Heal th Financia	al Systems	RI VERVI EW HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g)	42 CFR 413.20(b)). Fail	lure to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cos	t reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
	0 0		1 9	0,	EXPIRES 05-31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX COS	ST REPORT CERTIFICATION	Provider CCN: 15-0059	Peri od:	Worksheet S
AND SETTLEMENT	SUMMARY			From 01/01/2016	Parts I-III
				To 12/31/2016	Date/Time Prepared: 5/25/2017 10:52 am
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed c	ost report		Date: 5/25/20	17 Time: 10:52 am
use only	2. [] Manually submitted cos	t report			
	3. [0] If this is an amended 4. [F] Medicare Utilization.	report enter the number Enter "F" for full or "L	of times the provider r " for low.	esubmitted this co	ost report
Contractor	5. [1]Cost Report Status 6	. Date Received:	10.1	NPR Date:	
use only	(1) As Submitted 7	. Contractor No.	11. (Contractor's Vendo	or Code: 4
	(2) Settled without Audit	3. [N]Initial Report fo 9. [N]Final Report for	this Provider CCN 12.		
	(3) Settled with Addit	. EN FINAL Report for	this provider con	number of tim	es reopened = 0-9.
	(4) Reopened				
	(5) Amended				
PART II - CERT					
	ION OR FALSIFICATION OF ANY IN	EORMATION CONTAINED IN T	ULS COST DEDORT MAY DE L		
	ACTION, FINE AND/OR IMPRISONMI				-
	OCURED THROUGH THE PAYMENT DI RI				
	ACTION, FINES AND/OR IMPRISON		KI OKENOK OK WEKE OTHER	TOE TEEEONE, ONT	
	CERTIFICATION BY OFFICER OR	ADMINISTRATOR OF PROVIDE	FR(S)		
	SERVICES AND A DE OFFICER OR				

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERVIEW HOSPITAL (15-0059) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	37, 600	16, 612	3, 477	149, 753	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	2, 126	0		67, 025	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	7, 089	0		0	7.00
200.00	Total	0	46, 815	16, 612	3, 477	216, 778	200.00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex 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.

Date

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provio	ler CCN: 1		Period: From 01/01/	/2016	Workshe Part I	et S-2	
						To 12/31/		Date/Ti		
	1.00	2.00		3.00			4.00	5/24/20	<u>)17 3:5</u>	<u>4 pm</u>
	Hospital and Hospital Health Care Co			3.00		·	+. 00			
00	Street: 395 WESTFIELD ROAD	P0 Box:								1 1.
00	City: NOBLESVILLE	State: IN		e: 46060-		ty: HAMI LTON				2.
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		ent Syst , 0, or		
			Number	Number	Type	Certified	V V			1
		1.00	2.00	3.00	4.00	5.00	6.00			1
	Hospital and Hospital-Based Componer		-							
00	Hospi tal	RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	0	3.
00 00	Subprovi der - IPF Subprovi der - IRF	RI VERVI EW HOSPI TAL REHAB	15T059	26900	5	01/01/1994	N	Р	0	4. 5.
0	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
0	Swing Beds - NF									8.
0	Hospital -Based SNF	RIVERVIEW HOSPITAL SNF	155669	26900		10/26/1999	N	P	N	9.
00 00	Hospi tal -Based NF Hospi tal -Based OLTC									10. 11.
00	Hospital -Based HHA									12.
00	Separately Certified ASC									13.
00	Hospi tal -Based Hospi ce									14.
00	Hospital -Based Health Clinic - RHC									15. 16.
00 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									10.
00	Renal Dialysis									18.
00	Other					<u> </u>				19.
						From:		To		-
00	Cost Reporting Period (mm/dd/yyyy)					1.00		2. (12/31/		20.
00	Type of Control (see instructions)					9		12/01/	2010	21.
	Inpatient PPS Information					T				1
00	Does this facility qualify and is it					Y		N		22.
	share hospital adjustment, in accord for yes or "N" for no. Is this facil									
	amendment hospital?) In column 2, en			2. 100(C)	(Z) (PICKI	e				
01	Did this hospital receive interim un			s cost r	eporting	Y		Y		22.
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to									
	for no for the portion of the cost r (see instructions)	eporting period occurri	ng on or a	inter oct	oper 1.					
02	Is this a newly merged hospital that	requires final uncompe	ensated car	e paymen	its to be	N		N		22.
	determined at cost report settlement					s				
	or "N" for no, for the portion of th									
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the portion of	the cost i	reporting	period o	n				
03	Did this hospital receive a geograph	ic reclassification fro	m urban to	rural a	s a resul	t N		N		22.
	of the OMB standards for delineating	statistical areas adop	ted by CMS	5 in FY20	15? Enter					
	in column 1, "Y" for yes or "N" for									
	prior to October 1. Enter in column cost reporting period occurring on c					e				
	hospital contain at least 100 but no					h				
			s counteu	in accor						
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N" for	no.					N		
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	"Y" for yes or "N" for dicaid days on lines 24	no. and/or 2	below?			3			23.
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if	no. and/or 29 date of di	bel ow? scharge.	ls the		3			23.
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric	no. and/or 25 date of di d differen	5 below? scharge. nt from t	ls the he method		3			23.
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ente In-St	no. and/or 2! date of di d differer r "Y" for ate In-S	5 below? scharge. ht from t yes or " tate 0	Is the he method <u>N" for no</u> Dut-of	Out-of M	ledi cai		ther	23.
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ents In-St Medic	no. and/or 25 date of di d differen er "Y" for ate In-S aid Medi	5 below? scharge. ht from t yes or " tate 0 caid	Is the he method <u>N" for no</u> Dut-of State	Out-of M State H		ys Med	li cai d	23.
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ente In-St	no. and/or 25 date of di d differen <u>r "Y" for</u> ate In-S aid Medi days elig	5 below? scharge. ht from t yes or " tate (caid ible Me	Is the he method <u>N" for no</u> Dut-of State edicaid I	Out-of M State H Medicaid	ledi cai	ys Med		23.
00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ents In-St Medic	no. and/or 25 date of di d differen r "Y" for ate In-S aid Medi days elig unp	5 below? scharge. ht from t yes or " tate C caid ible Me	Is the he method <u>N" for no</u> Dut-of State edicaid I	Out-of M State H	ledi cai	ys Med	li cai d	23.
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ente In-St Medic paid of 1.C	no. and/or 29 date of di d differer r "Y" for ate In-S aid Medi days elig unp da 0 2.	i below? scharge. t from t yes or " tate (caid i ble Me aid pa ys (00 (Is the he method N" for no Dut-of State edicaid I id days 3.00	Out-of M State H Medicaid eligible unpaid 4.00	Aedi cai AMO day	ys Mec c	di cai d days 5. 00	-
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, enter In-St Medic paid of 1.C , enter the	no. and/or 25 date of di d differen <u>r "Y" for</u> ate In-S aid Medi days elig unp da	i below? scharge. it from t yes or " tate (caid ible Me aid pa ys	Is the he method <u>N" for no</u> Dut-of State edicaid I id days	Out-of N State H Medicaid eligible unpaid	Aedi cai AMO day	ys Mec c	di cai d days 5. 00	-
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, enter In-St Medic paid of 1.C , enter the n 1, in-state	no. and/or 29 date of di d differer r "Y" for ate In-S aid Medi days elig unp da 0 2.	i below? scharge. t from t yes or " tate (caid i ble Me aid pa ys (00 (Is the he method N" for no Dut-of State edicaid I id days 3.00	Out-of M State H Medicaid eligible unpaid 4.00	Aedi cai AMO day	ys Mec c	di cai d days 5. 00	-
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ente In-St Medic paid of 1.C , enter the n 1, in-state umn 2,	no. and/or 29 date of di d differer r "Y" for ate In-S aid Medi days elig unp da 0 2.	i below? scharge. t from t yes or " tate (caid i ble Me aid pa ys (00 (Is the he method N" for no Dut-of State edicaid I id days 3.00	Out-of M State H Medicaid eligible unpaid 4.00	Aedi cai AMO day	ys Mec c	di cai d days 5. 00	-
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ente In-St Medic paid of 1.C , enter the n 1, in-state umn 2, olumn 3,	no. and/or 29 date of di d differer r "Y" for ate In-S aid Medi days elig unp da 0 2.	i below? scharge. t from t yes or " tate (caid i ble Me aid pa ys (00 (Is the he method N" for no Dut-of State edicaid I id days 3.00	Out-of M State H Medicaid eligible unpaid 4.00	Aedi cai AMO day	ys Mec c	di cai d days 5. 00	-
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, enter Medic paid of 1.C , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	no. and/or 29 date of di d differer r "Y" for ate In-S aid Medi days elig unp da 0 2.	i below? scharge. t from t yes or " tate (caid i ble Me aid pa ys (00 (Is the he method N" for no Dut-of State edicaid I id days 3.00	Out-of M State H Medicaid eligible unpaid 4.00	Aedi cai AMO day	ys Mec c	di cai d days 5. 00	-
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00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in RF, enter th	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, entet In-State um 2, olumn 3, d days in column t unpaid days in column 6. e in-state	no. and/or 29 date of di d differer r "Y" for ate In-S aid Medi days elig unp da 0 2.	i below? scharge. t from t yes or " tate (caid i ble Me aid pa ys (00 (Is the he method N" for no Dut-of State edicaid I id days 3.00	Out-of M State H Medicaid eligible unpaid 4.00	Aedi cai AMO day	ys Mec c	di cai d days 5. 00	24.
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00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	"Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, ente iod? In column 2, ente m 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	no. and/or 21 date of di d differen r "Y" for ate In-S aid Medi days el ig unp da 0 2. 316	i below? scharge. ht from t yes or " tate (caid ible Me aid pa ys 00 615	Is the he method N" for no Dut-of State di cai d I i d days 3.00	Out-of M State H Medicaid eligible unpaid 4.00 0	Aedi cai AMO day	ys Mec c 448	di cai d days 5. 00	24.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	Period: From 01/01/ To 12/31/		Worksheet Part I Date/Time		
							5/24/2017	3:5	
					1.00	ai S	Date of G 2.00	eogr	
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural.	-	-		1			26.00 27.00
	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	-"2" fo cation	or rural. If ap in column 2.	pl i cabl e,					
	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number	r of periods SC	H status in		0			35.00
					Begi nni r 1. 00	ng:	Endi ng 2. 00	:	
	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	1.00		2.00		36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status		0			37.00
	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37. Oʻ
	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.00
	enter subsequent dates.				Y/N		Y/N		
9.00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	or low volume	1.00 N		2.00 N		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ent∉ quiremer	er in column 1 nts in accordan	"Y" for yes ce with 42					07.00
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. E	Enter "Y" for y		Y		Y		40.00
					-	V 1. 00		XI X 3. 00	
5.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for a	di sproporti onat	e share in ac	cordance	N	Y	N	45.00
6. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					Ν	N	N	46.00
7.00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	Ν			56.00
7. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or th of th (", comp	r "N" for no in nis cost report plete Worksheet	column 1. lf ing period?	column 1 Enter "Y"				57.00
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CNS Dub 15 1 chemter 21 S21402 for yes	oursemer	nt for physicia	ns' services	as	Ν			58.0
9.00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	s, compl	ete Wkst. D-2,			Ν			59.0
0. 00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"		1 9			Y	Direct (MF	60.00
		1.00	2.00	3.00	4.00		5.00		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00	2.00	3.00	4.00	0.00		0.00	61.00
1. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.0	o				61. 0
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0. 00	0.0	o				61. 02
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.0	o				61. 0
1. 04	determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or		0.00	0.0	o				61. 0 [.]
1. 05	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0. 00	0.0	o				61. 05
	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								

