 50-199)	o	0)	O		200. 00			
		·								

ealth Financial Systems	RI VERVI EW HO		CON 150050		eu of Form CMS-:	2552-T
PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PASS		CCN: 150059 CCN: 155669	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 3:3	pared:
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	о рііі
Cost Center Description	Non Physician N	ursing School	Allied Healt		Total Cost	
2001 201121 202011 211011	Anesthetist	ar orrig correct	, a r r ou r rour r	Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. 00
7. 00 05700 CT SCAN	0	0		0 0	0	57.00
7. 01 03630 ULTRA SOUND	0	0		0 0	0	57. 01
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
0. 00 06000 LABORATORY	0	0		0 0	0	60.00
O. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60. 0°
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
4. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
5. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
6. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.0
8. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 0
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.0
4. 00 07400 RENAL DIALYSIS	0	0		0	0	
6. 00 03020 OTHER ANCI LLARY	0	0		0	0	
6. 01 03140 CARDI AC REHAB	0	0		0	0	
6. 02 03070 WOMEN' S CENTER	0	0		0	0	1 , 0. 0
6. 03 03330 ENDOSCOPY	0	0		0 0	0	76. 0
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLI NI C	0	0		0 0	1	
0. 01 09001 0UTPATI ENT	0	0		0 0	0	
1. 00 09100 EMERGENCY	0	0		0	0	
1. 01 09101 SHORT STAY	0	0		0	0	1 / 0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.0
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES						95. 0
00.00 Total (lines 50-199)	l ol	0		0 0	1 0	200.0

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RI VERVI EW		CCN: 150059	Peri od:	u of Form CMS-2 Worksheet D	2332-10
	H COSTS	WICE UINER PAS	3 Provider	CCN. 150059	From 01/01/2014	Part IV	
TTIKOOC	11 00313			t CCN: 155669	To 12/31/2014	Date/Time Pre 5/27/2015 3:3	pared: 6 pm
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
	· · · · · · · · · · · · · · · · · · ·	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col	. to Charges	Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.	Ü	
		4)	ŕ		7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS				<u> </u>		
50.00	05000 OPERATING ROOM	0	42, 163, 097	0.00000	0. 000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0) (0. 00000	0. 000000	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 043, 592	0.00000	0. 000000	57, 052	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	5, 437, 02°	0. 00000	0. 000000	0	55.00
57.00	05700 CT SCAN	0	9, 625, 379	0. 00000	0. 000000	0	57.00
57. 01	03630 ULTRA SOUND	0	2, 422, 317	0. 00000	0. 000000	0	57. 01
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		1		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		1		0	59.00
60.00	06000 LABORATORY	0		1		806, 146	60.00
60. 01	06001 BLOOD LABORATORY	0		1		0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1	1		0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0		1		0	
65. 00	06500 RESPI RATORY THERAPY	0	1	1		217, 650	
66. 00	06600 PHYSI CAL THERAPY	0		•		896, 712	
67. 00	06700 OCCUPATI ONAL THERAPY	0	,	1		0	
68. 00	06800 SPEECH PATHOLOGY	0		0.00000		0	
69. 00	06900 ELECTROCARDI OLOGY	0	l ·	•		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			•		48, 002	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT			•		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS			1		992, 516	
74. 00	07400 RENAL DI ALYSI S			1		0	
76. 00	03020 OTHER ANCILLARY			1		0	
76. 01	03140 CARDI AC REHAB			1		26, 132	
76. 02	03070 WOMEN'S CENTER			1		0	
76. 03	03330 ENDOSCOPY					0	
70.00	OUTPATIENT SERVICE COST CENTERS		0,770,70	0.00000	0.00000		70.00
90. 00	09000 CLINI C	0	3, 803, 466	0.00000	0. 000000	0	90.00
90. 00	09001 OUTPATI ENT		-,,			0	
91. 00	09100 EMERGENCY			1		0	
91. 00	09101 SHORT STAY		,	1		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1	1		0	
12.00	OTHER REIMBURSABLE COST CENTERS		2,077,107	0.00000	0.00000	0	72.00
95. 00	09500 AMBULANCE SERVICES						95.00

Health Financial Systems	RI VERVI EW HOSPI	TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150059	Peri od: From 01/01/2014	Worksheet D
THOUGH COSTS		Component CCN: 155669		
		Title XVIII	Skilled Nursing	PPS

		11 (1)	e XVIII	Facility	PP3	
Cost Center Description	Inpatient	Outpati ent	Outpati ent	raciiity		
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	Ü	Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	C			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C			55.00
57.00 05700 CT SCAN	0	0	C			57. 00
57.01 03630 ULTRA SOUND	0	0	C)		57. 01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C			59. 00
60. 00 06000 LABORATORY	0	0	C			60.00
60. 01 06001 BLOOD LABORATORY	0	0	C			60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	C			64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	C			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	C			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS O	0	C			71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	C			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	C			73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	C			74. 00
76. 00 03020 OTHER ANCI LLARY	0	0	C			76. 00
76. 01 03140 CARDI AC REHAB	0	0	O			76. 01
76. 02 03070 WOMEN' S CENTER	0	0	O)		76. 02
76. 03 03330 ENDOSCOPY	0	0	C			76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C			90.00
90. 01 09001 0UTPATI ENT	O	0	Ü			90. 01
91. 00 09100 EMERGENCY	0	0	0			91.00
91. 01 09101 SHORT STAY	,_, O	0	O			91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	RT) 0	0	C			92. 00
OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVICES			_			95. 00
200.00 Total (lines 50-199)	0	0	C	'		200. 00

	Financial Systems RIVERVIEW HOSP	I TAL	In Lie	u of Form CMS-	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150059	Peri od: From 01/01/2014	Worksheet D-1		
			To 12/31/2014	Date/Time Pre	pared:	
				5/27/2015 3:3		
	Cook Courtous Donousisticus	Title XVIII	Hospi tal	PPS		
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS				1	
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		14, 599	1.00	
2.00	Inpatient days (including private room days, excluding swing-be	d and newborn days)		14, 599	2. 00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00	
	do not complete this line.					
4.00	Semi-private room days (excluding swing-bed and observation bed			12, 774	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00	
	reporting period	daya) after December	21 of the cost	0	/ 00	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00	
7.00	reporting period	days) through becember	31 01 1110 0031	O	7.00	
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)	<i>3</i> ,				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	5, 221	9. 00	
	newborn days)					
10. 00						
44.00	through December 31 of the cost reporting period (see instructions)					
11. 00	00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)					
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00	
12.00	through December 31 of the cost reporting period	only (Thereating privat	c room days)	O	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar year	r, enter O on this lin	e) , , ,			
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0		
15. 00	Total nursery days (title V or XIX only)			0		
16. 00	Nursery days (title V or XIX only)			0	16. 00	
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00	
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	r the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00	
10.00	reporting period	arter becember 31 or	the cost	0.00	10.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00	
	reporting period	3				
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00	
	reporting period					
21. 00	Total general inpatient routine service cost (see instructions)			18, 095, 673		
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	31 of the cost report	ing period (line	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	a ported (line 6	0	23. 00	
23.00	Ix line 18)	To the cost reportin	g period (Title o	O	23.00	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00	
	7 x line 19)		3 1 (1.1.0			
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00	
	x line 20)					
26. 00	Total swing-bed cost (see instructions)			0		
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		18, 095, 673	27. 00	

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14, 599	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14, 599	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	12, 774	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	5, 221	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period	_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	44.00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17.00	SWING BED ADJUSTMENT	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
10 00	reporting period Medicare rate for swing had SNE services applicable to services after December 21 of the cost	0.00	10 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
19.00	reporting period	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	18, 095, 673	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)	-	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18, 095, 673	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
	Average private room per diem charge (line 29 ÷ line 3)		32. 00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
	Average per diem private room cost differential (line 34 x line 31)		35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	18, 095, 673	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 239. 51	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	6, 471, 482	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	6, 471, 482	41.00

<u>Heal</u> th	Financial Systems	RI VERVI EW	HOSPI TAL		<u>In L</u> i e	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
					To 12/31/2014		
			Ti tl	e XVIII	Hospi tal	PPS	<u>э рііі </u>
	Cost Center Description	Total	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent cost	Impatrent bays	col. 2)		4)	
42.00	NUDCEDY (+; +l c V & VIV only)	1.00	2.00	3.00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	U	42. 00
43. 00	INTENSIVE CARE UNIT	4, 290, 862	2, 762	1, 553. 53	1, 371	2, 129, 890	43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGI CAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk			>		12, 048, 020	48. 00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ins)		20, 649, 392	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	1, 646, 457	50.00
51. 00	 Pass through costs applicable to Program inp	atient ancillar	rv services (fr	om Wkst. D. su	ım of Parts II	763, 150	51. 00
	and IV)		y 55. V. 555 (oot. 2, 60	01 141 15 11		
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		alated non-nhy	sician anestha	atist and	2, 409, 607 18, 239, 785	52. 00 53. 00
33.00	medical education costs (line 49 minus line		erated, non-pny	Si Ci ali allestile	etrst, and	10, 237, 703	33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)				. 50)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, u	pdated and com	pounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost renort ur	ndated by the m	arket hasket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	er of 50% of t		0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see						
62.00	2.00 Relief payment (see instructions)						
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the c	ost reporting	neriod (See	o	65. 00
05.00	instructions) (title XVIII only)	ts after becenik	der 31 of the C	ost reporting	perrou (see		03.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 o	of the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	a costs after [December 31 of	the cost repor	sting period		68. 00
00.00	(line 13 x line 20)	e costs after L	becember 31 01	the cost repor	triig perrou		08.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		`			0	69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from W	orksheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		provi der record	ls)			79. 00
80. 00 81. 00	Total Program routine service costs for comp		cost limitation	ı(line 78 minu	ıs line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				82. 00
83.00	Reasonable inpatient routine service costs (ıs)				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					1, 825	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 239. 51	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				2, 262, 106	89. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/27/2015 3:30	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 647, 051	18, 095, 673	0. 20154	3 2, 262, 106	455, 912	90.00
91.00 Nursing School cost	0	18, 095, 673	0.00000	2, 262, 106	0	91.00
92.00 Allied health cost	0	18, 095, 673	0.00000	2, 262, 106	0	92.00
93.00 All other Medical Education	0	18, 095, 673	0. 000000	2, 262, 106	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150059		Worksheet D-1
	Component CCN: 15T05	From 01/01/2014 To 12/31/2014	Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I RF	FF3	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 548	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		vata naom dava	5, 548 0	
3. 00	do not complete this line.	i. IT you have only pri	vate room days,	U	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		5, 548	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 3	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) area becomber a	The cost	o .	0.00
7.00	Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	Havs) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	lays) arter becomber 5	or the cost	O	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 630	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (including private re	om dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joili days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (including private	s room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program	-	,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed c	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
17 00	SWING BED ADJUSTMENT	+brough Docombon 21 of	the east	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	-brough Docombor 21 of	the cost	0.00	19. 00
17.00	reporting period	in ough becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			4, 216, 436	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00
22.00	5 x line 17)			0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3' x line 18)	i of the cost reporting	period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reportin	ng 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 reporting	pariod (line 0	0	25. 00
25. 00	x line 20)	of the cost reporting	perrou (Trile 6	U	23.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		4, 216, 436	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ 1	ino 20)		0. 000000	30.00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	THE 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 minus		i ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	4, 216, 436	
	27 minus line 36)		` '		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			759. 99	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	3)		2, 758, 764	39. 00
40.00	Medically necessary private room cost applicable to the Program	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	1111C 40)		2, 758, 764	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW 1		CCN: 150059	In Lie	worksheet D-1		
JOWN UT	S. C. THE ATTENT OF ENVITING COST			t CCN: 15T059	From 01/01/2014			
						5/27/2015 3:3	6 pm	
			11 11	e XVIII	Subprovi der - I RF	PPS		
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2. 00	3. 00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	00 0	0	42.00	
43. 00	INTENSIVE CARE UNIT	0	C	0.0	00 0	0		
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			2, 121, 487	48. 00	
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	<u> </u>		,		4, 880, 251		
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, sum	of Parts I and	430, 264	50.00	
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	66, 590	51.00	
52.00	Total Program excludable cost (sum of lines!					496, 854		
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	sıcıan anesth	etist, and	4, 383, 397	53.00	
54. 00	Program di scharges					0	54.00	
	Target amount per discharge						55. 00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and tar	rget amount (1	ine 56 minus	line 53)	0		
58. 00	Bonus payment (see instructions)	ng cost and tai	got amount (i	The oo minds	11110 00)	0	58. 00	
59. 00	Lesser of lines 53/54 or 55 from the cost reparted backet	porting period e	endi ng 1996, ι	ipdated and co	empounded by the	0.00	59. 00	
60. 00	market basket 00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 6							
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61. 00	
42.00	amount (line 56), otherwise enter zero (see instructions)							
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0		
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	cost reporti	ng period (See	0	64. 00	
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVII	I only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost re	porting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00	
71. 00	Adjusted general inpatient routine service co	ost per diem (li					71. 00	
	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 v li	ne 35)			72. 00 73. 00	
74. 00	Total Program general inpatient routine servi						74.00	
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from V	lorksheet B, P	Part II, column		75. 00	
76.00	Per diem capital-related costs (line 75 ÷ li	. *					76.00	
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00	
	Aggregate charges to beneficiaries for excess	.*	rovi der record	ls)			79. 00	
80.00	Total Program routine service costs for compa		ost limitation	ı (line 78 min	us line 79)		80.00	
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li)				81. 00 82. 00	
83. 00	Reasonable inpatient routine service costs (s	,					83. 00	
84.00	Program inpatient ancillary services (see ins		20)				84.00	
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00	
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PASS							
	Tatal abasement on had days (ass instructions)	·	· ·		·		87.00	
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			0	88.00	