JSPITAL AND HUSPI	TAL HEALTH CARE COMP	LEX IDENTIFICATION DA	IA	Provider CC	Fr	riod: om 01/01/2016	Worksheet S-2 Part I	
					To		Date/Time Pre 5/24/2017 3:54	pared 4 pm
			Y/N	IME	Direct GME	IME	Direct GME	
.06 Enter the ar	nount of ACA §5503 aw	and that is being	1.00	2.00	3.00 0.00	4.00	5.00	61.0
used for cap	p relief and/or FTEs eral surgery. (see in	that are nonprimary						01.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
specialty, i for each new column 1, th program code	in line 61.05, speci f any, and the number v program. (see instr he program name, enter e, enter in column 3, count and enter in co ted count.	r of FTE residents ructions) Enter in er in column 2, the the IME FTE				0.00	0. 00	61.
program spea residents fo instructions enter in col 3, the IME F	in line 61.05, speci cialty, if any, and t or each expanded prog s) Enter in column 1, umn 2, the program c TE unweighted count AE FTE unweighted cou	he number of FTE gram. (see the program name, code, enter in column and enter in column				0. 00	0. 00	61.
							1.00	
		I th Resources and Ser						
		s that your hospital funding (see instruc		in this cost	reporting peri	od for which	0.00	62.0
during in th	nis cost reporting pe	s that rotated from a riod of HRSA THC proc esidents in Nonprovide	gram. (s	<u>ee instruction</u>		your hospital	0.00	62.
3.00 Has your fac	cility trained reside	ents in nonprovider se umn 1. If yes, comple	ettings	during this co		eriod? Enter	N	63.
					Unwei ghted FTEs Nonprovi der	9	Ratio (col. 1/ (col. 1 + col. 2))	
				-	Si te 1.00	2.00	3.00	-
		ar FTE Residents in No July 1, 2009 and befor						
4.00 Enter in col in the base resident FT settings. I resident FT	umn 1, if line 63 is year period, the num Es attributable to ro Enter in column 2 the Es that trained in yo	s yes, or your facilit ber of unweighted nor tations occurring in number of unweighted pur hospital. Enter ir 1 + column 2)). (see	y train -primar all non non-pr column	ed residents y care provider imary care 3 the ratio	0. 00	0. 00	0. 000000	64.
		Program Name	Pro	gram Code	Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 3/ (col. 3 + col. 4))	
5 00 Entor in cal	ump 1 if line (2	1.00		2.00	3.00	4.00	5.00 0.000000	65
is yes, or y trained resi year period, associated v FTEs for ead program in v residents. I	umn 1, if line 63 your facility dents in the base the program name with primary care which you trained Enter in column 2, code, enter in he number of primary care FTE ttributable to				0.00	0. 00	0. 00000	05.0

Health Financial Systems	RIVE	ERVI EW HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DA	TA Provider CC	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-2 Part I Date/Time Pre 5/24/2017 3:54	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Vear FTF Residents in	Nonnrovider Setting	1.00	2.00	3.00	
beginning on or after July 1, 2	010					
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi	occurring in all nonpr unweighted non-primar tal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
(column 1 divided by (column 1 -	+ column 2)). (see ins Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
		Ĵ	FTĔs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
(7.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00	(7.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)			0. 00) O. OC	0. 000000	67.00
				1.0		
Inpatient Psychiatric Facility	PPS			1.00	0 2.00 3.00	
70.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or does it conta	ain an IPF subp	provider? N		70.00
71.00 If line 70 yes: Column 1: Did th recent cost report filed on or H 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CH Column 3: If column 2 is Y, indi (see instructions)	he facility have an ap before November 15, 20 Diumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" for ye lity train residents (D)? Enter "Y" for ye	es or "N" for r in a new teach es or "N" for r	no. (see ni ng no.	0	71.00
Inpatient Rehabilitation Facili75.00Is this facility an Inpatient Re	ty PPS ehabilitation Facility	(IRF), or does it co	ontain an IRF	Y		75.00
subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ento indicate which program year bega	and "N" for no. ne facility have an ap ding on or before Nove train residents in a er "Y" for yes or "N"	oproved GME teaching p ember 15, 2004? Enter new teaching program for no. Column 3: If	orogram in the "Y" for yes or in accordance column 2 is Y,	"N" for with 42	0	76.00
					1.00	
Long Term Care Hospital PPS						
80.00 Is this a long term care hospita 81.00 Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Enter	N N	80.00 81.00
85.00 Is this a new hospital under 42 86.00 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	ew Other subprovider ((excluded unit) under			N	85. 00 86. 00
87.00 Is this hospital a "subclause ((1)(B)(iv)(II)?	? Enter "Y"	Ν	87.00
for yes or "N" for no.				V	XI X	
Title V and XIX Services				1.00	2.00	
90.00 Does this facility have title V	and/or XIX inpatient	hospital services? Er	nter "Y" for	N	Y	90.00
yes or "N" for no in the applica 91.00 Is this hospital reimbursed for	title V and/or XIX th	nrough the cost report	t either in	N	Y	91.00
full or in part? Enter "Y" for 92.00 Are title XIX NF patients occup					N	92.00
instructions) Enter "Y" for yes 93.00 Does this facility operate an IC	or"N" for no in the	applicable column.	, ,	N	N	93.00
"Y" for yes or "N" for no in the	e applicable column.					
94.00 Does title V or XIX reduce capi applicable column.	tai cost?Enter "Y" fo	pr yes, and "N" for no	DIN THE	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	SPI TAL Provi der C	°N· 15_0059	Period:	LIEU	Workshe		2552-1
HOST THE AND HOST THE HEALTH CARE COMILEEN TEENTTECATION DATA		civ. 13-0037	From 01/01/ To 12/31/		Part I Date/Ti	me Prep	pared:
			V		5/24/20 XI X		4 pm
			1.00		2.0		
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N		0. 0 N	0	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	icable colum	n	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH 106.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)		hod of paymen	t N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst	ructions) lf	t				107.00
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							108. 00
-	Physi cal 1.00	Occupationa 2.00	I Speec 3.00		Respira 4.0		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109. 00
					1.0	0	
10.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for		on project (4	10A Demo)for	-	N		110. 0
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers 	If column 2 for long te	is "E", enter rm care (incl	in column udes	N		0	115. 0
Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for 17.00 Is this facility legally-required to carry malpractice insura			"N" for	N Y			116. 0 117. 0
no. 118.00 Is the malpractice insurance a claims-made or occurrence poli- claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1	if the policy	is	2			118. 0
		Premi ums	Losses	s	Insura	ance	
		Premi ums	Losses	S	Insura	ance	
		Premi ums	Losse: 2.00	-	I nsura 3. 0		
18.01 List amounts of malpractice premiums and paid losses:			2.00	-		0	118. 0
		1.00 822,5	2.00 79 2! 1.00	5,000		0 0 0	
118.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein.		1.00 822,5 than the	2.00 79 2!	5,000	3.0	0 0	118. 0
 18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment 	le listing c Harmless pro column 1, "Y lifies for t	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient	2.00 79 2! 1.00 N	5,000	3.0	0 0	118. 0 119. 0
 118.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implan 	le listing c Harmless pro column 1, "Y lifies for t s? (see inst	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions)	2.00 79 2! 1.00 N	5,000	3.0	000000000000000000000000000000000000000	118. 0 119. 0 120. 0
 18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the 	le listing c Harmless pro column 1, "Y lifies for t s? (see inst table device nter "Y" for	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	2.00 79 2! 1.00 N N	5,000	3.0	0	118. 0 119. 0 120. 0 121. 0
 18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 	le listing c Harmless pro column 1, "Y lifies for t s? (see inst table device nter "Y" for e Worksheet A	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	2.00 79 2! 1.00 N N Y	5,000	3.0	0 0	118. 0 119. 0 120. 0 121. 0 122. 0
 18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entities and the state and the	He listing c Harmless pro column 1, "Y lifies for t s? (see inst table device inter "Y" for Worksheet A worksheet A yes and "N" er the certi	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If	2.00 79 2! 1.00 N V N	5,000	3.0	0 0	118. 0 119. 0 120. 0 121. 0 122. 0 125. 0
 18.02 Are mal practice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in 21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 21.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2. 	le listing c Harmless pro column 1, "Y lifies for t s? (see inst table device nter "Y" for Worksheet A worksheet A ves and "N" er the certif	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	2.00 79 2! 1.00 N V N	5,000	3.0	0	118. 0 119. 0 120. 0 121. 0 122. 0 125. 0 126. 0 127. 0
 118. 02 Are mal practice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 122. 00 Does the cost report contain state heal th or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, ente in column 1 and termination date, if applicable, in column 2. 127. 00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2. 128. 00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2. 	He listing c Harmless pro column 1, "Y lifies for t s? (see inst table device nter "Y" for Worksheet A worksheet A yes and "N" er the certif or the certif	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	2.00 79 2! 1.00 N N Y N	5,000	3.0	0	118. 0. 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00
 118.02 Are mal practice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 122.00 Dees the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter 	le listing c Harmless pro column 1, "Y lifies for t s? (see inst table device nter "Y" for Worksheet A worksheet A yes and "N" er the certi r the certifient the certifient	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date i	2.00 79 2! 1.00 N N Y N	5,000	3.0	0	118. 0 119. 0 120. 0 121. 0 122. 0 125. 0 126. 0 127. 0 128. 0 129. 0
 and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in o "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ente in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter 	He listing c Harmless pro column 1, "Y lifies for t s? (see inst table device nter "Y" for Worksheet A worksheet A yes and "N" er the certif or the certifiente ce	1.00 822,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date i tification	2.00 79 2! 1.00 N N Y N	5,000	3.0	0	118.0° 118.0° 119.0° 120.0° 121.0° 122.0° 125.0° 126.0° 127.0° 128.0° 129.0° 130.0° 131.0°

Health Financial Systems	RIVERVIEW H	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX		Provider CC		eri od:	Worksheet S-2	
			F T	rom 01/01/2016 o 12/31/2016		narod
			1	0 12/31/2010	5/24/2017 3:5	
						_
133.00 If this is a Medicare certified of	per transplant center ent	er the certifi	cation date	1.00	2.00	133.00
in column 1 and termination date, i			cation date			133.00
134.00 If this is an organ procurement org			n column 1			134.00
and termination date, if applicable	e, in column 2.					-
All Providers 140.00 Are there any related organization	or home office costs as d	ofined in CMS	Dub 15 1	Y		140.00
chapter 10? Enter "Y" for yes or "I						140.00
are claimed, enter in column 2 the						
1.00	2.00			3.00		
If this facility is part of a chain home office and enter the home off				me and address	of the	
141. 00 Name:	Contractor's Name:			's Number:		141.00
142.00 Street:	PO Box:					142.00
143.00 Ci ty:	State:		Zip Code:			143.00
					1.00	-
144.00 Are provider based physicians' cost	ts included in Worksheet A	?			1.00 Y	144.00
		•				
				1.00	2.00	
145.00 If costs for renal services are cla				Y		145.00
inpatient services only? Enter "Y" no, does the dialysis facility incl						
period? Enter "Y" for yes or "N"			roportring			
146.00 Has the cost allocation methodology	, changed from the previou			N		146.00
Enter "Y" for yes or "N" for no in		5-2, chapter 4	40, §4020) lf			
yes, enter the approval date (mm/de	17 yyyy) in column 2.					
					1.00	-
147.00 Was there a change in the statistic					N	147.00
148.00 Was there a change in the order of		2			N	148.00
149.00 Was there a change to the simplifie	ed cost finding method? En	<u>ter "Y" for ye</u> Part A	es or "N" for r Part B	no. Title V	N Title XIX	149.00
	-	1.00	2.00	3.00	4.00	-
Does this facility contain a provi	der that qualifies for an					
or charges? Enter "Y" for yes or "I	<u>N" for no for each compone</u>					155 00
155.00Hospi tal 156.00Subprovi der – IPF		N N	I N N	N N	N N	155.00 156.00
157. 00 Subprovi der – TRF		N	N	N	N	157.00
158. 00 SUBPROVI DER						158.00
159.00 SNF		Ν	N	N	N	159.00
160.00 HOME HEALTH AGENCY		Ν	N N	N	N	160.00
161.00 CMHC			IN	N	N	161.00
					1.00	-
Multicampus						
165.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no.	npus hospital that has one	or more campu	uses in differe	ent CBSAs?	N	165.00
	Name	County	State Zip	Code CBSA	FTE/Campus	
	0	1.00		00 4.00	5.00	-
166.00 If line 165 is yes, for each					0.00	0166.00
campus enter the name in column						
0, county in column 1, state in column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	-
Health Information Technology (HIT) incentive in the America	n Recovery and	d Reinvestment	Act	1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter "Y	" for yes or "	'N" for no.		Y	167.00
168.00 If this provider is a CAH (line 10			e 167 is "Y"),	enter the		0168.00
reasonable cost incurred for the HI 168.01 If this provider is a CAH and is no			aualify for a	hardshi n		168. 01
exception under §413.70(a)(6)(ii)?				a narusni p		
169.00 If this provider is a meaningful us	ser (line 167 is "Y") and			N"), enter the	0.2	5169.00
transition factor. (see instruction	1S)				l	

Health Financial Systems					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	PITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0059 Pe				
			From 01/01/2016 To 12/31/2016	Date/Time Pre	
		5/24/2017 3:5	5 <u>4 pm</u>		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2016	09/30/2016	170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provide	er have any days for indiv	iduals enrolled in	N	(0171.00
section 1876 Medicare cost plans repo	orted on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column		nter the number of section	n		
1876 Medicare days in column 2. (see	instructions)				

DSPI T	Financial Systems RIVERVIEW H AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0059	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2016 To 12/31/2016	Part II Date/Time Pr	
				Y/N	<u>5/24/2017 3:</u> Date	54 pm
				1.00	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ent			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation					_
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in co	olumn 2. (see		·		
			Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in the Medicare Pr	rogram? If	1.00 N	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in columr voluntary or "I" for involuntary.	n 3, "V" for				
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	ffices, drug er or its f the board	N			3.
	relationships? (see instructions)		V /N	Tupo	Data	
			Y/N 1.00	Туре 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	0.00	
00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	03/28/2016	4.
00	Are the cost report total expenses and total revenues differ		Ν			5.
	those on the filed financial statements? If yes, submit reco			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities		· · · ·			
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider i	s N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions.		Y		7.
00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	and/or renewed	C C	Y		8.
00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions	,	cal education	N		9.
D. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	N		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes,	coo instruct	lana		Y	12.
	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	N	12.
4. 00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	°yes, see in	structions.	Ν	14.
5.00	Did total beds available change from the prior cost reportin	<u>v</u> 1	yes, see ins rt A	tructions. Par	N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	03/14/2017	Y	03/14/2017	16.
. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	I	0371472017		037 147 2017	10.
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		N		17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

eal th Financial Systems RIVERVIEW H		01 15 0050		eu of Form CMS-		
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0059	Period: From 01/01/2016 To 12/31/2016		epared:	
	Descr	i pti on	Y/N	Y/N		
		0	1.00	3.00		
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
Report data for other? Describe the other adjustments.	Y/N	Date	Y/N	Date		
	1.00	2.00	3.00	4.00		
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		N		21.00	
				1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS H	IOSPI TALS)		•	-	
2.00 Have assets been relifed for Medicare purposes? If yes, see 3.00 Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost		22. 00 23. 00	
reporting period? If yes, see instructions. 4.00 Were new leases and/or amendments to existing leases entered	d into during	this cost re	porting period?		24.00	
If yes, see instructions 5.00 Have there been new capitalized leases entered into during	the cost repo	ting period?	'lfyes, see		25.00	
6.00 Were assets subject to Sec.2314 of DEFRA acquired during the	e cost reporti	ng period? I	f yes, see		26.00	
Interest Expense	tered into du	ing the cost	reporting		28.00	
period? If yes, see instructions.						
treated as a funded depreciation account? If yes, see instr 0.00 Has existing debt been replaced prior to its scheduled matu	uctions				29.00	
instructions. 1.00 Has debt been recalled before scheduled maturity without is	5	5			31.00	
instructions. Purchased Services		-				
2.00 Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru-		ed through co	ontractual		32.00	
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	lied pertainin	ng to competi	tive bidding? If		33.00	
Provi der-Based Physi ci ans				1		
4.00 Are services furnished at the provider facility under an ar If yes, see instructions.	0				34.00	
5.00 If line 34 is yes, were there new agreements or amended exist physicians during the cost reporting period? If yes, see in:		nts with the	·		35.00	
			<u>Y/N</u> 1.00	Date 2.00		
Home Office Costs			1.00	2.00		
6.00 Were home office costs claimed on the cost report?					36.00	
7.00 If line 36 is yes, has a home office cost statement been pro- If yes, see instructions.	epared by the	home office?			37.00	
8.00 If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	of the home of	offi ce.			38.00	
9.00 If line 36 is yes, did the provider render services to othe see instructions.		5	;,		39.00	
0.00 If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40.00	
	1.	00	2.	00		
Cost Report Preparer Contact Information	MICHAEL		ALESSANDRI NI		41.00	
			1		11	
held by the cost report preparer in columns 1, 2, and 3, respectively.					42.00	
 held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report preparer. 	BLUE AND CO 317.713.7959		MALESSANDRI NI @		42.00	