	IIAL		III LI E	u of Form CMS-2	2552-10
	Provi der	CCN: 150059		Worksheet D-1	
		CON 15TOFO			
	Component	CCN: 151059	10 12/31/2014		
	Ti tl	e XVIII	Subprovi der -	PPS	<u> </u>
			. I RF		
		column 1 ÷	Total	Observation	
(fro	m line 27)	column 2	Observati on	Bed Pass	
			Bed Cost (from	Through Cost	
			line 89)	(col. 3 x col.	
				4) (see	
				instructions)	
	2.00	3.00	4. 00	5. 00	
17	4, 216, 436	0. 15596	55 0	0	90.00
0	4, 216, 436	0.00000	00	0	91.00
0	4, 216, 436	0.00000	00	0	92.00
0	4, 216, 436	0. 00000	00 0	0	93. 00
	Rou	Component Title Routine Cost (from line 27) 2.00 17 4,216,436 0 4,216,436 0 4,216,436	Provider CCN: 150059 Component CCN: 15T059 Title XVIII Routine Cost (from line 27) 2.00 3.00 17 4,216,436 0,4,216,436 0,00000 0,4,216,436 0,00000000000000000000000000000000000	Provider CCN: 150059	Provider CCN: 150059

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150059		Worksheet D-1
	Component CCN: 155669	From 01/01/2014 To 12/31/2014	
	Title XVIII	Skilled Nursing	
	11 61 0 7,1111	Facility	

		Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			4, 820	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed	<i>3</i> /		4, 820	2.00
3. 00	Private room days (excluding swing-bed and observation bed days) do not complete this line.	0	3. 00		
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		4, 820	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period	3 ,			
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) thuayah Dagamban	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room or reporting period	lays) through becember	31 Of the Cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room o	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 /			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 349	9. 00
10.00	newborn days)	. (:		0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter	er O on this line)	, ,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including privat	e room days)	0	12.00
12 00	through December 31 of the cost reporting period	anly (including agivet	a raam daya)	0	13. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of after December 31 of the cost reporting period (if calendar year			U	13.00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	.		0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
	reporting period			2.22	
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20.00	reporting period	-£1 Db 21 -£ 1		0.00	20.00
20. 00	Medicald rate for swing-bed NF services applicable to services a reporting period	arter December 31 of t	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			3, 409, 963	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 3	R1 of the cost reporti	ng period (line	0	24. 00
21.00	7 x line 19)	or the cost reporti	ing period (Trite	G	21.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
04.00	x line 20)			0	07.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (li	no 21 minus Lino 26)		0 3, 409, 963	26. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus ime 20)		3, 407, 703	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00 0. 00	32. 00 33. 00
34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	=/	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	3, 409, 963	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in				38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38				39. 00
40. 00	Medically necessary private room cost applicable to the Program				40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)			41. 00

Heal th	Financial Systems	RI VERVI EW 1	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			Fi	eriod: com 01/01/2014	Worksheet D-1	
			Component	t CCN: 155669 To		Date/Time Pre 5/27/2015 3:3	
			Ti tl	e XVIII S	killed Nursing Facility	PPS	
	Cost Center Description	Total Inpatient Costl	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43. 00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1. 00	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)			49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine :	services (from	n Wkst. D. sum o	of Parts L and		50.00
	[111)		·				
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (fr	om Wkst. D, sur	n of Parts II		51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)					52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	sician anesthe	tist, and		53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					<u>.</u>
	Program di scharges						54.00
	Target amount per discharge						55. 00
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (L	ine 56 minus li	ne 53)		56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and tal	rget amount (r	THE 50 III HGS TI	110 33)		58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period (endi ng 1996, u	pdated and comp	bounded by the		59. 00
60. 00	market basket Lesser of Lines 53/54 or 55 from prior year	cost report un	dated by the m	narket basket			60.00
61. 00							61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see instructions) .00 Relief payment (see instructions)						
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost reporting	neriod (See		64.00
	instructions)(title XVIII only)	· ·			, ,		
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting p	period (See		65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For		66. 00
47.00	CAH (see instructions)	o costs through	Docombon 21 o	of the cost ron	orting poriod		67. 00
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 C	i the cost repo	of tring period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repor	ting period		68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	. 68)			69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/MR O	NLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil					3, 409, 963	
71.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ iine	2)		707. 46 2, 369, 284	
	Medically necessary private room cost applic		(line 14 x li	ne 35)		0	
74.00	Total Program general inpatient routine serv					2, 369, 284	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	lorksheet B, Pai	rt II, column	0	75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				0.00	76. 00
	Program capital -related costs (line 9 x line	· · · · · · · · · · · · · · · · · · ·				0	
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider record	ls)		0	
80.00	Total Program routine service costs for comp				s line 79)	0	1
81. 00	Inpatient routine service cost per diem limi					0.00	
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•			0 2, 369, 284	82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		٠,			2, 369, 284 1, 168, 941	1
85. 00	Utilization review - physician compensation	(see instruction				0	85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)			3, 538, 225	86. 00
87. 00	Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)			ļ	0	89. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 155669	From 01/01/2014 To 12/31/2014		nared:
		Component		10 12/31/2014	5/27/2015 3: 3	
		Ti tl	e XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	0	0	0.00000	0 0	0	90.00
91.00 Nursing School cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000	0 0	0	93. 00

	Financial Systems RIVERVIEW HOSE			u of Form CMS-1		
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 150059	Period: From 01/01/2014 To 12/31/2014		pared:	
		Title XIX	Hospi tal	5/27/2015 3:3 Cost	6 pm	
	Cost Center Description	THE XIX	nospi tai	0031		
	·			1. 00		
	PART I - ALL PROVIDER COMPONENTS				-	
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		14, 599	1.00	
2.00	Inpatient days (including private room days, excluding swing-be			14, 599	1	
3.00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3. 00	
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	I days)		12, 774	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period		r 31 of the cost	0	1	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00	
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00	
9. 00						
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi	0				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	0				
12. 00	through December 31 of the cost reporting period					
13. 00 14. 00	Swing-bed Nr type Inpattent days applicable to titles v or XIX after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program	nr, enter O on this lin	e)	0		
15. 00	Total nursery days (title V or XIX only)	r (excruding swing-bed	uays)	0		
16. 00	Nursery days (title V or XIX only)			0	1	
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s through December 31 o	f the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0.00	18. 00	
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20. 00	
21. 00	Total general inpatient routine service cost (see instructions)			18, 095, 673	1	
22. 00	5 x line 17)					
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	·		0		
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	·		0		
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20) Tatal swings had cost (see instructions)	of the cost reporting	perioa (iinė 8	0		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 18, 095, 673		
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation hed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)	SSS. Tation SSG On	300/	0	1	

Impatient days (including private room days and saing-bed days, excluding neekorn) 14,599 1.00 14,590 1.40 14,590 1.40 14,590 14,		INPATIENT DAYS		
Inpatient days (including private room days, excluding swing-bed and newborn days) 14,599 2,00 3,00 Private room days (cocluding swing-bed and observation bed days). 17 you have only private room days (and on the complete this line. 12,774 4,00 5,00 12,00 12,	1.00		14, 599	1. 00
Private room days (excluding swing-bed and observation bed days) If you have only private room days, 0 3.00				
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) 1. 12,774 4. 00 Sell-private room days (excluding private room days) after December 31 of the cost 7. 00 Total swing-bed SW type Inpatient days (including private room days) after December 31 of the cost 7. 00 Total say ing-bed SW type Inpatient days (including private room days) after December 31 of the cost 7. 00 Total say ing-bed SW type inpatient days (including private room days) through December 31 of the cost 8. 00 Total say ing-bed SW type inpatient days (including private room days) after December 31 of the cost 8. 00 Total say ing-bed SW type inpatient days (including private room days) after December 31 of the cost 9. 00 Total inpatient days including private room days and including swing-bed and 10. 00 Swing-bed SW type inpatient days applicable to this line) 10. 00 Swing-bed SW type inpatient days applicable to the SW of				
Total saing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) through December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) through December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or Potal inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) or Potal inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) or Potal SNF type inpatient days applicable to the Program (excluding swing-bed and proper size of the cost reporting period (if calendar year, enter 0 on this line) or Potal SNF type inpatient days applicable to this exclusion of the cost reporting period (if calendar year, enter 0 on this line) or Potal SNF type inpatient days applicable to titles V or XIX only (including private room days) or 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) or Potal December 31 of the cost reporting period (if calendar year, enter 0 on this line) or Potal December 31 of the cost reporting period (if calendar year, enter 0 on this line) or 13.00 are potal period (if calendar year, enter 0 on this line) or 14.00 period period (if calendar year, enter 0 on this line) or 14.00 period (if calendar year, enter 0 on this line) or 14.00 period (if calendar year, enter 0 on this line) or 14.00 period (if calendar year, enter 0 on this line) or 14.00 period (if calendar year, enter 0 on this line) or 14.00 period (if calendar year, enter 0 on this line) or 14.00 period (if calendar year, enter 0 on this line) or 14.00 period (if calendar year, ente		do not complete this line.		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting beriod (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to the SNF type inpatient days applicable to the Program (excluding private room days) 11.00 Swing-bed SNF type inpatient days applicable to title SVI or XIX only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title SVI or XIX only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title SVI or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title SVI or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title SVI or XIX only (including private room days) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 17.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 18.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 19.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 19.00 Medical program (and the private room days applicable to services through December 31 of the cost reporting period (including private room days applicable to Services after December 31 of the cost reporting period (including private room days	4.00	Semi-private room days (excluding swing-bed and observation bed days)	12, 774	4.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00	5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) through December 31 of the cost 1 or reporting period 1 or the swing-bed type inpatient days (including private room days) after December 31 of the cost 1 or 8.00 Total inpatient days including private room days april cable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0 or through December 31 of the cost reporting period (is calendar year, enter 0 or this line) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (is calendar year, enter 0 or this line) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 30 or through December 31 of the cost reporting period (is calendar year, enter 0 or this line) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 or this line) 14.00 Redically necessary private room days applicable to titles V or XX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 or this line) 15.00 Intal nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Redically necessary private room days applicable to services through December 31 of the cost or porting period (if calendar year, enter 0 or this line) 18.00 Redical rate for swing-bed SMF services applicable to services through December 31 of the cost or porting period (in pursery days (title V or XIX only) 19.00 Redical rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (line 6 or xi ine 1) 19.00 Redical rate for swing-bed SMF services applicable to services after December 31 of the cost reporting perio		reporting period		
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reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Sking-bed Skit type inpatient days applicable to title XVIII only (including private room days) after on December 31 of the cost reporting period (see instructions) 11. 00 Sking-bed Skit type inpatient days applicable to title XVIII only (including private room days) after on December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Sking-bed Skit type inpatient days applicable to titles Vor XIX only (including private room days) after of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Sking-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) of 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) of 15. 00 Total nursery days (title V or XIX only) of 15. 00 Total nursery days (title V or XIX only) of 15. 00 Total care rate for swing-bed SNF services applicable to services through December 31 of the cost of 10. 00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost of 10. 00 Teporting period (including private room days) of 18. 00 Medical d rate for swing-bed SNF services applicable to services after December 31 of the cost of 10. 00 Medical d rate for swing-bed SNF services after December 31 of the cost reporting period (line size in the private room swing-bed SNF services after December 31 of the cost reporting period (line six in line 17). 10. 00 Medical d rate for swing-bed SNF services s		reporting period (if calendar year, enter 0 on this line)		
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost propring period (if Calleader year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the Program (excluding private room days) Total inpatient days including private room days applicable to the though December 31 of the cost reporting period (see instructions) Total period (see instructions	7.00		0	7.00
reporting period (if callendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 or the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SNF type inpatient days applicable to title X or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles X or XIX only (including private room days) 14.00 Swing-bed SNF type inpatient days applicable to titles X or XIX only (including private room days) 15.00 Swing-bed SNF type inpatient days applicable to titles X or XIX only (including private room days) 16.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nersery days (title Y or XIX only) 17.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nedically necessary private room days applicable to services through December 31 of the cost 18.00 Nedical care rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Nedical care rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Nedical day rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Nedical day rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Nedical day rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Nedical day rate for swing-bed NF services through December 31 of the cost reporting period (line 8 or SNF type services through December 31 o		reporting period		
10.00 Notal inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00	8.00		0	8. 00
newborn days) 10.00 Swings-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 10.00 through December 31 of the cost reporting period (see instructions) 11.00 Swings-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 Swings-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 12.00 Swings-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 13.00 Swings-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 13.00 Swings-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 13.00 Swings-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 13.00 Swings-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 15.00 Total nursery days (title V or XIX only) 1 15.00 Swings-bed NF Swings-bed SWIR Swings-bed				
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 10.00	9. 00		703	9. 00
through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically inecessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 15.00 Total nursery days (title V or XIX only) 16.00 Nersery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including period care rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including period care rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including period care rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including period one period in period (including period one perio	40.00			
11.00 Swing-bed SNF type inpatient days applicable to fittle XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Iotal nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 SWING BED ADJUSTMENT 18.00 North of the cost reporting period (if calendar year, enter 0 on this line) 18.00 North of the Cost of the C	10.00		0	10.00
December 31 of the cost reporting period (If calendar year, enter 0 on this line) 12.00	11 00		0	11 00
12.00 Swing-bed NF Type Inpatient days applicable to titles V or XIX only (including private room days) 12.00	11.00		U	11.00
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28.00 29.00 Private room charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18,095,673) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Aounce of the charges (excluding swing-bed and observation bed charges) 30.00 29.00 29.00 30.00 0 30.00 0 30.00 0 30.00 0 30.00 0 30.00 0 30.00 0 31.00 0 32.00 Average per diem private room cost differential (line 3 x line 33) 30.00 Private room cost differential (line 3 x line 33) 31.00 Program general inpatient routine service cost per diem (see instructions) 32.00 Average per diem private room cost differential (line 3 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 33) 34.00 Average per diem private room cost differential (line 3 x line 33) 35.00 Average per diem private room cost differential (line 3 x line 33) 36.00 Private room cost differential (line 3 x line 33) 37.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 3 x line 33	27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18, 095, 673	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18, 095, 673) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18, 095, 673) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 30.00 30.00 31.00 32.00 32.00 32.00 33.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00	28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18, 095, 673) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Average per diem charge (line 29 ÷ line 3) 40.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	29. 00	Private room charges (excluding swing-bed charges)	0	29.00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18, 095, 673) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00			0	30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18, 095, 673) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 37.00 18, 095, 673 38.00 18, 095, 673 38.00 19, 09, 09, 09, 09, 09, 09, 09, 09, 09, 0	31. 00		0.000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18,095,673) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 34.00 35.00 36.00 37.00 18,095,673 37.00 18,095,673 37.00 37.00 40.00	32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
35. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 18, 095, 673) 37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 239. 51 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 871, 376 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 18,095,673 37.00	34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 18, 095, 673 37. 00 18, 095, 673 38. 00 19, 239, 51 38. 00 40. 00		, , , , , , , , , , , , , , , , , , , ,		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 239.51 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, ,		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 239.51 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 871,376 39.00	37. 00		18, 095, 673	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 239.51 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,239.51 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,239.51 38.00 871,376 39.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 871,376 39.00 40.00				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	· ·	
		, , , , , , , , , , , , , , , , , , , ,		
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 871,376 41.00				
	41.00	Total Program general impatient routine service cost (line 39 + line 40)	8/1, 3/6	41.00