Heal th	Financial Systems RIVERVIEW	N HOSPI TAL	u of Form CMS-	2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0059	Period:	Worksheet S-2	
			From 01/01/2016 To 12/31/2016		pared: 4 pm
		3.00			
	Cost Report Preparer Contact Information				
	Enter the first name, last name and the title/position	SENI OR 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 of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
	0	Washakat	Na of Dada	Dad Dava		5/24/2017 3:5 I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	90	32, 94		0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HMO IRF Subprovider					0	2.00 3.00 4.00 5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		90	32, 94	0 0.00	0	6. 00 7. 00
8.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	31.00	15	5, 49	0 0.00	0	8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF	43.00	105	38, 43	0 0.00	0 0 0	13.00 14.00 15.00 16.00
17. 00 18. 00	SUBPROVI DER – I RF SUBPROVI DER	41.00	24	8, 78		0	17. 00 18. 00
19.00 20.00 21.00 22.00 23.00 24.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	44.00	25	9, 15	0	0	19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89.00	154 0		0	0	26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	5, 276	316	13, 27			1.00
2.00	HMO and other (see instructions)	2, 356	2, 055				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	310	233				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5, 276	316	13, 27	7		7.00
8.00	INTENSIVE CARE UNIT	1, 103	0	2, 37	'9		8.00
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0		0		13.00
14.00	Total (see instructions)	6, 379	316	15, 65	0.00	998.91	14.00
15.00	CAH visits	0	0		0		15.0
16.00	SUBPROVI DER – I PF						16.0
17.00	SUBPROVIDER - IRF	4, 088	74	5, 96	0. 00	24.69	17.0
8.00	SUBPROVI DER						18.0
19.00	SKILLED NURSING FACILITY	3, 093	0	4, 24	6 0.00	0.00	
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPICE						24.0
24.10	HOSPICE (non-distinct part)	0	0		0		24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC		0		0 0 00	0.00	26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00 28.00	Total (sum of lines 14-26)		21	2.02	0.00	1, 023. 60	27.0
28.00	Observation Bed Days	0	21	2, 02	5		28.0
30.00	Ambulance Trips	0			0		•
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF				0		30.0 31.0
					0		
32.00	Labor & delivery days (see instructions)	0	8		8		32.0
32. 01	Total ancillary labor & delivery room				U		32.0
	outpatient days (see instructions) LTCH non-covered days	0					33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	RIVERVIEW HO	Provi der C	°N· 15_0050	Peri od:	u of Form CMS-2 Worksheet S-3	
103511	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		FIOVIDEI CI		From 01/01/2016 To 12/31/2016	Part I	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1, 5	57 49	3, 928	1.00
2.00	HMO and other (see instructions)			5	34 494		2.0
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				18		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.0
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		_				13.00
14.00	Total (see instructions)	0.00	0	1, 5	67 49	3, 928	
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00				170	16.00
17.00	SUBPROVIDER - IRF	0.00	0	3.	37 3	470	
18.00		0.00					18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20. 0 21. 0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.0
24.00	HOSPICE HOSPICE (non-distinct part)						24.0
25.00	CMHC - CMHC						24. 1
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.0
20.25	Total (sum of lines 14-26)	0.00					20.2
28.00	Observation Bed Days	0.00					27.00
29.00	Ambul ance Trips						28.0
30.00	Employee discount days (see instruction)						30.0
30.00	Employee discount days (see first detron)						31.0
32.00	Labor & delivery days (see instructions)						32.0
32.00	Total ancillary labor & delivery room						32.0
JZ. UI	outpatient days (see instructions)						32.0
~ ~ ~	LTCH non-covered days						33.00

	AL WAGE INDEX INFORMATION			Provider CO	F	Period: From 01/01/2016 To 12/31/2016		pare
		Worksheet A Line Number		Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							-
00	SALARIES Total salaries (see	200.00	69, 690, 665	3, 152, 084	72, 842, 749	2, 129, 077. 00	34. 21	1.
0	instructions)	200.00	07, 070, 005	3, 152, 004	72,042,745	2, 129, 077.00	34.21	1.
00	Non-physician anesthetist Part		0	0	C	0.00	0. 00	2.
	A							
00	Non-physician anesthetist Part		0	0	C	0.00	0.00	3
00	Physician-Part A -		0	0	C	0.00	0.00	4
	Admi ni strati ve		0			0.00	0.00	'
)1	Physicians - Part A - Teaching		0	0	C	0.00	0.00	4
00	Physician and Non		0	0	C	0.00	0.00	5
	Physician-Part B		0	0		0.00	0.00	
00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	C	0.00	0.00	6
	servi ces							
00	Interns & residents (in an	21.00	0	0	C	0.00	0.00	7
	approved program)		_	_				
01	Contracted interns and		0	0	C	0.00	0.00	7
	residents (in an approved programs)							
00	Home office and/or related		0	0	C	0.00	0.00	8
	organization personnel							
00	SNF	44.00	0	0	C	0.00		
00	Excluded area salaries (see		26, 989, 957	192, 217	27, 182, 174	605, 390. 00	44. 90	10
	instructions) OTHER WAGES & RELATED COSTS							
	Contract Labor: Direct Patient		707, 302	0	707, 302	8, 391. 00	84.29	111
	Care		,	_	,	-,		
00	Contract labor: Top level management and other management and administrative		0	0	C	0.00	0.00	12
	servi ces							
00	Contract Labor: Physician-Part		341, 310	0	341, 310	2, 579. 00	132.34	13
00	A - Administrative Home office and/or related		0	0	C	0.00	0.00	1
00	orgainzation salaries and		0			0.00	0.00	·
	wage-related costs							
	Home office salaries		0	-	C	0.00		
	Related organization salaries		0	-	(0.00		
00	Home office: Physician Part A - Administrative		0	0	L L	0.00	0.00	
00	Home office and Contract		0	0	C	0.00	0.00	16
	Physicians Part A - Teaching							
	WAGE-RELATED COSTS		44 400 407		44,400,407	-	1	
00	Wage-related costs (core) (see instructions)		11, 488, 697	0	11, 488, 697	<i>(</i>		17
00	Wage-related costs (other)		0	0	C)		18
	(see instructions)							
	Excluded areas		4, 701, 810	0	4, 701, 810			19
00	Non-physician anesthetist Part		0	0	C	ע		20
00	A Non-physician anesthetist Part		0	0	r)		21
	B		0					- '
00	Physician Part A -		0	0	C			22
~	Administrative		-	-	-			
	Physician Part A - Teaching Physician Part B		0	0				22
	Wage-related costs (RHC/FQHC)		0			Ó		23
	Interns & residents (in an		0	0	0			25
	approved program)							
	Home office wage-related		0	-	C)		25
51	Related orgainzation wage-related		0	0	C	ע		25
52	Home office: Physician Part A - Administrative -		0	0	C			25
E 2	wage-related		~	_	-			1
53	Home office & Contract Physicians Part A - Teaching -		0	0	C	,		25
	wage-related							
	OVERHEAD COSTS - DIRECT SALARIE	S						1
	OVERHEAD COSTS DIRECT SALARTE	-			816, 270			

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO	1	Period: From 01/01/2016 Fo 12/31/2016		pared:
		Worksheet A		Reclassi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		774, 960	0	774, 960	3, 949. 00	196. 24	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 618, 595	-563	1, 618, 032	2 64, 390. 00	25. 13	30.00
31.00	Laundry & Linen Service	8.00	62, 623	-2	62, 62	1 4, 470. 00	14.01	31.00
32.00	Housekeepi ng	9.00	794, 694	-168	794, 520	6 46, 844. 00	16. 96	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10.00	1,033,477	-762, 404	271, 073	3 17, 282. 00	15.69	34.00
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00
36.00	Cafeteria	11.00	0	696, 220	696, 220	44, 359. 00	15. 70	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	555, 728	-497	555, 23 ⁻	1 12, 749. 00	43.55	38.00
39.00	Central Services and Supply	14.00	448, 523	193, 999	642, 52	2 26, 547. 00		
40.00	Pharmacy	15.00	2, 471, 006					
41.00	Medi cal Records & Medi cal Records Li brary	16.00	805, 326					
42.00	Social Service	17.00	614, 081	-548	613, 533	3 17, 966. 00	34.15	42.00
43.00	Other General Service	18.00	0	0	(0.00		43.00

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2016 To 12/31/2016		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	,	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-1		
1.00	Net salaries (see		70, 465, 625	3, 152, 084	73, 617, 70	9 2, 133, 026. 00	34.51	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		26, 989, 957	192, 217	27, 182, 17	4 605, 390. 00	44. 90	2.00
3.00	Subtotal salaries (line 1 minus line 2)		43, 475, 668	2, 959, 867	46, 435, 53	5 1, 527, 636. 00	30. 40	3.00
4.00	Subtotal other wages & related costs (see inst.)		1, 048, 612	0	1, 048, 61	2 10, 970. 00	95. 59	4.00
5.00	Subtotal wage-related costs (see inst.)		11, 488, 697	0	11, 488, 69	7 0.00	24.74	5.00
6.00	Total (sum of lines 3 thru 5)		56,012,977	2, 959, 867	58, 972, 84	4 1, 538, 606. 00	38. 33	6.00
7.00	Total overhead cost (see instructions)		18, 318, 114					7.00

Heal th	Financial Systems	RI VERVI EW HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN: 15-0059	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
					5/24/2017 3:5 Amount	4 pm
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					İ
	RETI REMENT COST					İ
1.00	401K Employer Contributions				1, 089, 944	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribut	tion			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see in	nstructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instr	ructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Or	rgani zati on)				
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 F	Fees			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				9, 380, 840	8.00
8.01	Health Insurance (Self Funded without a Third				0	
8.02	Health Insurance (Self Funded with a Third Par	rty Administrato	r)		0	
8.03	Health Insurance (Purchased)				0	
9.00	Prescription Drug Plan				134, 692	
10.00	Dental, Hearing and Vision Plan				190, 623	
11.00	Life Insurance (If employee is owner or benefi				38, 823	•
12.00	Accident Insurance (If employee is owner or be				0	
13.00	Disability Insurance (If employee is owner or				0	
14.00	Long-Term Care Insurance (If employee is owner	r or beneficiary)		255, 606	
15.00	'Workers' Compensation Insurance				35, 801	•
16.00	Retirement Health Care Cost (Only current year	r, not the extra	ordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion)					
17 00	TAXES FICA-Employers Portion Only				E 004 42E	17 00
					5, 006, 425	
18.00 19.00	Medicare Taxes - Employers Portion Only Unemployment Insurance				0	18.00
20.00	State or Federal Unemployment Taxes				0, 899 0	
20.00	OTHER				0	20.00
21 00	Executive Deferred Compensation (Other Than Re	atiroment Cost R	enorted on lines 1 throu	igh 1 above (see	0	21.00
21.00	instructions))		eported on times i through	igii 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tui ti on Rei mbursement				50, 855	
	Total Wage Related cost (Sum of lines 1 -23)				16, 190, 508	
	Part B - Other than Core Related Cost				,	
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00
				1	0	

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0059	Peri od:	Worksheet S-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/24/2017 3:5	
	Cost Center Description		Contract Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identifi	cation:			
1.00	Total facility's contract labor and benefit co	st	0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF		0	0	8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospital-Based Hospice				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	Renal Dialysis		0	0	17.00
18.00	Other		0	0	18.00

	Financial Systems RIVERVIEW				eu of Form CMS-2	
PROSPE	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider C	F	eriod: rom 01/01/2016 o 12/31/2016		
					5/24/2017 3:5	
1 00	If this facility contains a hospital-based SNF, were all pa	tionto undon m	anagad aana	1.00	2.00	1.00
1.00	or was there no Medicare utilization? Enter "Y" for yes in					1.00
2.00	complete the rest of this worksheet. Does this hospital have an agreement under either section 1 swing beds? Enter "Y" for yes or "N" for no in column 1. I	883 or section fyes, enter t	n 1913 for The agreement			2.00
	date (mm/dd/yyyy) in column 2.	Group	SNF Days	Swing Bed SNF	Total (sum of	
		1.00	2.00	Days 3.00	col. 2 + 3) 4.00	
3.00 4.00		RUX RUL	0	-		3.00 4.00
5.00		RVX	0	0	0	5.00
6.00 7.00		RVL RHX	0	-	-	6.00 7.00
8.00		RHL	0	0	0	8.00
9.00 10.00		RMX RML				9.00 10.00
11.00		RLX		-		11.00
12.00 13.00		RUC RUB	789 980		789 980	12.00 13.00
14.00		RUA	523			
15.00		RVC RVB	306		306	
16. 00 17. 00		RVA	153 145			
18.00		RHC	51			18.00
19.00 20.00		RHB RHA	45			19.00 20.00
21.00		RMC	8		-	21.00
22.00 23.00		RMB RMA	0		0	22.00 23.00
24.00		RLB	0	-	-	24.00
25.00 26.00		RLA ES3	0	-	-	25.00 26.00
27.00		ES2	0	-		27.00
28. 00 29. 00		ES1 HE2	7	-		28.00 29.00
30.00		HE1	0	-	-	30.00
31.00 32.00		HD2 HD1	0		-	31.00 32.00
33.00		HC2 HC1	0	-	0	33.00
34.00 35.00		HB2	0	0	1	34.00 35.00
36.00		HB1 LE2	3	0	3	36.00 37.00
37.00 38.00		LE2	0	0	0	
39. 00 40. 00		LD2			0	39.00 40.00
40.00		LD1 LC2				40.00
42.00 43.00		LC1 LB2				42.00 43.00
44.00		LB1	0			44.00
45.00 46.00		CE2 CE1	0			45.00 46.00
47.00		CD2	5	-	5	47.00
48.00 49.00		CD1 CC2	3			48.00 49.00
50.00		CC1	7	0	7	50.00
51.00 52.00		CB2 CB1	0			51.00 52.00
53.00		CA2	0	0	0	53.00
54.00 55.00		CA1 SE3	4	-		54.00 55.00
56.00		SE2	0	0	0	56.00
57.00 58.00		SE1 SSC				57.00 58.00
59.00		SSB	0	0	0	59.00
60. 00 61. 00		SSA I B2				60. 00 61. 00
62.00		I B1	0		0	62.00
63.00 64.00		I A2 I A1		0	0	63.00 64.00
65.00		BB2	0	0	0	65.00
66.00 67.00		BB1 BA2				66. 00 67. 00
68.00		BA1	0			

Health Financial Systems RIVERVIEW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		CN: 15-0059	Period: From 01/01/2016 To 12/31/2016	Worksheet S-7	pared:
	Group	SNF Days	Swing Bed SNF Days		
	1.00	2.00	3.00	4.00	
69.00	PE2		0 0	0	69.00
70.00	PE1		0 0	o c	70.00
71.00	PD2		0 0	o c	71.00
72.00	PD1		8 0	8	72.00
73.00	PC2		0 0		73.00
74.00	PC1		5 0	5	74.00
75.00	PB2		0 0		
76.00	PB1		7 0	7	
77.00	PA2		0 0		
78.00	PA1		1 0	1	
199.00	AAA		4 0		199.00
200. 00 TOTAL	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3.0	93 0		200.00
		0,0	CBSA at	CBSA on/after	200100
			Beginning of	October 1 of	
			Cost Reporting	the Cost	
			Peri od	Reporting	
				Period (if	
				appl i cabl e)	
			1.00	2.00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBS	A code if a rur	al facility,	26900	26900	201.00
in effect at the beginning of the cost reporting period. E					
in effect on or after October 1 of the cost reporting peri	od (if applicat				
		Expenses	Percentage	Associated	
				with Direct	
				Patient Care and Related	
				Expenses?	
		1.00	2,00	3, 00	
A notice published in the Federal Register Volume 68, No.	140 August 4 - 2				-
payments beginning 10/01/2003. Congress expected this incr					
expenses. For lines 202 through 207: Enter in column 1 the					
column 2 the percentage of total expenses for each categor					
line 7, column 3. In column 3, enter "Y" for yes or "N" fo					
with direct patient care and related expenses for each cat					
202. 00 Staffing			0 0.00		202.00
203. 00 Recrui tment		1	0 0.00		203.00
204.00 Retention of employees			0 0.00		204.00
205. 00 Trai ni ng			0 0.00		205.00
206. 00 OTHER (SPECI FY)			0 0.00		206.00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2, 272, 1			207.00
	-		1		1