<u>H</u> eal th	h Financial Systems RIVERVIEW HOSPITAL	In Lie	u of Form CMS-2	<u>255</u> 2-10				
COMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 150059 Perio	od: 01/01/2014	Worksheet D-1					
	To	12/31/2014	Date/Time Prep					
	Ti tle XIX H	lospi tal	5/27/2015 3:30 Cost	5 piii				
	Cost Center Description Total Total Average Per Pro	ogram Days	Program Cost (col. 3 x col.					
	col. 2)		4)					
42.00	1.00 2.00 3.00 NURSERY (title V & XIX only) 0 0 0.00	4. 00	5. 00	42. 00				
42.00	Intensive Care Type Inpatient Hospital Units	0	0	42.00				
43. 00 44. 00		0	0	43. 00 44. 00				
	BURN INTENSIVE CARE UNIT			45. 00				
46.00				46.00				
47.00	O OTHER SPECIAL CARE (SPECIFY) Cost Center Description			47. 00				
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		1. 00 1, 045, 708	48. 00				
	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		1, 917, 084					
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of F	Parts L and	0	50. 00				
50.00	Pass through costs appricable to Program ripatient routine services (from wkst. b, sum of P	arts r and						
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of and IV)	Parts II	0	51. 00				
52. 00	Total Program excludable cost (sum of lines 50 and 51)		0	52. 00				
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist medical education costs (line 49 minus line 52)	:, and	0	53. 00				
	TARGET AMOUNT AND LIMIT COMPUTATION							
54. 00 55. 00	Program discharges Target amount per discharge		0 0. 00					
56. 00	Target amount (line 54 x line 55)		0.00	56. 00				
57. 00		53)	0	57. 00 58. 00				
58. 00 59. 00		nded by the	0. 00					
(0.00	market basket	0. 00	60. 00					
	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by							
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62. 00		0	62. 00					
63. 00		0	63. 00					
64. 00		eriod (See	0	64. 00				
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting peri	od (See	0	65. 00				
	instructions)(title XVIII only)							
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII onl CAH (see instructions)	y). For	0	66. 00				
67. 00		ng period	0	67. 00				
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting	g period	0	68. 00				
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		0	69. 00				
07.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		0					
70. 00 71. 00				70. 00 71. 00				
72. 00	Program routine service cost (line 9 x line 71)			72. 00				
73. 00 74. 00				73.00				
75. 00		I, column		74. 00 75. 00				
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)			76. 00				
77. 00				77. 00				
78. 00 79. 00				78. 00 79. 00				
80.00		ne 79)		80.00				
81.00				81.00				
82. 00 83. 00				82. 00 83. 00				
84.00	Program inpatient ancillary services (see instructions)			84. 00				
85. 00 86. 00				85. 00 86. 00				
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87. 00 88. 00			1, 825 1, 239. 51	87. 00 88. 00				
	Observation bed cost (line 87 x line 88) (see instructions)		2, 262, 106					

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	aanad.
				10 12/31/2014	5/27/2015 3:30	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	3, 647, 051	18, 095, 673	0. 20154	3 2, 262, 106	455, 912	90.00
91.00 Nursing School cost	0	18, 095, 673	0.00000	0 2, 262, 106	0	91.00
92.00 Allied health cost	0	18, 095, 673	0.00000	0 2, 262, 106	0	92.00
93.00 All other Medical Education	0	18, 095, 673	0.00000	0 2, 262, 106	0	93.00

Health Financial Systems	RIVERVIEW HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150059	Peri od: From 01/01/2014	Worksheet D-1
	Component CCN: 15T059		
	Title XIX	Subprovi der -	Cost
		IDE	

			I RF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 548	
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		to room days	5, 548 0	2. 00 3. 00
3.00	do not complete this line.	7. IT you have only pirva	te room days,	O	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed			5, 548	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December 3	1 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 31	of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	daya) through Dagambar 21	of the cost	0	7 00
7. 00	reporting period	aays) tiii ougii becellibei 31	or the cost	U	7. 00
8.00	Total swing-bed NF type inpatient days (including private room or reporting period (if calendar year, enter 0 on this line)	days) after December 31 o	f the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding sw	ing-bed and	266	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (i neludi na pri vate reem	daye)	0	10. 00
	through December 31 of the cost reporting period (see instruction	ons)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, ento		days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including private r	oom days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year		oom days)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed day	s)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 of t	he cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of the	cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of th	e cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of the	cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			4, 216, 436	
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporting	period (line	4, 210, 430	
23. 00	$5 ext{ x line 17}$ Swing-bed cost applicable to SNF type services after December 3	l of the cost reporting p	eriod (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December:	31 of the cost reporting	period (line	0	24. 00
05.00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting pe	riod (line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)	04 1 11 04		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (II PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus iine 26)		4, 216, 436	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed charg	es)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ 1	ino 29)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	THE 20)		0. 000000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instructio	ns)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	´	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost diffe	rential (line	4, 216, 436	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			759. 99	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3			202, 157	
40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)	I	202, 157	41. 00

Heal th	Financial Systems	RIVERVIEW HOS	PI TAL		In Li€	eu of Form CMS-	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der 0	F	Period: From 01/01/2014		
					To 12/31/2014	5/27/2015 3:3	
			litl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Total Inpatient CostInp	Total Patient Days	Average Per iem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
10.00	Thursday, (1) 11 to 14 to 14 to 1	1.00	2. 00	3.00	4. 00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00) C	η	42. 00
43.00	INTENSIVE CARE UNIT	0	0	0.00	C	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	1						46. 00
47.00	OST Center Description					1.00	47. 00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3. I	ine 200)			1. 00 186, 714	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			s)		388, 871	1
50.00	Pass through costs applicable to Program inp	atient routine ser	rvices (from	Wkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillary s	services (fro	m Wkst. D, su	um of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	· ·				0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ed, non-phys	ician anesthe	etist, and	0	53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					1 0	54.00
55.00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targe	et amount (li	ne 56 minus l	ine 53)	0 0	
58.00	Bonus payment (see instructions)	0	·		ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period end	ii ng 1996, up	dated and con	ipounaea by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	riisti ucti olis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructi	ons)			0	63. 00
64. 00		ts through Decembe	er 31 of the	cost reportir	ng period (See	0	64. 00
65. 00		ts after December	31 of the co	st reporting	period (See	0	65. 00
66. 00	1	ne costs (line 64	plus line 65)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through De	ecember 31 of	the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dece	ember 31 of t	he cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		e 70 ÷ line 2)			71. 00 72. 00
73. 00	Medically necessary private room cost application	abĺe to Program (I		e 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	rksheet B, Pa	art II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	,		vider records)			79. 00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		limitation	(line 78 minu	ıs line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00							83. 00 84. 00
85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıgh 85)				86. 00
87. 00	Total observation bed days (see instructions)	-,			0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	ne 2)			l l	88. 00 89. 00
	(30)						

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		pared·
		ooporrorre		12, 01, 2011	5/27/2015 3:3	
		Ti t	le XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	657, 617	4, 216, 436	0. 15596	5 0	0	90. 00
91.00 Nursing School cost	0	4, 216, 436	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 216, 436	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 216, 436	0. 00000	0 0	0	93. 00

	RIVERVIEW HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150059	Peri od: From 01/01/2014	Worksheet D-3	
			To 12/31/2014	Date/Time Pre	pared:
				5/27/2015 3:3	
		e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
		ro charges	Charges	(col. 1 x col.	
			Chai ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		11.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			7, 706, 855		30.00
31.00 03100 INTENSIVE CARE UNIT			2, 957, 854		31.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 22559		1, 975, 889	
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 28239		255, 694	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 28407		38, 800	
57. 00 05700 CT SCAN		0. 03556		29, 156	
57. 01 03630 ULTRA SOUND	•	0. 09069			
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07283 0. 10715			
60. 00 06000 LABORATORY		0. 10713		934, 106	
60. 01 06001 BLOOD LABORATORY		0. 00000		934, 100	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 58967		199, 655	
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000	·	177, 659	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 27663		_	
66. 00 06600 PHYSI CAL THERAPY		0. 37561		318, 720	
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	·	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000	00	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 20097	77 953, 107	191, 553	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 38280	9, 869, 681	3, 778, 153	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 29634	13 780, 978	231, 437	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 57400	07 4, 531, 129	2, 600, 900	73. 00
74. 00 07400 RENAL DI ALYSI S		0. 83745		137, 490	
76. 00 03020 OTHER ANCI LLARY		0.00000		0	76. 00
76. 01 03140 CARDI AC REHAB	,	0. 36167			
76. 02 03070 WOMEN' S CENTER		0. 28191			
76. 03 03330 ENDOSCOPY		0. 14540)3 41, 963	6, 102	76. 03
OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC		0.51088	2 994		90 00

2, 994 127, 087

1, 638, 223

38, 933, 577

38, 933, 577

1, 530

38, 340

0

12, 048, 020 200. 00

376, 903

90.00

90.01

91. 00

91. 01

92.00

95.00

201. 00

202. 00

0.510881

0.301686

0. 230068

0.000000

0. 786230

90.00

90. 01

91.00

91.01

92.00

201.00

202.00

09000 CLI NI C

09001 OUTPATI ENT

09100 EMERGENCY

09101 SHORT STAY

95. 00 09500 AMBULANCE SERVICES
200. 00 Total (sum of lines

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

ealth Financial Systems RIVERVIEW HOSPIT. NPATIENT ANCILLARY SERVICE COST APPORTIONMENT F		CCN: 150059	Peri od:	u of Form CMS-2 Worksheet D-3	
		CCN: 15T059	From 01/01/2014 To 12/31/2014	Date/Time Pre	epare
	Titl	e XVIII	Subprovi der - I RF	5/27/2015 3:3 PPS	ь рт
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
1. 00 04100 SUBPROVI DER - I RF			3, 786, 744		41.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS		2 2255	24 222	10.450	
0. 00 05000 0PERATING ROOM		0. 22559		19, 159	
2.00 05200 DELIVERY ROOM & LABOR ROOM 4.00 05400 RADIOLOGY-DIAGNOSTIC		0. 00000		10 210	
4. 00 05400 RADI OLOGY-DI AGNOSTI C 5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 28239 0. 28407		19, 218 8, 043	
7. 00 05700 CT SCAN		0. 03556		2, 274	
7. 01 03630 ULTRA SOUND		0. 09069		517	
8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07283		1, 700	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10715		2, 722	
0. 00 06000 LABORATORY		0. 1963		125, 298	
0. 01 06001 BLOOD LABORATORY		0. 00000		0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 58967		8, 737	63
4. 00 06400 I NTRAVENOUS THERAPY		0.00000	00 00	0	64
5. 00 06500 RESPI RATORY THERAPY		0. 27663	39 414, 535	114, 677	65
6. 00 06600 PHYSI CAL THERAPY		0. 3756	19 3, 028, 151	1, 137, 431	66
7. 00 06700 OCCUPATI ONAL THERAPY		0.00000	00	0	67
8. 00 06800 SPEECH PATHOLOGY		0.00000	00	0	68
9. 00 06900 ELECTROCARDI OLOGY		0. 20097	77 51, 750	10, 401	69
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 38280			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 29634		3, 707	
3.00 O7300 DRUGS CHARGED TO PATIENTS		0. 57400		410, 702	
4. 00 07400 RENAL DI ALYSI S		0. 83745		91, 023	
6. 00 03020 OTHER ANCI LLARY		0.00000		0	
6. 01 03140 CARDI AC REHAB		0. 36167	•	3, 538	
6. 02 03070 WOMEN' S CENTER		0. 28191		13	
6. 03 O3330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS		0. 14540	03 1, 074	156	76
0. 00 09000 CLINIC		0. 51088	81 61	31	90
0. 00 09000 CETNIC 0. 01 09001 OUTPATI ENT		0. 31088		4, 696	
1. 00 09100 EMERGENCY		0. 23006		11, 585	
1. 01 09101 SHORT STAY		0. 00000	•	0	
2. OO O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 78623		0	
OTHER REIMBURSABLE COST CENTERS		3. 73023	0		1 ′′
5. 00 09500 AMBULANCE SERVI CES					95
00.00 Total (sum of lines 50-94 and 96-98)			5, 741, 779	2, 121, 487	
01.00 Less PBP Clinic Laboratory Services-Program only charges (Li	ne 61)		0	, , , , , ,	201
02.00 Net Charges (line 200 minus line 201)			5, 741, 779		202