Heal th	Financial Systems	RI VERVI EW HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provid	ler CCN: 15-0059	Peri od:	Worksheet S-1	0
				From 01/01/2016		
				To 12/31/2016		
					5/24/2017 3:5	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 2		hy line 202 colum	n 8)	0. 314938	1.00
1.00	Medicaid (see instructions for each line)		by The 202 Colu	11 0)	0. 314730	1.00
2.00	Net revenue from Medicaid				5, 585, 946	2.00
3.00	Did you receive DSH or supplemental payments fro	om Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH		ents from Medicai	d?	Ý	4.00
5.00	If line 4 is "no", then enter DSH or supplementa					
6.00	Medi cai d charges		ouru		31, 622, 300	
7.00	Medicaid cost (line 1 times line 6)				9, 959, 064	
8.00	Difference between net revenue and costs for Med	dicaid program (line	7 minus sum of li	nes 2 and 5: if	4, 373, 118	
	< zero then enter zero)	p9 (.,	
	Children's Health Insurance Program (CHIP) (see	instructions for eac	h line)			
9.00	Net revenue from stand-alone CHIP				C	9.00
10.00	Stand-alone CHIP charges				c c	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				c c	11.00
12.00	Difference between net revenue and costs for sta	and-alone CHIP (line	11 minus line 9;	if < zero then	C	12.00
	enter zero)					
	Other state or local government indigent care pr					
13.00	Net revenue from state or local indigent care p				C	
14.00	Charges for patients covered under state or loca	al indigent care prog	ram (Not included	lin lines 6 or	C	14.00
	10)					
15.00	State or local indigent care program cost (line			45 1 11	C	
16.00	Difference between net revenue and costs for sta	ate or local indigent	care program (II	ne 15 minus line	C	16.00
	13; if < zero then enter zero) Uncompensated care (see instructions for each li	20)				-
17.00	Private grants, donations, or endowment income		chari tu cara		0	17.00
17.00	Government grants, appropriations or transfers					
19.00	Total unreimbursed cost for Medicaid , CHIP and			c (cum of lines	4, 373, 118	
19.00	8, 12 and 16)	state and focal find	gent care program	is (suil of fiftes	4, 373, 110	17.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (se	ee instructions)	6, 720, 2	270 0	6, 720, 270	20.00
21.00	Cost of patients approved for charity care (line	e 1 times line 20)	2, 116, 4	68 0	2, 116, 468	21.00
22.00	Partial payment by patients approved for charity	y care		0 0	C	22.00
23.00	Cost of charity care (line 21 minus line 22)		2, 116, 4	68 0	2, 116, 468	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include chan			of stay limit	N	24.00
	imposed on patients covered by Medicaid or other					
25.00	If line 24 is "yes," charges for patient days I			th of stay limit	C	
26.00	Total bad debt expense for the entire hospital of				8, 895, 000	
27.00	Medicare bad debts for the entire hospital compl				208, 519	
28.00	Non-Medicare and non-reimbursable Medicare bad				8, 686, 481	1
29.00	Cost of non-Medicare and non-reimbursable Medica		(line 1 times lir	ie 28)	2, 735, 703	
30.00	Cost of uncompensated care (line 23 column 3 plu				4, 852, 171	
31.00	Total unreimbursed and uncompensated care cost	(line 19 plus line 30)		9, 225, 289	31.00

	DJUSTMENTS OF TRIAL BALANCE (JI LAFLINGLO		F	Period: from 01/01/2016	Worksheet A	
				Т	o 12/31/2016	Date/Time Pre 5/24/2017 3:5	
Cost Cente	r Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE							
	L COSTS-BLDG & FIXT	770 (41	13, 409, 518				
0 00400 EMPLOYEE E 0 00500 ADMI NI STRA	ENEFITS DEPARTMENT	773, 641 8, 365, 460	8, 334, 021 16, 909, 215	9, 107, 662 25, 274, 675		9, 621, 479 24, 208, 382	
0 00700 OPERATI ON		1, 618, 595	4, 501, 126	6, 119, 721		6, 119, 165	
0 00800 LAUNDRY &		62, 623	377, 860	440, 483		440, 481	
0 00900 HOUSEKEEPI		794, 694	654, 924	1, 449, 618		1, 449, 452	
00 01000 DI ETARY		1,033,477	1, 702, 110	2, 735, 587	-2, 017, 788	717, 799	10
00 01100 CAFETERIA		0	0	C	.,,	1, 842, 876	
00 01300 NURSI NG AI		555, 728	115, 836	671, 564		671,073	
00 01400 CENTRAL SI 00 01500 PHARMACY	RVICES & SUPPLY	448, 523 2, 471, 006	13, 101, 011 16, 310, 917	13, 549, 534 18, 781, 923		14, 312, 758 18, 522, 273	
00 01600 MEDI CAL RI	CORDS & LIBRARY	805, 326	776, 518	1, 581, 844		1, 581, 128	
00 01700 SOCIAL SEI		614, 081	218, 087	832, 168		831, 627	
00 02300 PARAMED EL	PRGM PHARMACY	0	0	C	257, 418	257, 418	23
	IE SERVICE COST CENTERS				1		
00 03000 ADULTS & F		6, 647, 845	820, 812	7, 468, 657		8, 038, 497	
00 03100 I NTENSI VE 00 04100 SUBPROVI DI		1, 722, 421 1, 257, 068	193, 187 1, 038, 564	1, 915, 608 2, 295, 632		1, 914, 077 2, 294, 515	
00 04300 NURSERY	R - IRF	1,257,008	1, 036, 304	2, 293, 032	-1, 117	2, 294, 515	
00 04400 SKI LLED NI	RSING FACILITY	0	2,057,707	2,057,707	-36, 988	2, 020, 719	
ANCI LLARY SERVI		1					
00 05000 OPERATI NG		1, 477, 871	7, 427, 848	8, 905, 719	-619, 807	8, 285, 912	50
	OOM & LABOR ROOM	0	0	C	0 0	0	
00 05400 RADI OLOGY		1, 521, 655	779, 482	2, 301, 137		2, 313, 885	
00 05500 RADI OLOGY 00 05700 CT SCAN	THERAPEUTIC	383, 343 251, 058	514, 196 39, 660	897, 539 290, 718		949, 118 290, 495	
01 03630 ULTRA SOU	Π	231,038	39,000 0	290, 718	-223	290,493	
	ESONANCE IMAGING (MRI)	169, 242	63, 996	233, 238	-150	233, 088	
00 05900 CARDI AC C/		747, 895	571, 454	1, 319, 349		1, 318, 769	
00 06000 LABORATOR		2, 395, 441	3, 162, 802	5, 558, 243	58, 231	5, 616, 474	60
01 06001 BL00D LAB		0	0	C	0 0	0	
	ING, PROCESSING & TRANS.	0	526, 315	526, 315	0	526, 315	
00 06400 I NTRAVENOU 00 06500 RESPI RATOR		953, 588	153, 942	1, 107, 530	349, 153	0 1, 456, 683	
00 06600 PHYSI CAL		3, 781, 745	2, 115, 967	5, 897, 712		5, 894, 351	
00 06700 OCCUPATIO		0	0	C, 51, 7, 1, 1	0	0	
00 06800 SPEECH PA	HOLOGY	0	0	C	0	0	68
00 06900 ELECTROCAL		838, 953	102, 018	940, 971	85, 461	1, 026, 432	
	PPLIES CHARGED TO PATIENTS	0	0	1 000 010	0	0	
00 07200 I MPL. DEV. 00 07300 DRUGS CHAI	CHARGED TO PATIENT	0	1, 083, 212	1, 083, 212		1, 083, 212	73
00 07400 RENAL DI AI		0	266, 341	266, 341	, i i i i i i i i i i i i i i i i i i i	266, 341	
00 03020 OTHER ANCI		0	200, 011	200,011	0	0	
01 03140 CARDI AC RI		748, 991	973, 400	1, 722, 391	-7, 164	1, 715, 227	76
02 03070 WOMEN' S CI	NTER	415, 058	87, 903	502, 961	-368	502, 593	
03 03330 ENDOSCOPY		0	0	C	0 0	0	76
	CE COST CENTERS	755 107	110 070	1 202 4//	E2 407	1 161 050	
00 09000 CLI NI C 01 09001 OUTPATI EN		755, 187 462, 832	448, 279 469, 120	1, 203, 466 931, 952		1, 151, 059 937, 541	
00 09100 EMERGENCY		1, 884, 429	813, 310	2, 697, 739		2, 716, 139	
01 09101 SHORT STA		0	0	_, _, , , , , , , , , , , , , , , , , ,	0	0	
00 09200 OBSERVATI	N BEDS (NON-DISTINCT PART)						92
OTHER REI MBURSA							4
00 09500 AMBULANCE		54, 490	19, 876	74, 366	-48	74, 318	95
. 00 SUBTOTALS	COSI CENTERS (SUM OF LINES 1-117)	44, 012, 266	100, 140, 534	144, 152, 800	227, 810	144, 380, 610	1110
NONREI MBURSABLE		44,012,200	100, 140, 534	144, 152, 600	227,010	144, 300, 010	1,16
	ER, COFFEE SHOP & CANTEEN	91, 566	154, 635	246, 201	-57	246, 144	190
. 00 19200 PHYSI CI ANS	PRIVATE OFFICES	22, 893, 541	15, 081, 250	37, 974, 791	-401, 104	37, 573, 687	192
. 01 19201 FOUNDATI OF		158, 118	12, 335	170, 453		170, 313	
. 02 19202 CLI NI CS		1, 025, 915	207, 865	1, 233, 780		1, 233, 602	
. 03 19206 HOME HEAL . 04 19207 WESTFIELD		0	152 113 240	921 060		152 920 514	
. 04 19207 WESTFIELD . 05 19203 PRACTICE 1		807, 820 701, 439	113, 249 -649, 411	921, 069 52, 028		920, 514 51, 504	
. 06 19204 MOB - NOBI		701, 439	344, 322	344, 322		344, 322	
. 08 19205 RI VERVI EW		0	180, 069	180, 069		180, 069	
. 00 19300 NONPALD W		0	0	C	0	0	193
. 00 07950 WORKMED		0	0	C	0		194
. 01 07951 MEALS ON N		0	0	C	174, 748		
. 00 TOTAL (SUM	OF LINES 118-199)	69, 690, 665	115, 585, 000	185, 275, 665	0	185, 275, 665	1200