Health Financial Systems RIVE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	RVI EW HOSPI TAL	CCN: 150059	Peri od:	eu of Form CMS-2 Worksheet D-3	
THE ATTEMPT AND LEARLY SERVICE COST ATTORTTONIMENT	110VI dei		From 01/01/2014	Worksheet D-3	
	Componen ⁻		To 12/31/2014	Date/Time Pre 5/27/2015 3:3	pare
	Ti tl	e XVIII	Skilled Nursing	PPS	
Cost Center Description		Ratio of Cos	Facility t Inpatient	Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			onal ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			0		30
31.00 03100 INTENSIVE CARE UNIT			0		31
1. 00 04100 SUBPROVI DER - 1 RF			0		41
3. 00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
D. 00 05000 OPERATING ROOM		0. 22559		0	1 -
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 28239		16, 111	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 28407		0	
7. 00 05700 CT SCAN		0. 03556		0	
7.01 03630 ULTRA SOUND		0. 09069		0	
3.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 07283		0	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10715		0	1 -
D. 00 06000 LABORATORY		0. 19631			
0. 01 06001 BLOOD LABORATORY		0.00000		0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 58967		0	
4. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 27663			
6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 OCCUPATI ONAL THERAPY		0. 37561		336, 822	1
3. 00 06800 SPEECH PATHOLOGY		0.00000		0	
9. 00 06900 ELECTROCARDI OLOGY		0. 20097		0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 38280		1	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 29634	· ·	0,373	1
3. 00 07300 DRUGS CHARGED TO PATLENTS		0. 57400			
4. 00 07400 RENAL DIALYSIS		0. 83745		0	
6. 00 03020 OTHER ANCI LLARY		0.00000		0	1
6. 01 03140 CARDI AC REHAB		0. 36167		9, 451	
6. 02 03070 WOMEN' S CENTER		0. 28191		0	1
6. 03 03330 ENDOSCOPY		0. 14540			
OUTPATIENT SERVICE COST CENTERS					1
0. 00 09000 CLI NI C		0. 51088	31 0	0	90
D. 01 09001 OUTPATI ENT		0. 30168	86 0	0	90
1.00 09100 EMERGENCY		0. 23006		0	91
1. 01 09101 SHORT STAY		0.00000		0	91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 78623	0 0	0	92
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95
00.00 Total (sum of lines 50-94 and 96-98)			3, 044, 210	1, 168, 941	land

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

95. 00 1, 168, 941 200. 00 201. 00 202. 00

3, 044, 210

3, 044, 210

200.00

201. 00 202. 00

Health Financial Systems	RIVERVIEW HOSPITAL			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	r CCN: 150059	Peri od:	Worksheet D-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
				5/27/2015 3:3	6 pm
	Ti	tle XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			866, 092		30.00
31.00 03100 INTENSIVE CARE UNIT			391, 261		31.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 22559		93, 021	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 28239		21, 344	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 28407		0	55.00
57. 00 05700 CT SCAN		0. 03556		2, 550	1
57. 01 03630 ULTRA SOUND		0.09069		1, 887	1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION		0. 07283 0. 10715			58. 00 59. 00
60. 00 06000 LABORATORY		0. 10713			
60. 01 06001 BLOOD LABORATORY		0. 00000	·	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 58967			
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 27663		111, 058	
66. 00 06600 PHYSI CAL THERAPY		0. 3756	41, 159	l	
67. 00 06700 OCCUPATIONAL THERAPY		0.00000	00	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000	00	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 20097	77 51, 294	10, 309	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S	0. 38280		269, 039	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 29634		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 57400		336, 555	1
74. 00 07400 RENAL DIALYSIS		0. 83745		3, 054	1
76. 00 03020 OTHER ANCI LLARY		0.00000		0	
76. 01 03140 CARDI AC REHAB		0. 36167		l	
76. 02 03070 WOMEN' S CENTER		0. 28191		0	
76. 03 03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS		0. 14540	39, 990	5, 815	76. 03
OUTPATIENT SERVICE COST CENTERS		0. 51000	120	/1	1 00 00

0. 510881

0.301686

0. 230068

0.000000

0. 786230

120

13, 506

134, 832

3, 258, 288

3, 258, 288

61

0

0

1, 045, 708 200. 00

4, 075

31, 021

90.00

90.01

91. 00

91. 01

92.00

95.00

201. 00 202. 00

90.00

90.01

91.00

91. 01

92.00

201.00

202.00

09000 CLI NI C

09001 OUTPATI ENT

09100 EMERGENCY

09101 SHORT STAY

95. 00 09500 AMBULANCE SERVICES
200. 00 Total (sum of lines

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

alth Financial Systems RIVERVIEW HOSPITAL IPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr		CCN: 150059	Peri od:	u of Form CMS-: Worksheet D-3	
Co	mponent	CCN: 15T059	From 01/01/2014 To 12/31/2014	Date/Time Pre	nare
	<u> </u>			5/27/2015 3:3	6 pm
	Tit	le XIX	Subprovi der - I RF	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	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			2.00	0.00	
0.00 03000 ADULTS & PEDIATRICS			0		30
. 00 03100 INTENSIVE CARE UNIT			0		31
. 00 O4100 SUBPROVI DER - I RF			295, 937		41.
3. 00 O4300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS 0.00 OFFRATI NG ROOM		0. 22559	22, 649	5, 110	50
2. OO O5200 DELI VERY ROOM & LABOR ROOM		0. 00000		0,110	
H. OO O5400 RADI OLOGY-DI AGNOSTI C		0. 28239		2, 856	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 28407		0	
7. 00 05700 CT SCAN		0. 03556	5, 581	198	57
'. 01 03630 ULTRA SOUND		0. 09069	97 0	0	57
B. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 07283		0	
0.00 05900 CARDI AC CATHETERI ZATI ON		0. 10715		0	
0. 00 06000 LABORATORY		0. 1963		10, 292	
D. 01 06001 BL00D LABORATORY B. 00 06300 BL00D STORI NG, PROCESSI NG & TRANS.		0. 00000 0. 58967		0 596	
1. 00 00300 BEOOD STOKING, PROCESSING & TRANS.		0. 00000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 27663		19, 737	
5. 00 06600 PHYSI CAL THERAPY		0. 3756	· ·	84, 385	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 00000	00	0	67
B. 00 06800 SPEECH PATHOLOGY		0. 00000		0	68
0. 00 06900 ELECTROCARDI OLOGY		0. 20097		387	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 38280			
2.00 O7200 IMPL. DEV. CHARGED TO PATIENT		0. 29634		0	
B. 00 07300 DRUGS CHARGED TO PATIENTS B. 00 07400 RENAL DIALYSIS		0. 57400 0. 83745		40, 781 0	
5. 00 03020 OTHER ANCI LLARY		0. 00000		0	
5. 01 03140 CARDI AC REHAB		0. 36167		0	
0. 02 03070 WOMEN' S CENTER		0. 28191		0	
o. 03 03330 ENDOSCOPY		0. 14540	03	0	76
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C		0. 51088		0	
0. 01 09001 0UTPATI ENT		0. 30168		2, 021	
. 00 09100 EMERGENCY . 01 09101 SHORT STAY		0. 23006		0	
		0. 00000		0	
2. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 78623	JO _I 0		72
5. 00 09500 AMBULANCE SERVICES					95
00.00 Total (sum of lines 50-94 and 96-98)			520, 616	186, 714	
11.00 Less PBP Clinic Laboratory Services-Program only charges (lin	ne 61)		0		201
Net Charges (line 200 minus line 201)			520, 616		202

Name				Т	o 12/31/2014	Date/Time Pre 5/27/2015 3:3	
Name			Ti tl	e XVIII	Hospi tal		, piii
Name				0	1 00	2.00	
1.00 1.00		PART A - INPATIENT HOSPITAL SERVICES UNDER LPPS		0	1.00	2.00	
to detaber 1 (see Instructions) 1.02 GR amounts other than collier payments for discharges occurring on or after October 1 (see Instructions) 3.886.164 1.02 discharges occurring in or or october 1 (see Instructions) 1.03 discharges occurring in or or after October 1 (see Instructions) 1.04 discharges occurring in or after October 1 (see Instructions) 1.05 discharges occurring in or after October 1 (see Instructions) 1.06 discharges occurring in or after October 1 (see Instructions) 1.07 discharges occurring in or after October 1 (see Instructions) 1.08 discharges occurring in or after October 1 (see Instructions) 1.09 discharges occurring in or after October 1 (see Instructions) 1.00 discharges occurring in or after October 1 (see Instructions) 1.01 discharges occurring in or after October 1 (see Instructions) 1.02 discharges occurring in or after October 1 (see Instructions) 1.03 discharges occurring in or after October 1 (see Instructions) 1.04 discharges occurring in or after October 1 (see Instructions) 1.05 discharges occurring in or after October 1 (see Instructions) 1.06 discharges occurring in or after October 1 (see Instructions) 1.07 discharges occurring in or after October 1 (see Instructions) 1.08 discharges wait after divided by number of days in the cost reporting in order occurring in the October 1 (see Instructions) 1.08 discharges wait after divided by number of days in the cost reporting in occurring in the October 1 (see Instructions) 1.00 discharges wait after 0 (see Instructions) 1.00 dis	1.00				0		1. 00
1.02 080 amounts other than outlier payments for discharges occurring on or after official specified presentations of the control of the	1. 01		g prior		10, 895, 883		1. 01
a filter October 1 (see instructions)	1 02		a on or		3 886 164		1 02
discharges occurring prior to October 1 (see Instructions)	02	, ,	9 0 0.		0,000,101		
1.04 BRC for Federal specific operating payent for Model 4 BPC for discharges occurring on or artror Orbober 1 (see instructions) 215, 862 2.00	1. 03				0		1. 03
discharges occurring on or after October 1 (see instructions) 215,862 2.00 2.00 2.01 2.00 2.01 2.00 2.01 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.0	1 04				0		1 04
2.01 Out In Freehand I I I I I I I I I	1.01						1.01
2.00 Dutil en payment for di scharges for Model 4 BPCI (see Instructions) 0 2.00					215, 862		1
			nc)		0		1
Bed days available divided by number of days in the cost reporting 100.00 4.00		, , ,	115)				1
Indirect Medical Education Adjustment			i ng		100.00		1
FTE count for all opathics and osteopathic programs for the most recent cost reporting period ending on or before 12/3/1996, (see instructions)							
Cost reporting period ending on or before 12/31/1906, (see instructions) 6.00 6.	5 00		recent		0.00		5.00
Criteria for an add-on to the cap for new programs in accordance with 42 CR 413.79(e) 7.00 7.0	5.00				0.00		3.00
CFR 413.79(e) 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 0.00 7.00 7.00 CFR \$412.105(f)(1)(iv)(B)(1) 7.00 7	6.00				0.00		6. 00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR 9412.1091(71)(1)(1)(9)(8)(1) (1)(9)(8)(1) (1)(9)(8)(2) If the cost report stradid as July 1.2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for affil lated programs in accordance with 42 CFR osteopathic programs for affil lated programs in accordance with 42 CFR (August 1.2007)(2)(1)(1) 4 FR 26340 (May 12, 1998). and 67 FR 30009 (August 1.2007) 8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report stradides July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report stradides July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.0 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01) 10.00 FTE count for all opathic and osteopathic programs in the current year 10.00 FTE count for residents in dental and podiatric programs. 11.00 FTE count for residents in dental and podiatric programs. 12.00 Current year all owable FTE count for the prior year. 13.00 Total allowable FTE count for the prior year. 14.00 Total allowable FTE count for the pomultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 0.00 15.00 16.00 17.00 Adjustment for residents in initial years of the program 0.00 17.00 17.00 Adjustment for residents in initial years of the program 0.00 17.0		1 1 9	e with 42				
CFR §412.105(f)(1)(iv)(B)(I) CFR §412.105(f)(1)(iv)(B)(I) If the cost report straddles July 1, 2011 then see instructions.	7. 00		der 42		0.00		7. 00
CFR \$412.105(fr)(1)(1)(g)(2) If the cost report straddles July 1, 2011		l					
then see Instructions. 8. 00 Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)/2(l)/0, 64 FR 26340 (May 12, 1998), and 67 FR 50099 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9. 00 Sum of teaching hospital under section 5506 of ACA. (see instructions) 9. 01 Sum of teaching hospital under section 5506 of ACA. (see instructions) 9. 02 Sum of teaching hospital under section 5506 of ACA. (see instructions) 9. 03 Sum of Count for allopathic and osteopathic programs in the current year from your records 10. 00 FTE count for residents in dental and podlatric programs. 9. 00 Sum of Count for allopathic and osteopathic programs. 9. 00 Sum of Count for allowable FTE (see instructions) 10. 00 Total allowable FTE count for the perior year. 10. 00 Total allowable FTE count for the prior year. 10. 00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 10. 00 Sum of Lines 12 through 14 divided by 3. 10. 00 Total allowable FTE count for she program or hospital closure 10. 00 Adjustment for residents in initial years of the program 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 0.00 17.00 Adjustment for residents in initial years of the program 0.00 17.00 Adjustment for residents in Section 18.00 18.00 0.00 18.0	7. 01				0.00		7. 01
Adjustment (Increase or decrease) to the FTE count for al lopathic and osteppathic programs for affiliated programs in accordance with 42 CFR A13.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002)			1, 2011				
413.75(b), 413.79(c) (2) (IV), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	8. 00		ic and		0.00		8. 00
(August 1, 2002). 8.01		1 1 3					
1.00 The amount of Increase If the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			FR 50069				
Section 5503 of the ACA If the cost report straddles July 1, 2011, see Instructions. Section 5503 of the ACA If the cost report straddles July 1, 2011, see Instructions Section 5503 of ACA (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) Sum of lines 1 plus left 5 (see instructions) Sum of lines 1 plus left 5 (see instructions) Sum of lines 1 plus left 5 (see instructions) Sum of lines 12 through 14 divided by 3. Sum of lines 12 through 14 divided by 3. Sum of lines 12 through 14 divided by 3. Sum of lines 12 through 14 divided by 3. Sum of lines 12 through 14 divided by 3. Sum of lines 12 through 14 divided by 3. Sum of lines 14 plus left 5 (see instructions) Sum of lines 15 (see instructions) Sum of lines 16 plus left 5 (see instructions) Sum of lines 17 plus left 6	8. 01		s under		0.00		8. 01
Section Sect		· ·					
closed teaching hospital under section 5506 of ACA. (see instructions) 0.00 9.00 and 8.02) (see instructions) 0.00 and 8.02) (see instructions) 0.00 and 8.02) (see instructions) 0.00 10.	0.00		- 6		0.00		0.00
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 0.00 0.0	8. 02				0.00		8.02
10.00 FTE count for all opathic and osteopathic programs in the current year from your records 11.00 FTE count for resi dents in dental and pod latric programs. 0.00 11.00 12.00 12.00 12.00 12.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 16.00 16.00 17.00 17.00 17.00 17.00 18.00 18.00 18.00 19.00 18.00 18.00 19.00 18.00 19.00 18.00 19.0	9. 00				0.00		9. 00
from your records							
11.00 TEE count for residents in dental and podiatric programs. 0.00 11.00 12.00 10.00 10.00 12.00 10.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 14.00 10.00 15.00 14.00 15.00 16.00 1	10.00	, , , , ,	t year		0.00		10.00
12.00 Current year allowable FTE (see instructions) 12.00 13.00 10.01 10.00 11.0	11. 00				0.00		11. 00
14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 14.00 15.00 15.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 17.00 17.00 18.00 18.00 19.00 18.00 19.00		, , , , , , , , , , , , , , , , , , ,			l :		1
or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3. 15.00 16.00 Adj ustment for residents in initial years of the program O.00 Adj ustment for residents displaced by program or hospital closure O.00 Adj usted rolling average FTE count O.00 Adj usted rolling average FTE count O.00 O.00 D.00 O.00 O.00 D.00 O.00 O.00			andad an		l .		
15. 00 Sum of lines 12 through 14 divided by 3. 0. 00 15. 00 16. 00 16. 00 17. 00 17. 00 17. 00 18. 00 18. 00 19. 00 17. 00 18. 00 19.	14.00	, , , , , , , , , , , , , , , , , , , ,	enaea on		0.00		14.00
17. 00	15. 00				0.00		15. 00
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 20.00 Frior year resident to bed ratio (see instructions) 0.000000 20.00 20.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.000000 22.00 IME payment adjustment - Managed Care (see instructions) 0.000000 22.00 IME payment adjustment - Managed Care (see instructions) 0.00 22.00 IME roll and care (see instructions) 0.00 23.00 IME roll and care (see instructions) 0.00 24.00 25.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 IME amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 25.00 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.000000 28.00 28.01 IME add-on adjustment amount (see instructions) 0.000000 28.01 29.0					l .		1
19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22. 00 IME payment adjustment (see instructions) 0 22.00 22. 01 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 8 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 0.00 23.00 24. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25. 00 If the amount on line 24 (see instructions) 0.00 25.00 If the amount on line 24 (see instructions) 0.00000 26.00 27. 00 IME payments adjustment factor. (see instructions) 0.00000 27.00 28. 00 IME payments adjustment amount (see instructions) 0.00000 27.00 28. 01 IME payment adjustment amount - Managed Care (see instructions) 0.00000 27.00 29. 00 Total IME payment - Managed Care (see i			е		l .		
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f) (1) (iv) (C) 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 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 27.00 IME payments adjustment amount (see instructions) 0.000000 28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.00 29.00					l .		
22.00 IME payment adjustment (see instructions) 10 IME payment adjustment - Managed Care (see instructions) 11 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.02 Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Recreatage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions)		, ,			l .		1
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 0. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 29. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 01 Total IME payment (sum of lines 22 and 28) 10 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 IME payment - Managed Care (see instructions) 30. 02 Sum of lines 30 and 31 30. 03 Sum of lines 30 and 31 30. 04 Allowable disproportionate share percentage (see instructions)		, , , , , , , , , , , , , , , , , , ,			l		1
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Image of the MMA 34.00 Sum of lines 30 and 31 35.00 Allowable disproportionate share percentage (see instructions) 35.00 Sum of lines 30 and 31 36.00 Allowable disproportionate share percentage (see instructions) 37.00 Sum of lines 30 and 31 38.00 Allowable disproportionate share percentage (see instructions)					- I		1
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment factor. (see instructions) 29.00 IME payments adjustment amount (see instructions) 20.00 IME add-on adjustment amount - Managed Care (see instructions) 20.00 Total IME payment (sum of lines 22 and 28) 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days 31.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions)	22.01		n 422 of t	he MMA	l o] 22.01
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25.00							
Line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 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 28.01) 0 29.01 29.0			wer of		l .		1
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28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 7					l .		1
28.01 IME add-on adjustment amount - Managed Care (see instructions) 7					0. 000000		1
29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 29.00 29.00 29.00 29.01 30.00 31.00 32.39 33.00		The state of the s					1
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 33.00					o		
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 30.00 Comparison of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Comparison of Medicaid patient days (see instructions) 31.00 Comparison of Medicaid patient days (see instructions) 32.00 Comparison of Medicaid patient days (see instructions) 33.00 Comparison of Medicaid patient days (see instructions)		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		
(see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 32.00 33.00 Allowable disproportionate share percentage (see instructions) 31.00 31.00	20.00				0.5-1		20.00
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 32.00 33.00	30.00		ent days		2. 39		30.00
32.00 Sum of Lines 30 and 31 16.33 32.00 33.00 Allowable disproportionate share percentage (see instructions) 3.37 33.00	31. 00				13. 94		31.00
	32. 00	Sum of lines 30 and 31			16. 33		32. 00
34. 00 pursproportionate snare adjustment (see instructions) 124, 539 34. 00		, , , , , , , , , , , , , , , , , , , ,			l .		1
	34.00	pri sproporti onate share aujustillent (see thistructi ons)		I	124, 539		J 34. UU

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	F	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/27/2015 3:3	
		Title XVIII	Hospi tal	PPS	<u> </u>
			Prior to	On/After	
	-	0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment	0	1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		9, 046, 380, 143	7, 647, 644, 855	35. 00
35. 01	Factor 3 (see instructions)		0. 000094264	0. 000086639	
35. 02	Hospital uncompensated care payment (If line 34 is zero,		852, 745	662, 586	35. 02
35. 03	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment		637, 806	167, 008	35. 03
33. 03	amount (see instructions)		037, 800	107,008	33.03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		804, 814		36. 00
	35.03)				
40. 00	Additional payment for high percentage of ESRD beneficiary d Total Medicare discharges on Worksheet S-3, Part I	discharges (Lines 40 through	1 46)		40. 00
40.00	excluding discharges for MS-DRGs 652, 682, 683, 684 and				40.00
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41. 00
41. 01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41. 01
41.01	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42. 00
	qualify for adjustment)				
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43. 00
44. 00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44. 00
	divided by line 41 divided by 7 days)				
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
46. 00	instructions) Total additional payment (line 45 times line 44 times line		0		46. 00
40.00	41.01)				46.00
47.00	Subtotal (see instructions)		15, 927, 262		47. 00
48. 00	Hospital specific payments (to be completed by SCH and		0		48. 00
40.00	MDH, small rural hospitals only. (see instructions)		15 027 2/2		40.00
49. 00	Total payment for inpatient operating costs (see instructions)		15, 927, 262		49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		1, 272, 505		50.00
	and Pt. II, as applicable)				
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52. 00
	line 49 see instructions).				
53. 00	Nursing and Allied Health Managed Care payment		0		53.00
54. 00 55. 00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		54. 00 55. 00
33.00	line 69)				33.00
56.00	Cost of physicians' services in a teaching hospital (see		0		56. 00
F7 00	intructions)				F7 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57. 00
58. 00	Ancillary service other pass through costs from Wkst. D,		0		58. 00
	Pt. IV, col. 11 line 200)				
59.00	Total (sum of amounts on lines 49 through 58)		17, 199, 767		59.00
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59		13, 409 17, 186, 358		60. 00 61. 00
01.00	minus line 60)		17, 100, 330		01.00
62.00	Deductibles billed to program beneficiaries		1, 471, 904		62. 00
63.00	Coinsurance billed to program beneficiaries		37, 088		63. 00
64. 00	Allowable bad debts (see instructions)		61, 488		64.00
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see		39, 967 -20, 753		65. 00 66. 00
00.00	instructions)		20, 700		00.00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15, 717, 333		67. 00
68. 00	Credits received from manufacturers for replaced devices		0		68. 00
69. 00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
07.00	96). (For SCH see instructions)				09.00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70. 00
70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
	instructions)				
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)		-27, 801		70. 92 70. 93
	HRR adjustment amount (see instructions)		-27, 801		70. 93
	Recovery of accelerated depreciation		0		70. 95
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	Financial Systems RIVERVIEW HOS				u of Form CMS-	2552-1
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150059		iod: m 01/01/2014 12/31/2014	Worksheet E Part A Date/Time Pre 5/27/2015 3:3	
		Title XVIII		Hospi tal	PPS	о р
				Prior to	On/After	
				October 1	October 1	
		0		1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0	0		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0	0		70. 97
70. 98	Low Volume Payment-3			o		70. 98
70. 99	HAC adjustment amount (see instructions)			o		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			15, 689, 532		71.00
71. 01	Sequestration adjustment (see instructions)			313, 791		71. 0
72. 00	Interim payments			15, 220, 490		72.00
73. 00	Tentative settlement (for contractor use only)			0		73.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			155, 251		74.00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1, 573, 313		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0		91.0
92. 00	Operating outlier reconciliation adjustment amount (see instructions)			0		92.00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)			0		93. 0
4. 00	The rate used to calculate the time value of money (see instructions)			0. 00		94. 0
5. 00	Time value of money for operating expenses (see instructions)			0		95. 0
6. 00	Time value of money for capital related expenses (see instructions)			0		96. 0
			Р		On/After 10/1	
				1. 00	2.00	

0

0.0000

0 101. 00 0 102. 00

0. 0000 103. 00 0 104. 00

HVBP Adjustment for HSP Bonus payment

101.00 HVBP adjustment factor (see instructions)

102.00 HVBP adjustment amount for HSP bonus payment (see instructions)

HRR Adjustment for HSP Bonus Payment

103.00 HRR adjustment factor (see instructions)

104.00 HRR adjustment amount for HSP bonus payment (see instructions)

MCRI F32	-	7. 2.	157. 2	1

| Period: | Worksheet E | From 01/01/2014 | Part A Exhibit 4 | Date/Time Prepared: | 5/27/2015 3:36 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150059