CLASSIFICATION AND AD	JUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN	I: 15-0059	Period: From 01/01/2016	Worksheet A	
					To 12/31/2016	Date/Time Pre	
Cost Center	Description	Adjustments	Net Expenses		<u> </u>	5/24/2017 3:5	54 pm
		(See A-8) 6.00	For Allocation 7.00				
GENERAL SERVICE	COST CENTERS						
	COSTS-BLDG & FIXT	-1, 517					1.
	NEFITS DEPARTMENT	-41, 586					4.
00 00500 ADMI NI STRAT		-7, 218, 397					5.
00 00700 OPERATI ON (-10, 398					7.
00 00800 LAUNDRY & I 00 00900 HOUSEKEEPII		0					8.
00 00900 HOUSEKEEPI 00 01000 DI ETARY	16	0					9.
. 00 01100 DIETARY		-760, 863					111.
. 00 01300 NURSING ADI		-700,803					13.
00 01400 CENTRAL SE		-1, 389					14.
00 01500 PHARMACY		-6, 136, 924					15.
00 01600 MEDI CAL RE	CORDS & LIBRARY	-589					16.
00 01700 SOCIAL SERV		-307					17.
00 02300 PARAMED ED							23.
	E SERVICE COST CENTERS		207,110				1 20.
. 00 03000 ADULTS & PI		-575, 618	7, 462, 879				30.
00 03100 I NTENSI VE (0					31
00 04100 SUBPROVI DEI		0					41
00 04300 NURSERY		0	0				43
00 04400 SKI LLED NUE	SING FACILITY	-125, 211	1, 895, 508				44
ANCI LLARY SERVI C							
. 00 05000 OPERATI NG F	ROOM	-2, 433, 206	5, 852, 706				50.
. 00 05200 DELIVERY R	OOM & LABOR ROOM	0	0				52
00 05400 RADI OLOGY-I	DI AGNOSTI C	-2, 107	2, 311, 778				54
00 05500 RADI OLOGY-	HERAPEUTI C	0	949, 118				55.
00 05700 CT SCAN		0					57
01 03630 ULTRA SOUND		0	-				57
	SONANCE I MAGING (MRI)	0					58
00 05900 CARDI AC CA	HETERI ZATI ON	-428, 445					59
00 06000 LABORATORY	17051	-99, 464	1 1				60
01 06001 BLOOD LABOR		0					60
	NG, PROCESSING & TRANS.	0	526, 315				63
00 06400 I NTRAVENOUS		210,000					64
00 06500 RESPI RATOR		-310,000					65.
00 06600 PHYSI CAL TH		0					66
00 06700 0CCUPATI 0N/		0	0				67
00 06900 ELECTROCARI			1, 026, 432				69
	PLIES CHARGED TO PATIENTS		.,				71
	CHARGED TO PATIENTS		-				72
00 07300 DRUGS CHAR			1,003,212				73
00 07400 RENAL DIAL		0	-				74
00 03020 OTHER ANCI I		0					76.
01 03140 CARDI AC REI		0					76.
02 03070 WOMEN' S CEI		-209					76
03 03330 ENDOSCOPY		0					76
OUTPATIENT SERVI	CE COST CENTERS		<u> </u>				1.0
00 09000 CLINIC	······	0	1, 151, 059				90
01 09001 OUTPATI ENT		-400					90
00 09100 EMERGENCY		0					91
01 09101 SHORT STAY		0					91
1 1	BEDS (NON-DISTINCT PART)						92
OTHER REI MBURSAB							1
00 09500 AMBULANCE S		-780	73, 538				95
SPECIAL PURPOSE							
	SUM OF LINES 1-117)	-18, 147, 103	126, 233, 507				118
NONREI MBURSABLE							-
	R, COFFEE SHOP & CANTEEN	0					190
2. 00 19200 PHYSI CI ANS'	PRI VATE OFFI CES	0					192
. 01 19201 FOUNDATI ON		0					192
2. 02 19202 CLI NI CS		0	1, 233, 602				192
2.03 19206 HOME HEALTH		0	152				192
2. 04 19207 WESTFIELD 3		0	920, 514				192
2. 05 19203 PRACTICE M		0	51, 504				192
2.06 19204 MOB - NOBLE		0	344, 322				192
2. 08 19205 RI VERVI EW 1		0	180, 069				192
3. 00 19300 NONPALD WOR	RKERS	0	0				193
4.0007950WORKMED		0	-				194
4.01 07951 MEALS ON WH		0					194
D. 00 TOTAL (SUM	OF LINES 118-199)	-18, 147, 103	167, 128, 562				200

	Financial Systems SIFICATIONS		RIVERVIEW H	OSPITAL Provider CCN: 15-0059	Peri od:	<u>i of Form CMS-2552-10</u> Worksheet A-6
					From 01/01/2016 To 12/31/2016	Date/Time Prepared:
		Increases				5/24/2017 3:54 pm
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
	A - CAFETERIA RECLASS	3.00	4.00	5.00		
1.00	CAFETERI A		696, 220	<u>1, 146, 6</u> 56		1.00
	O B - MEALS ON WHEELS		696, 220	1, 146, 656		
1.00	MEALS ON WHEELS	194.01	66, 018	108, 730		1.00
			66, 018	108, 730		
1.00	C – I NSURANCE RECLASS ADMI NI STRATI VE & GENERAL	5.00	0	230, 579		1.00
1.00			<u>0</u>	230, 579		1.00
1 00	D - MED SUPPLY RECLASS	14.00	0	FF3 020		1.00
1.00 2.00	CENTRAL SERVICES & SUPPLY CARDIAC CATHETERIZATION	59.00	0	553, 939 85		1.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00 6.00		0. 00 0. 00	0	0		5.00
7.00		0.00	0	0		7.00
			0	554,024		
1.00	E - RSMA RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00		471, 716		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	194, 403	15, 281		2.00
3.00	OPERATING_ROOM	50.00	3, 120, 442	226,033		3.00
	O F - PHYSICIAN PROFESSIONAL FEI	ES	3, 314, 845	713, 030		
1.00	ADULTS & PEDIATRICS	30.00	0	575, 618		1.00
2.00	OPERATING ROOM	50.00	0	61, 800		2.00
3.00 4.00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	0	14, 100 52, 800		3.00
5.00	LABORATORY	60.00	0	60, 360		5.00
6.00	RESPI RATORY THERAPY	65.00	0	350,000		6.00
7.00 8.00	ELECTROCARDI OLOGY OUTPATI ENT	69.00 90.01	0	86, 250 6, 000		7.00
9.00	EMERGENCY	91.00	0	20, 000		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	<u>62, 500</u>		10.00
	G – BONUS RECLASS		0	1, 289, 428		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	42, 629	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	93		2.00
3.00 4.00	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	0	7 2		3.00
5.00	DI ETARY	10.00	0	2		5.00
6.00	NURSING ADMINISTRATION	13.00	0	6		6.00
7.00 8.00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	5 28		7.00 8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	9		9.00
10.00	SOCIAL SERVICE	17.00	0	7		10.00
11. 00 12. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	72 19		11.00
13.00	SUBPROVI DER – I RF	41.00	0	14		13.00
14.00	OPERATING ROOM	50.00	0	3		14.00
15. 00 16. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	0	17 4		15.00 16.00
17.00	CT SCAN	57.00	0	3		17.00
18.00	MAGNETIC RESONANCE IMAGING	58.00	О	2		18.00
19. 00	(MRI) CARDIAC CATHETERIZATION	59.00	0	8		19.00
20.00	LABORATORY	60.00	0	° 27		20.00
21.00	RESPI RATORY THERAPY	65.00	0	11		21.00
22. 00 23. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	42 9		22. 00 23. 00
23.00 24.00	CARDI AC REHAB	76.01	0	8		23.00
25.00	WOMEN'S CENTER	76.02	О	5		25.00
26.00		90.00	0	8		26.00
27.00 28.00	OUTPATIENT EMERGENCY	90. 01 91. 00	0	5 20		27.00 28.00
29.00	AMBULANCE SERVICES	95.00	0	1		29.00
30.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	1		30.00
31.00	CANTEEN PHYSICIANS' PRIVATE OFFICES	192.00	0	72		31.00
32.00	FOUNDATI ON	192.01	0	2		32.00
33.00		192.02	o	2		33.00
34.00	WESTFIELD SCHOOLS PRACTICE MANAGEMENT	192.04 192.05	0	7 7		34. 00 35. 00
35.00						

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider C	CCN: 15-0059	Period: From 01/01/2016	Worksheet A-	6
						To 12/31/2016	Date/Time Pr 5/24/2017 3:	
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	0		42, 629	528				
	H - PARAMED ED PHARMACY RESID	DENCY PRG						
1.00	PARAMED ED PRGM PHARMACY	23.00	134, 654	122, 764				1.00
	0 — — — — — — — —		134, 654	122, 764				
	I - COMMUNITY RELATIONS RECLA	ISS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	162, 761				1.00
	TOTALS		0	162, 761				
500.00	Grand Total: Increases		4, 254, 366	4, 328, 500				500.00