Title XVIII	On/After 10/01 4.00 33 3,886,164 33 0 0 3,886,164 0 0 0 0 72 35,990 0 0 0 0 95 863,063	5.00 14,782,047 10,895,883 4 3,886,164 0 0 215,862 0 0 3,920,158	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00
Iine E, Part A) Entitlement to 10/01	On/After 10/01 4.00 33 3,886,164 33 0 0 3,886,164 0 0 0 0 72 35,990 0 0 0 0 95 863,063	through 4) 5.00 14,782,047 10,895,883 3,886,164 0 215,862 0 3,920,158	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00
1.00 DRG amounts other than outlier payments 1.01 DRG amounts other than outlier payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.00 Outlier payments for discharges (see instructions) 2.02 Outlier payments for discharges for Model 4 BPCI Operating outlier 2.01 Outlier payments for conciliation 0.00 Outlier payments for outlier payments for discharges for Model 4 BPCI 0.00 Outlier payments for outlier	4. 00 33 3, 886, 164 83 0 3, 886, 164 0 0 0 0 0 72 35, 990 0 0 0 0 95 863, 063	5.00 14,782,047 10,895,883 4 3,886,164 0 0 215,862 0 0 3,920,158	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00
1.00 DRG amounts other than outlier payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for odischarges (see instructions) 2.01 Outlier payments for discharges (see instructions) 2.02 Operating outlier conciliation 4.00 Managed care simulated 3.00 Operating outlier and the set of the payment outlier outlier in the payment outlier	33 3, 886, 164 33 0 3, 886, 164 0 0 0 72 35, 990 0 0 95 863, 063	14, 782, 047 10, 895, 883 3, 886, 164 0 0 215, 862 0 0 3, 920, 158	1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 3. 00
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for odischarges (see instructions) 2.01 Outlier payments for operating outlier payments for operating outlier payments for odischarges for Model 4 BPCI Operating outlier payments for odischarges for Model 4 BPCI Operating outlier operating outlier payments for operating outlier operations outlier operating outlier operations of operating outlier operations outlier operations outlier operations of operating outlier operations outlie	0 3, 886, 164 0 0 0 0 72 35, 990 0 0 95 863, 063	3, 886, 164 0 C 0 215, 862 0 C 3, 920, 158	1. 02 1. 03 1. 04 2. 00 2. 01 3. 00
payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for odischarges (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI operating outlier payments for odischarges for Model 4 BPCI operating outlier payments for odischarges for Model 4 BPCI operating outlier payments for odischarges for Model 4 BPCI operating outlier operations of the Managed care simulated operating outlier operations of the Managed care simulated operating outlier operations of the Managed care simulated operating outlier operations operating outlier operations of the Managed care simulated operations operating outlier operations operation	0 3, 886, 164 0 0 0 0 72 35, 990 0 0 95 863, 063	3, 886, 164 0 C 0 215, 862 0 C 3, 920, 158	1. 02 1. 03 1. 04 2. 00 2. 01 3. 00
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for condischarges (see instructions) 2.01 Outlier payments for operating outlier operating operating outlier operatin	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	215, 862 0 215, 862 0 0 0 0 3, 920, 158	1. 03 1. 04 2. 2. 00 2. 01 3. 00
1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for of discharges (see instructions) 2.01 Outlier payments for of discharges for Model 4 BPCI operating on or after October 1 2.00 Outlier payments for of discharges for Model 4 BPCI operating outlier of conciliation of the Managed care simulated of the Managed care simulated of the Model of th	72 35, 990 0 0 0 0	215, 862 0 C 0 C 3, 920, 158	2. 00 2. 01 3. 00
October 1 1.04 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 2.00 Outlier payments for discharges (see instructions) 2.01 Outlier payments for 2.02 Odischarges for Model 4 BPCl occurring outlier payments for 3.00 Operating outlier 2.01 Ocerating outlier 2.01 Odischarges for Model 4 BPCl occurring outlier 3.00 Managed care simulated 3.00 Odischarges for Model 4 BPCl occurring outlier	72 35, 990 0 0 0 0	215, 862 0 C 0 C 3, 920, 158	2. 00 2. 01 3. 00
October 1 2.00 215,862 0 179,8	0 0 0 0 0 95 863, 063	0 C 0 C 3 3, 920, 158	2. 01
2.01 Outlier payments for 2.02 0 0 0 discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 0 0 creconciliation 4.00 Managed care simulated 3.00 0 0 3,057,00 0 0 3,057,00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		3, 920, 158	3.00
discharges for Model 4 BPCI 3.00 Operating outlier 2.01 0 0 reconciliation 4.00 Managed care simulated 3.00 0 0 3,057,00		3, 920, 158	3.00
3.00 Operating outlier 2.01 0 0			
4.00 Managed care simulated 3.00 0 0 3,057,0			4. 00
	0. 000000		3
Indirect Medical Education Adjustment	0.000000	기	
5.00 Amount from Worksheet E, Part 21.00 0.000000 0.000000 0.000000 0.000000 0.000000			5. 00
6.00 IME payment adjustment (see 22.00 0 0 instructions)	0 0	C	6. 00
6.01 IME payment adjustment for 22.01 0 0 managed care (see	0	C	6. 01
instructions)			_
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000	0. 000000	<u> </u>	7. 00
(see instructions)	0.000000	1	7.00
8.00 IME adjustment (see 28.00 0 0 instructions)	0 0	C	8. 00
8.01 IME payment add ustment add on 28.01 0 0 for managed care (see instructions)	0	С	8. 01
9.00 Total IME payment (sum of 29.00 0 0 lines 6 and 8)	0 0	C	9. 00
9.01 Total IME payment for managed 29.01 0 0 care (sum of lines 6.01 and	0	0	9. 01
8.01) Di sproporti onate Share Adjustment			-
10. 00 Allowable disproportionate 33. 00 0. 0337 0. 0337 0. 0337	37 0. 0337	7	10.00
share percentage (see instructions)	0.0007		10.00
11.00 Disproporti onate share 34.00 124,539 0 91,74 adjustment (see instructions)	98 32, 741	124, 539	11. 00
11.01 Uncompensated care payments 36.00 804,814 0 637,80	06 167, 008	804, 814	11. 01
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment	0 0	C	12. 00
(see instructions) 13.00 Subtotal (see instructions) 47.00 15,927,262 0 7,919,19	95 8, 008, 067	15, 927, 262	13 00
14.00 Hospital specific payments 48.00 0 0 (completed by SCH and MDH, small rural hospitals only.)	0 0	0	14.00
(see instructions) 15.00 Total payment for inpatient operating costs (see	95 8, 008, 067	15, 927, 262	15. 00
instructions)	329, 802	1, 272, 505	16. 00
capi tal	0	C	17. 00
17. 01 Net organ aquisition cost 55. 00 0 0	0		17. 01
17.02 Capital received from 68.00 0 0 manufacturers for replaced	0	C	
devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 adjustment amount (see instructions)	0	O C	18. 00

Health Financial Systems	RIVERVIEW HOSPITAL	In Lieu of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provi der CCN: 150059	Peri od: Worksheet E From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/27/2015 3: 36 pm

						10 12/31/2014	5/27/2015 3:3	
					e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
19.00	SUBTOTAL			0	8, 861, 898	8, 337, 869	17, 199, 767	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	1, 181, 769	0	870, 92 ⁻	310, 843	1, 181, 770	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	50, 910	0	42, 420	8, 484	50, 910	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.0000	0.0000	0.0000		22. 00
23.00	Indirect medical education	6. 00	0	0)	0	0	23. 00
	adjustment (see instructions)							
24. 00	Allowable disproportionate share percentage (see	10.00	0. 0337	0. 0337	0. 033	0. 0337		24. 00
	instructions)							
25. 00	Di sproporti onate share	11. 00	39, 826	0	29, 35°	1 10, 475	39, 826	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	1, 272, 505	0	942, 703	329, 802	1, 272, 505	26. 00
	payments (see instructions)							
			(Amounts to E,					
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 000000	0. 000000		27. 00
28. 00	Low volume adjustment	70. 96					0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.	l			[

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der		eriod: rom 01/01/2014	Worksheet E Part A Exhibi	+ 5
					o 12/31/2014	Date/Time Pre	pared:
			Ti tl	e XVIII	Hospi tal	5/27/2015 3: 30 PPS	6 pm
		Wkst. E, Pt.	Amt. from	Period to		Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)	0.00	2.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2. 00	3. 00	4. 00	1. 00
1.00	DRG amounts other than outlier payments for	1. 00	10, 895, 883	10, 895, 883		10, 895, 883	1. 00
1.01	di scharges occurring prior to October 1	1.01	10,070,000	10,070,000		10, 070, 000	1.01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 886, 164		3, 886, 164	3, 886, 164	1. 02
1.03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
	for Model 4 BPCI occurring prior to October 1						
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2.00	Outlier payments for discharges (see	2. 00	215, 862	179, 872	35, 990	215, 862	2. 00
2. 01	instructions) Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2 00	BPCI	2.01					2 00
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0	0	0	3. 00 4. 00
4.00	Indirect Medical Education Adjustment	3.00	J		J	U	4.00
5.00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6. 00	(see instructions) IME payment adjustment (see instructions)	22. 00		0	0	0	6. 00
6. 01	IME payment adjustment (see Instructions)	22.00	0	0	0	0	6. 01
	instructions)					_	
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
	care (see instructions)						
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	U	U	0	9. 01
	Di sproporti onate Share Adjustment	l.					
10.00	Allowable disproportionate share percentage	33.00	0. 0337	0. 0337	0. 0337		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	124, 539	91, 798	32, 741	124, 539	11. 00
11.00	instructions)	34.00	124, 539	71, 770	32, 741	124, 539	11.00
11. 01	Uncompensated care payments	36.00	804, 814	637, 806	167, 008	804, 814	11. 01
40.00	Additional payment for high percentage of ESR						40.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	15, 927, 262	11, 805, 359	4, 121, 903	15, 927, 262	13. 00
14. 00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14. 00
	and MDH, small rural hospitals only.) (see						
15 00	instructions)	40.00	15 007 0/0	11 005 250	4 121 002	15 007 0/0	15 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	15, 927, 262	11, 805, 359	4, 121, 903	15, 927, 262	15.00
16.00	Payment for inpatient program capital	50. 00	1, 272, 505	942, 703	329, 802	1, 272, 505	
17. 00	Special add-on payments for new technologies	54.00	0	0	0	0	
17. 01 17. 02	Net organ aquisition cost Capital received from manufacturers for	55. 00 68. 00	0	0	0	0	
17.02	replaced devices for applicable MS-DRGs	00.00					17.02
18. 00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
19 00	amount (see instructions) SUBTOTAL			12, 748, 062	4, 451, 705	17, 199, 767	19 00
17.00	JODI O INE	l .	1	12, 140, 002	7,451,705	17, 177, 107	1 7.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibi Date/Time Pre 5/27/2015 3:3	t 5 pared:
				e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 181, 769	870, 92	6 310, 843	1, 181, 769	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	(0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	50, 910	42, 42	6 8, 484	50, 910	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	(0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	C		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0337	0. 033	7 0. 0337		24. 00
25. 00	Disproportionate share adjustment (see	11.00	39, 826	29, 35	1 10, 475	39, 826	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 272, 505	942, 70	3 329, 802	1, 272, 505	26. 00
	, mott dott dine	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	27. 00 28. 00 29. 00
30. 00	HVBP payment adjustment (see instructions)	70. 97	-27, 801	, -14, 31	5 -13, 486	-	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	-27, 801	-14, 31	0 0	-27, 801	30. 00
31. 00 31. 01	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see	70. 94 70. 91			0 0	0 0	31. 00 31. 01

1.00

Υ

0

70. 99

2.00

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

0 32.00

100. 00

3. 00

0

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	RIVERVIEW HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 1	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 3:36 pm

MANY II - WIND CAL AND DIRECT HIALTH SERVICES 1.00				10 12/31/2014	5/27/2015 3:3	
PART 8 - MEDICAL AND OTHER HEALTH SERVICES 7, 107 1.0 Medical and other services (see instructions) 7, 107 1.0 Medical and others services (see instructions) 13, 37, 70 2.0			Title XVIII	Hospi tal		Орш
PART 8 - MEDICAL AND OTHER HEALTH SERVICES 7, 107 1.0 Medical and other services (see instructions) 7, 107 1.0 Medical and others services (see instructions) 13, 37, 70 2.0						
					1. 00	
200 Medical and other services reinbursed under OPPS (see instructions) 10, 337, 170 2.0	1 00				7 107	1 00
PSP payments			one)			
1.00		· · · · · · · · · · · · · · · · · · ·	ons)			
Cheer The hospital specific payment to cost ratio (see Instructions) 0.000 5.00 0.00 1.00 0.00 1.00 0.00 1.00 0.0						
1.00 Line 2 times line 5 0.00 0.		, , , , , , , , , , , , , , , , , , , ,	ions)			
20,000 2	6.00					1
	7.00				0.00	
10.00 Organ acquisitions 0 10.00 Organ acquisitions 7, 107 10.00 Organ acquisition cost (sum of lines 1 and 10) (see instructions) 10.00 Organ acquisition charges 10.00 Ancillary service charges 14, 049 12.00 Organ acquisition charges (from Wkst. D-4, Pt. 111, line 69, col. 4) 14, 049 14.00 Organ acquisition charges (from Wkst. D-4, Pt. 111, line 69, col. 4) 14, 049 14.00 Organ acquisition charges (from Wkst. D-4, Pt. 111, line 69, col. 4) 14, 049 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from wkst. D-4, Pt. 111, line 69, col. 4) 14.00 Organ acquisition charges (from patients libele for payment for services on a chargebasis of cause of collection acquisition charges (from patients libele for payment for services on a chargebasis of cause of c	8.00					1
11.00 Total cost (sum or lines 1 and 10) (see instructions) 7.107 11.0	9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
Computation for Lesser of cost or charges 14,049 12.00 12.00 14.00 13.00 15.00	10.00	Organ acquisitions			0	10.00
Reasonable charges 14,049 12.0 20.0 Ancil Tarry service charges 14,049 12.0 20.0 2	11.00				7, 107	11. 00
12.00 Ancil Harry service charges 14,049 12.0 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, Hine 69, col. 4) 12.0 13.00 13.00 14.00						1
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4) 14.00 15.00					11.010	
14.09 1.4 (as 1.5 (but 1.					· ·	
Description			11. 4)		_	
15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.0	14.00				14, 049	14.00
Amounts that would have been realized from patients liable for payment for services on a chargebasis had buch payment been made in accordance with 42 CFR \$413.13(e)	15 00		nyment for services on	a charge hasis	0	15 00
had such payment been made in accordance with 42 CFR §413.13(e)						
	10.00			ii a chargebasi s	l	10.00
17.00 1.00	17. 00				0.000000	17. 00
Instructions						
Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 7, 107 21.0	19.00	,	if line 18 exceeds li	ne 11) (see	6, 942	19.00
Instructions		instructions)				
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 7, 107 21.0	20.00		if line 11 exceeds li	ne 18) (see	0	20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 9, 453, 586 24.00 Total prospective payment (sum of lines 3, 4, 8 and 9) 9, 453, 586 24.00 0 0 0 0 0 0 0 0 0						
Total prospective payment (sum of lines 3, 4, 8 and 9) 9, 453, 586 24.0		· · · · · · · · · · · · · · · · · · ·				
COMPUTATION OF REIMBURSEMENT SETTLEMENT					0 453 586	
Deductibles and coinsurance (for CAH, see instructions) 2,069,717 26.00	24.00				7, 433, 300	24.00
Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions) 2,069,717 26.0 27.0 28.0 27.0 28.0 27.0 28.0	25. 00				14	25. 00
CAH, see instructions Direct graduate medical education payments (from Wkst. E-4, line 50) Direct graduate medical education costs (from Wkst. E-4, line 50) 0 28.0	26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		2, 069, 717	26.00
28.00 Direct graduate medical education payments (From Wkst. E-4, line 50) 28.00 28.00 28.00 29.00	27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23) (for	7, 390, 962	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.0						
Subtotal (sum of lines 27 through 29) 7, 390,962 30.0	28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		-	
Primary payer payments					_	
Subtotal (line 30 minus line 31)		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.0 00 00 00 00 00 00						
33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 34.00 Allowable bad debts (see instructions) 171, 644 34.0 35.00 Adjusted reimbursable bad debts (see instructions) 111, 569 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 86, 821 36.00 37.00 Subtotal (see instructions) 7, 499, 933 37.0 37.00 Subtotal (see instructions) 7, 499, 933 37.0 38.00 MSP-LCC reconciliation amount from PS&R -121 38.0 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 Poineer ACO demonstration payment adjustment (see instructions) 0 39.9 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.9 40.00 Sequestration adjustment (see instructions) 7,500,054 40.00 Sequestration adjustment (see instructions) 150,001 40.00 10,001	32.00		5)		7, 300, 304	32.00
34.00	33 00		3)		0	33 00
35.00					_	
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 01 Subtotal (see instructions) 40. 02 Subtotal (see instructions) 40. 03 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Utilier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 On On 93. 0						
MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) O 139.00 OTHER ADJUSTMENT (SPECIFICATION) (SPECIFY) O 139.00 OTHER ADJUSTMENT (SPECIFICATION) (SPECIFICATIONS) O 139.00 OTHER ADJUSTMENT (SPECIFICATIONS) (SPECIF	36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		86, 821	36.00
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 9 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Untlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 39.	37.00	Subtotal (see instructions)			7, 499, 933	37.00
Pioneer ACO demonstration payment adjustment (see instructions) 9. Partial or full credits received from manufacturers for replaced devices (see instructions) 9. RECOVERY OF ACCELERATED DEPRECIATION 9. Subtotal (see instructions) 150,001 101 101 101 101 101 101	38. 00				-121	38. 00
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 60 39. 99 Acceleration adjustment (see instructions) 60 39. 99 Acceleration adjustment (see instructions) 61 50, 001 40. 00 62 40. 00 The rate used to calculate the Time Value of Money 63 90. 90 Acceleration adjustment (see instructions) 64 90. 00 Time Value of Money (see instructions) 7, 500, 054 40. 00 7, 500, 054 40. 00 7, 236, 876 41. 00 7, 2	39. 00					
RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Tentative settlement (for contractors use only) 42. 00 Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 0 39. 9 40. 00 7, 500, 054 40. 0 7, 236, 876 41. 0 0 13. 0 44. 00 7, 236, 876 41. 0 113, 177 43. 0 44. 0 90. 00 113, 177 90. 00 91. 00 91. 00 92. 00 93. 00 Time Value of Money (see instructions) 0 93. 0	39. 50					
40.00 Subtotal (see instructions) 7, 500, 054 40.01 Sequestration adjustment (see instructions) 1150, 001 40.00 7, 236, 876 41.00 7, 236, 876 41.00 7, 236, 876 41.00 8 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 91.50 91.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 92.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions)		· ·	ed devices (see instruc	tions)	_	
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)					_	
41.00 Interim payments 7, 236, 876 41.0 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\{\frac{1}{2}\}{\}}{\}\] 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 7, 236, 876 41.0 42.00 43.00 91.00 Outlier contractors use only) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)						1
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)						
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90.00 To BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 113,177 43.0 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.0 90.00 Policy Protested amounts (nonallowable cost report items) in accordance with C						
44.00 Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 92.00 Original outlier amount (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 95.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions) 98.00 Original outlier amount (see instructions) 99.00 Original outlier amount (see instructions)						
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 01.00 Outlier reconciliation adjustment amount (see instructions) 02.00 The rate used to calculate the Time Value of Money 03.00 Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,	e with CMS Pub 15-2	chapter 1		1
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 93.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 93.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 94.00 95.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00	r=. 00		ONIO FUD. 10-2,	chapter 1,		00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 99.00 99.0 99.00 99.00 99.00 99.00 99.00 99.00						1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00 93.00	90.00				0	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.0 93.00 Time Value of Money (see instructions)		, ,			0	91.00
	92.00	The rate used to calculate the Time Value of Money			0.00	92.00
94.00 Total (sum of lines 91 and 93) 0 94.0						
	94. 00	Total (sum of lines 91 and 93)			0	94.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet E-1 | From 01/01/2014 | Part | | To 12/31/2014 | Date/Time Prepared: | Period: | Pe Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150059

				0 12/31/2014	5/27/2015 3:30	
		Ti tl	e XVIII	Hospi tal	PPS	•
		Inpatien	nt Part A	Par	t B	
	mn	n/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00 Total interim payments paid to provider		1.00	15, 220, 490		7, 236, 876	1. 00
2.00 Interim payments payable on individual bills, eit	her		10, 220, 170		0	2.00
submitted or to be submitted to the contractor for			`		Ĭ	2.00
services rendered in the cost reporting period.						
write "NONE" or enter a zero						
3.00 List separately each retroactive lump sum adjustm	nent					3.00
amount based on subsequent revision of the interi						
for the cost reporting period. Also show date of						
payment. If none, write "NONE" or enter a zero. (
Program to Provider						
3. 01 ADJUSTMENTS TO PROVIDER			()	0	3. 01
3. 02)	0	3. 02
3. 03)	0	3. 03
3. 04)	0	3. 04
3. 05)	0	3. 05
Provider to Program						
3.50 ADJUSTMENTS TO PROGRAM			()	0	3. 50
3. 51)	0	3. 51
3. 52			()	0	3. 52
3. 53			()	0	3. 53
3. 54			()	0	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lin	nes		()	0	3. 99
3. 50-3. 98)						
4.00 Total interim payments (sum of lines 1, 2, and 3.			15, 220, 490)	7, 236, 876	4.00
(transfer to Wkst. E or Wkst. E-3, line and colum	nn as					
appropri ate)						
TO BE COMPLETED BY CONTRACTOR	- C:		I		I	
5.00 List separately each tentative settlement payment						5. 00
desk review. Also show date of each payment. If n	none,					
write "NONE" or enter a zero. (1) Program to Provider						
5.01 TENTATIVE TO PROVIDER				<u> </u>	0	5. 01
5.02						5. 01
5. 03						5. 02
Provider to Program				/	0	3.00
5. 50 TENTATI VE TO PROGRAM					0	5. 50
5. 51					0	5. 51
5. 52					l ol	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lin	nes				0	5. 99
5. 50-5. 98)	103		`		Ĭ	0. 77
6.00 Determined net settlement amount (balance due) ba	ased on					6. 00
the cost report. (1)] 5. 50
6. 01 SETTLEMENT TO PROVIDER			155, 25°		113, 177	6. 01
6.02 SETTLEMENT TO PROGRAM			(0	6. 02
7.00 Total Medicare program liability (see instruction	ns)		15, 375, 74		7, 350, 053	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8.00 Name of Contractor						8. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Ti tl	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 945, 338		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 52			0		Ö	3. 52
3. 53			0		Ö	3. 53
3. 54			0		o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 945, 338		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program			1		
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50 5. 51
5. 51 5. 52			0		0	5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
5. 77	5. 50-5. 98)		O		O	3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		45, 805		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 991, 143		0	7. 00
				Contractor	NPR Date	
		()	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	()	1.00	2.00	8. 00
5.00	name of contractor			I	!	0.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 01/01/2014 | Part I | Date/Time Prepared: | 5/27/2015 3:36 pm | Skilled Nursing | PPS | Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 150059 Component CCN: 155669 Title XVIII

		liti	e XVIII S	Facility	PPS	
		Inpatien	t Dart A		t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
4 00	T	1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 647, 100		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		Ü		0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	3. 04
3. 05			0		0	3. 05
0.50	Provi der to Program				0	0 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		0		0	3. 50 3. 51
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
0. 77	3. 50-3. 98)		Ü		o o	0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 647, 100		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATI VE TO TROVIDER		0		Ö	5. 02
5. 03			0		Ö	5. 03
	Provider to Program			I.		
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		0		0	6. 01
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
7. 00	Total Medicare program liability (see instructions)		1, 647, 100		0	7. 00
7.00	10 car modered by ogram Trability (see Thatractions)		1, 047, 100	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems RIVERVIEW HOSE	PI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150059	Period: From 01/01/2014	Worksheet E-1 Part II	
			To 12/31/2014		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			3, 810	
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			6, 592	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				1, 708	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200				314, 065, 225	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li			3, 957, 481	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of celline 168	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)			1, 027, 630	8. 00
9. 00				20, 553	
10. 00				1, 007, 077	
I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			865, 765	30.00
31. 00	Other Adjustment (specify)			0	31. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150059		Worksheet E-3
		From 01/01/2014	Part III
	Component CCN: 15T059	To 12/31/2014	Date/Time Prepared:
			5/27/2015 3:36 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

	IRF	113	
		1.00	
4 00	PART III - MEDICARE PART A SERVICES - IRF PPS	F 400 000	4 00
1.00	Net Federal PPS Payment (see instructions)	5, 123, 822	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0101	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	112, 724	3.00
4. 00 5. 00	Outlier Payments	25, 505 or 0. 00	4. 00 5. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prio to November 15, 2004 (see instructions)	0.00	5.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
3.01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	3.01
	CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6, 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7. 00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8. 00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	15. 200000	10.00
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	11. 00
12. 00	Teaching Adjustment (see instructions)	0	12.00
13. 00	Total PPS Payment (see instructions)	5, 262, 051	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16. 00
17. 00	Subtotal (see instructions)		
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	5, 262, 051	
20.00	Deducti bl es	89, 856	
21. 00	Subtotal (line 19 minus line 20)	5, 172, 195	
22. 00	Coinsurance	79, 192	
23. 00 24. 00	Subtotal (line 21 minus line 22)	5, 093, 003	23. 00 24. 00
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions) Adjusted reimbursable bad debts (see instructions)		25. 00
26. 00			26. 00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (sum of lines 23 and 25)	5, 093, 003	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0,043,003	28.00
29. 00	Other pass through costs (see instructions)		29.00
30. 00	Outlier payments reconciliation		30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	l ol	31. 50
31. 99	Recovery of Accel erated Depreciation	l ol	31. 99
32. 00	Total amount payable to the provider (see instructions)	5, 093, 003	32.00
32. 01	Sequestration adjustment (see instructions)	101, 860	32. 01
33. 00	Interim payments	4, 945, 338	33. 00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	45, 805	35. 00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	3, 740, 214	36. 00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	25, 505	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52. 00
53. 00	Time Value of Money (see instructions)	0	53. 00

Heal th	Financial Systems RIVERVIEW HOS	PI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150059	Peri od:	Worksheet E-3	
		Component CCN: 155669	From 01/01/2014 To 12/31/2014	Part VI Date/Time Pre 5/27/2015 3:3	
		Title XVIII	Skilled Nursing Facility	PPS	
				1 00	
	DADT VI CALCULATION OF DELADUDCEMENT CETTLEMENTAL ALL OTHE	D HEALTH CEDWICEC FOR T	LTLE VIII DADT A	1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHE SERVICES	R HEALTH SERVICES FOR T	IILE XVIII PARI A	N PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			1, 797, 298	1. 00
2.00	Routine service other pass through costs			0	2. 00
3.00					3. 00
4.00	Subtotal (sum of lines 1 through 3)			1, 797, 298	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine co	sts are included in lin	e 1 of W/S E,		5. 00
	Part B. This line is now shaded.)			_	
6.00	Deducti bl e			0	6. 00
7.00	Coinsurance			116, 584	7. 00
8.00	Allowable bad debts (see instructions)			0	8. 00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see in Adjusted reimbursable bad debts (see instructions)	istructions)		0	9. 00 10. 00
10. 00 11. 00	Utilization review			0	10.00
	2.00 Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions) 3.00 Inpatient primary payer payments			1, 680, 714 0	13. 00
	. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14. 00
	Pioneer ACO demonstration payment adjustment (see instructions	3)		0	14. 50
	Recovery of Accelerated Depreciation			0	14. 99
15. 00	Subtotal (see instructions			1, 680, 714	15. 00
	Sequestration adjustment (see instructions)			33, 614	15. 01
16.00	Interim payments			1, 647, 100	16.00
17 00	Tontative settlement (for contractor use only)			0	17 00

0 17.00

0 18.00

0 19.00

17.00 Tentative settlement (for contractor use only)
18.00 Balance due provider/program (line 15 minus lines 15.01, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: Worksheet E-3 From 01/01/2014 Part VII To 12/31/2014 Date/Time Prepared:

			To 12/31/2014	Date/Time Pre 5/27/2015 3:3	
		Title XIX	Hospi tal	Cost	<u></u>
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		1, 917, 084		1. 00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		5		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 917, 089	0	
5. 00	Inpatient primary payer payments		0	_	5. 00
6.00	Outpatient primary payer payments		4 047 000	0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		1, 917, 089	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
8. 00	Reasonable Charges Routine service charges		1, 257, 353		8.00
9.00	Ancillary service charges		3, 258, 288	0	
10. 00	Organ acquisition charges, net of revenue		5, 250, 266		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		4, 515, 646	0	1
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)	0.00000	0 000000	45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000		15. 00 16. 00
16. 00 17. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 14 exceeds	4, 515, 646 2, 598, 557	0	
17.00	line 4) (see instructions)	II IIIle 10 exceeds	2, 370, 337	0	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16	<i>'</i>	1, 917, 089	0	21. 00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid			00.00
22. 00 23. 00	Other than outlier payments		0	0	
24. 00	Outlier payments Program capital payments		0	U	23. 00 24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	Ö	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 917, 089	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 917, 089	0	
32. 00	Deducti bl es		0	0	
	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review	22)	1 017 000		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 30 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	1, 917, 089	0	
38. 00	Subtotal (line 36 ± line 37)		1, 917, 089	0	
	Direct graduate medical education payments (from Wkst. E-4)		1, 717, 007		39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		1, 917, 089	0	
41. 00	Interim payments		2, 009, 901	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		-92, 812	ő	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Peri od: From 01/01/2014	Worksheet E-3
	Component CCN: 15T059		Date/Time Prepared:
			5/27/2015 3:36 pm
	Title XIX	Subprovi der -	Cost

		TI LI E XIX	I RF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	CES FOR TITLES V OR XIX		2.00	1
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		388, 871		1
00	Medical and other services		000,071	0	
0	Organ acquisition (certified transplant centers only)			Ü	
0	Subtotal (sum of lines 1, 2 and 3)		388, 871	0	
0	Inpatient primary payer payments		000,071	Ü	
0	Outpatient primary payer payments			0	
0	Subtotal (line 4 less sum of lines 5 and 6)		388, 871	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				1
00	Routine service charges		295, 937		1
00	Ancillary service charges		520, 616	0	1
00	Organ acquisition charges, net of revenue		0		1
00	Incentive from target amount computation		o		1
00	Total reasonable charges (sum of lines 8 through 11)		816, 553	0	1
	CUSTOMARY CHARGES				
00	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	1
	basis				
00	Amounts that would have been realized from patients liable for pa	ayment for services on	0	0	1
	a charge basis had such payment been made in accordance with 42 (CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
	Total customary charges (see instructions)		816, 553	0	1 1
00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	427, 682	0	1
	line 4) (see instructions)			_	١.
00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	0	0	1
00	16) (see instructions)			0	
00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	ti ons)	0	0	1 '
	Cost of covered services (enter the lesser of line 4 or line 16)	LI OIIS)	388, 871	0	
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	onleted for DDS provide		0	4 4
00	Other than outlier payments	preted for 113 provide	0	0	1 2
	Outlier payments		Ö	0	
	Program capital payments		Ö	Ü	2
	Capital exception payments (see instructions)		o o		2
	Routine and Ancillary service other pass through costs		o	0	
	Subtotal (sum of lines 22 through 26)		0	0	1 2
00	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27)		388, 871	0	1 2
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		0	0	3
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		388, 871	0	3
00	Deducti bl es		0	0	3
	Coi nsurance		0	0	1 -
	Allowable bad debts (see instructions)		0	0	1 -
	Utilization review		0		3
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	388, 871	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1 -
	Subtotal (line 36 ± line 37)		388, 871	0	1 -
	Direct graduate medical education payments (from Wkst. E-4)		0	_	3
	Total amount payable to the provider (sum of lines 38 and 39)		388, 871	0	
	Interim payments		458, 348	0	
			-69, 477	0	4
	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance		0	0	4

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

Period: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/27/2015 3:36 pm Provi der CCN: 150059

					5/27/2015 3:3	6 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1. 00	Cash on hand in banks	8, 832, 191		0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	20, 699, 262	0	0	0	4. 00
5.00	Other recei vabl e	192, 000	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	3, 228, 533	0	0	0	7. 00
8.00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	20, 445, 545	0	0	0	9. 00
10. 00	Due from other funds	0	0	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	53, 397, 531	0	0	0	11. 00
	FIXED ASSETS					
12. 00	Land	15, 917, 384		0	0	
13. 00	Land improvements	6, 134, 813	0	0	0	13. 00
14. 00	Accumul ated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	199, 994, 008		0	0	15. 00
16. 00	Accumul ated depreciation	-122, 307, 016	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equi pment	0	0	0	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	0	0	0	0	23. 00
24. 00	Accumulated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	99, 739, 189	0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	82, 145, 890		0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	6, 733, 510		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	88, 879, 400		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	242, 016, 120	0	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	5, 408, 507		0	0	37. 00
38. 00	Salaries, wages, and fees payable	9, 229, 319	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	4, 202, 957	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44. 00	Other current liabilities	53, 463, 573		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	72, 304, 356	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	-	0	0	46. 00
47. 00	Notes payable	0		0	0	47. 00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	36, 230, 973		0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	36, 230, 973		0	0	50. 00
51. 00	Total liabilites (sum of lines 45 and 50)	108, 535, 329	0	0	0	51. 00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	133, 480, 791				52. 00
53. 00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	133, 480, 791		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	242, 016, 120	0	0	0	60. 00
	[59]	I	I I			l

Provider CCN: 150059

| Peri od: | Worksheet G-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					То	12/31/2014	Date/Time Prep 5/27/2015 3:30	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	5 piii
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		127, 001, 986			()	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5, 675, 733					2.00
3.00	Total (sum of line 1 and line 2)		132, 677, 719			(3.00
4.00	DEFERRED INFLOWS - INT. RATE SWAP	803, 072			0		0	4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6. 00
7. 00		0			0		0	7. 00
8.00		0			0		0	8. 00
9.00	T	O	000 070		0	,	0	9. 00
10.00	Total additions (sum of line 4-9)		803, 072			(10.00
11.00	Subtotal (line 3 plus line 10)		133, 480, 791		0	(1	11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0		0	12. 00 13. 00
14. 00					0			14. 00
15. 00					0			15. 00
16. 00					0			16. 00
17. 00					0			17. 00
18. 00	Total deductions (sum of lines 12-17)		0			(ı	18. 00
19. 00	Fund balance at end of period per balance		133, 480, 791			Ċ	1	19. 00
	sheet (line 11 minus line 18)		,,					
		Endowment Fund	PI ant	Fund				
4.00	TE	6. 00	7. 00	8. 00				4 00
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
3. 00 4. 00	DEFERRED INFLOWS - INT. RATE SWAP	١	0		U			4. 00
5. 00	DEFERRED INFLOWS - INT. RATE SWAP	1	0					5. 00
6. 00		1	0					6. 00
7. 00			0					7. 00
8.00			0					8. 00
9. 00			o					9. 00
10.00	Total additions (sum of line 4-9)	o			0			10.00
11.00	Subtotal (line 3 plus line 10)	o			0			11.00
12.00	Deductions (debit adjustments) (specify)		o					12.00
13.00			o					13.00
14.00			0					14.00
15.00			0					15.00
16.00			0					16.00
17. 00		1	0					17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)	1	I		- 1			

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150059

			То	12/31/2014	Date/Time Prep 5/27/2015 3:30	
	Cost Center Description	Inpati ent		Outpati ent	Total	J pili
	3331 3311131 33331 1 211 311	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES				2. 22	
	General Inpatient Routine Services					
1.00	Hospi tal	24, 491, 0	05		24, 491, 005	1. 00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF	5, 747, 1	63		5, 747, 163	3. 00
4.00	SUBPROVI DER					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	2, 456, 0	21		2, 456, 021	7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	32, 694, 1	89		32, 694, 189	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>				
11.00	INTENSIVE CARE UNIT	5, 895, 7	71		5, 895, 771	11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of lin	ies 5, 895, 7	71		5, 895, 771	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	38, 589, 9	60		38, 589, 960	17.00
18.00	Ancillary services	93, 688, 9	78	149, 616, 983	243, 305, 961	18.00
19.00	Outpati ent servi ces	3, 688, 6	19	28, 480, 685	32, 169, 304	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES		0	0	0	23. 00
24.00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	PHYSI CI AN PROFESSI ONAL FEES		0	3, 561, 453	3, 561, 453	
27. 01	PHYSI CI AN OFFI CES	72, 1		46, 797, 594	46, 869, 724	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 136, 039, 6	87	228, 456, 715	364, 496, 402	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			164, 652, 561		29. 00
30.00	ADD (SPECIFY)		0			30. 00
31. 00			0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00	T-t-1 -		0	o		35. 00 36. 00
36.00	Total additions (sum of lines 30-35)		0	٩		
37. 00 38. 00	DEDUCT (SPECIFY)		0			37. 00 38. 00
39. 00			0			39. 00
40.00			0			40. 00
41. 00			0			40.00
41.00	Total deductions (sum of lines 37-41)		U			41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		164, 652, 561		42.00
45.00	to Wkst. G-3, line 4)	1 01131 51		104, 032, 301		73.00
	10 1100 1	I .	- 1	ı		

Heal th	n Financial Systems RIVERVIEW HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15005	59 Peri od:	Worksheet G-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 3:3	
1.00	T-1-1 12 1 0 0 D 1 1 0 0 D	20)		1.00	1 00
1. 00 2. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 1	28)		364, 496, 402	1. 00 2. 00
2. 00 3. 00	Less contractual allowances and discounts on patients' accounts Net patient revenues (line 1 minus line 2)			203, 767, 921 160, 728, 481	2. 00 3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	\		160, 728, 481	4. 00
5.00	Net income from service to patients (line 3 minus line 4))		-3, 924, 080	5. 00
5.00	OTHER I NCOME			-3, 924, 000	3.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			1, 300, 765	7. 00
8. 00	Revenues from telephone and other miscellaneous communication se	ervi ces		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other than	n patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	3 11 1			0	21. 00
22. 00				0	22. 00
23. 00	The state of the s			0	23. 00
24. 00				8, 299, 048	24. 00
25. 00				9, 599, 813	25. 00
	Total (line 5 plus line 25)			5, 675, 733	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)		ļ	5, 675, 733	29. 00

CALCIII	Financial Systems RIVERVIEW ATION OF CAPITAL PAYMENT	Provi der CCN: 150059	Period:	u of Form CMS-2 Worksheet L	∠55Z-I
0/12002		77007 dei 7000. 100007	From 01/01/2014 To 12/31/2014	Parts I-III Date/Time Pre 5/27/2015 3:3	
		Title XVIII	Hospi tal	PPS	о рііі
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 181, 769	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			50, 910 0	1
3. 00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructions)	43. 19	
4. 00	Number of interns & residents (see instructions)	reporting period (see inst	i de ti ons)	0.00	1
5. 00	Indirect medical education percentage (see instructions)			0.00	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part (30) (see instructions)		, part A line	2. 39	
3. 00 9. 00	Percentage of Medicaid patient days to total days (see ins: Sum of lines 7 and 8	tructions)		13. 94 16. 33	
10.00	Allowable disproportionate share percentage (see instruction	ons)		3. 37	
11. 00	Disproportionate share adjustment (line 10 times the sum of			39, 826	1
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2	•		1, 272, 505	12. 00
				1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions))		0	
3. 00	Total inpatient program capital cost (line 1 plus line 2)	,		0	
4. 00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1
1.00 2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta	ancas (saa instructions)		0	
3. 00	Net program inpatient capital costs (line 1 minus line 2)	ances (see This tructions)		0	
4. 00	Applicable exception percentage (see instructions)			0.00	4.00
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see			0.00	
7. 00 3. 00	Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7)	ary circumstances (line 2 x	(line 6)	0	
9. 00	Current year capital payments (from Part I, line 12, as app	nlicable)		0	
10.00	Current year comparison of capital minimum payment level to		less line 9)	0	
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)			0	11.00
12.00	Net comparison of capital minimum payment level to capital	1 3 1	,	0	
10 00	Current year exception payment (if line 12 is positive, en		·	0	1
	Carryover of accumulated capital minimum payment level over	r capital payment for the f	following period	0	14. 0
	l(if line 12 is negative onter the amount on this line)				
13. 00 14. 00 15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	instructions)		0	15.00
14. 00 15. 00	, ,			0	