	Financial Systems		RI VERVI EW F	IOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-0059	Period: From 01/01/2016	Worksheet A-6)
						To 12/31/2016	Date/Time Pre 5/24/2017 3:5	
		Decreases						
	Cost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00	<u>.</u>		
	A - CAFETERIA RECLASS	7.00	0.00	7.00	10.00			
1.00	DI ETARY	<u> </u>	696, 220	1, 146, 656		이		1.00
	B - MEALS ON WHEELS		696, 220	1, 146, 656				
1.00	DI ETARY		66,018	108, 730		0		1.00
			66, 018	108, 730				
1.00	C - INSURANCE RECLASS NEW CAP REL COSTS-BLDG &	1.00	0	230, 579	1	2		1.00
	<u>FIX</u> T]				I	
	O D - MED SUPPLY RECLASS		0	230, 579				
1.00	SKILLED NURSING FACILITY	44.00	0	36, 988		0		1.00
2.00	OPERATI NG ROOM	50.00	0	6		0		2.00
3.00	RADI OLOGY-THERAPEUTI C	55.00	0	880		0		3.00
4.00 5.00	ELECTROCARDI OLOGY CARDI AC REHAB	69.00 76.01	0	43 6, 498		0	ſ	4.00 5.00
6.00	CLINIC	90.00	0	51, 735		0		6.00
7.00	PHYSICIANS PRIVATE OFFICES	192.00	0	457,874		의		7.00
	U E – RSMA RECLASS		0	554, 024				
1.00	OPERATI NG ROOM	50.00		4, 027, 875		0		1.00
2.00		0.00	0	0		0		2.00
3.00	<u> </u>		<u>0</u>	00 4, 027, 875		0	ſ	3.00
	F - PHYSICIAN PROFESSIONAL FE	EES	0	4,027,875				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 289, 428		0		1.00
2.00 3.00		0. 00 0. 00	0	0		0		2.00 3.00
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	I	6.00
7.00 8.00		0.00	0	0		0		7.00 8.00
9.00		0.00	0	0		0		9.00
10.00		0.00	0	0		Q		10.00
	U G - BONUS RECLASS		0	1, 289, 428				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	528		0		1.00
2.00	ADMINI STRATI VE & GENERAL	5.00	7, 537	0		0	I	2.00
3.00 4.00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7.00 8.00	563 2	0		0		3.00 4.00
5.00	HOUSEKEEPI NG	9.00	168	0		0		5.00
6.00		10.00	166 497	0		0	I	6.00
7.00 8.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	497	0		0		7.00 8.00
9.00	PHARMACY	15.00	2, 260	0		0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	725	0		0		10.00
11. 00 12. 00	SOCI AL SERVI CE ADULTS & PEDI ATRI CS	17.00 30.00	548 5, 850	0		0	ľ	11.00 12.00
13.00	INTENSIVE CARE UNIT	31.00	1, 550	0		0		13.00
14.00	SUBPROVIDER - IRF	41.00	1, 131	0		0		14.00
15.00 16.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50. 00 54. 00	204 1, 369	0		0	ſ	15.00 16.00
17.00	RADI OLOGY-THERAPEUTI C	55.00	345	0		0		17.00
18.00	CT SCAN	57.00	226	0		0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	152	0		0	I	19.00
20.00	CARDI AC CATHETERI ZATI ON	59.00	673	0		0		20.00
21.00	LABORATORY	60.00	2, 156	0		0		21.00
22.00 23.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	858 3, 403	0		0	ſ	22.00 23.00
23.00	ELECTROCARDI OLOGY	69.00	755	0		0		23.00
25.00	CARDI AC REHAB	76.01	674	0		0		25.00
26.00	WOMEN'S CENTER	76.02	373	0		0		26.00
27.00 28.00	CLINIC OUTPATIENT	90. 00 90. 01	680 416	0 0		0		27.00 28.00
29.00	EMERGENCY	91.00	1, 620	0		0		29.00
30.00	AMBULANCE SERVICES	95.00	49	0		0		30.00
31.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	58	0		0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	5, 802	0		0		32.00
33.00	FOUNDATION	192.01	142	0		0		33.00
34.00 35.00	CLINICS WESTFIELD SCHOOLS	192.02 192.04	180 562	0 0		0	ſ	34.00 35.00
	1	1 1/2.04	502	0	1	-1		

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provi der (CCN: 15-0059	Period: From 01/01/2016	Worksheet A-	6
						To 12/31/2016		epared: 54 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	-		
	6.00	7.00	8.00	9.00	10.00			
36.00	PRACTICE MANAGEMENT	192.05	531	0		0		36.00
	0		42, 629	528				
	H - PARAMED ED PHARMACY RESID	ENCY PRG						
1.00	PHARMACY	15.00	134, 654	122, 764		0		1.00
	0		134, 654	122, 764				
	I - COMMUNITY RELATIONS RECLA	ISS						
1.00	ADMINISTRATIVE & GENERAL	5.00	162, 761	0		0		1.00
	TOTALS		162, 761	0				
500.00	Grand Total: Decreases		1, 102, 282	7, 480, 584				500.00

Heal th	Financial Systems	RI VERVI EW			In Lie	eu of Form CMS-:	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0059	Period: From 01/01/2016 To 12/31/2016		pared:
				Acqui si ti on	IS		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASS	ET BALANCES					
1.00	Land	15, 917, 384	0		0 C	0	1.00
2.00	Land Improvements	2, 798, 479	74, 217		0 74, 217	0	2.00
3.00	Buildings and Fixtures	99, 094, 822	2, 406, 439		0 2, 406, 439	948	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	38, 274, 401	1, 762, 633		0 1, 762, 633	4, 782	5.00
6.00	Movable Equipment	75, 312, 463	22, 501, 080		0 22, 501, 080	2, 878, 734	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	231, 397, 549	26, 744, 369		0 26, 744, 369	2, 884, 464	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	231, 397, 549	26, 744, 369		0 26, 744, 369	2, 884, 464	10.00
		Endi ng Bal ance	Fully				
		-	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASS						
1.00	Land	15, 917, 384	0				1.00
2.00	Land Improvements	2, 872, 696	0				2.00
3.00	Buildings and Fixtures	101, 500, 313	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	40, 032, 252	0				5.00
6.00	Movable Equipment	94, 934, 809	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	255, 257, 454	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	255, 257, 454	0				10.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2016	Worksheet A-7 Part II	
					To 12/31/2016		
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	11, 653, 700	0	1, 395, 60	0 360, 218	0	1.00
3.00	Total (sum of lines 1-2)	11, 653, 700	0	1, 395, 60	0 360, 218	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13, 409, 518				1.00
3.00	Total (sum of lines 1-2)	0	13, 409, 518				3.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2016 To 12/31/2016		pared:
	COM	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)	instructions)	Insurance	
	1,00	2.00	3,00	4,00	5,00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 1.000000		1.00
3.00 Total (sum of lines 1-2)	0	0		0 1.000000		3.00
	ALLOCA	FION OF OTHER (CAPITAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
	6.00	d Costs 7.00	through 7) 8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	8.00	9.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 11, 653, 700	0	1.00
3.00 Total (sum of lines 1-2)	0	-		11, 653, 700		3.00
	-	SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		.2.00				
1.00 NEW CAP REL COSTS-BLDG & FIXT	1, 394, 083	129, 639		0 0	13, 177, 422	1.00
3.00 Total (sum of lines 1-2)	1, 394, 083	129, 639		0 0	13, 177, 422	3.00

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0059 P	eriod: rom 01/01/2016	Worksheet A-8	
					o 12/31/2016	Date/Time Prep 5/24/2017 3:54	pared: 4 pm
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1.00	2.00	3.00 DNEW CAP REL COSTS-BLDG & FLXT	4.00	5.00 0	1. C
. 00	2) Investment income - CAP REL		()*** Cost Center Deleted ***	2.00	0	2. (
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		(0.00	0	3. (
00	(chapter 2) Trade, quantity, and time discounts (chapter 8)		(0.00	0	4. (
. 00	Refunds and rebates of expenses (chapter 8)		(0.00	0	5.0
. 00	Rental of provider space by suppliers (chapter 8)		(0.00	0	6.0
00	Telephone services (pay stations excluded) (chapter 21)		(0.00	0	7.(
. 00	Television and radio service (chapter 21)		(0.00	0	8. (
. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	(-2, 750, 851		0.00	0 0	9. (10. (
1. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		(þ	0.00	0	11. (
2. 00	Related organization transactions (chapter 10)	A-8-1	-423, 205	5		0	12. (
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	(-590_616) 5 CAFETERI A	0.00 11.00	0	13. 14.
5. 00	Rental of quarters to employee and others		-370, 010		0.00	0	15.
5.00	Sale of medical and surgical supplies to other than		(0.00	0	16. (
7.00	patients Sale of drugs to other than patients		(0.00	0	17. (
3. 00	Sale of medical records and abstracts		(0.00	0	18. (
9. 00	Nursing school (tuition, fees, books, etc.)		(0.00	0	19. (
	Vending machines Income from imposition of interest, finance or penalty		(0. 00 0. 00	0	20. 21.
2.00	overpayments and borrowings to		(0.00	О	22. (
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. (
4.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	(PHYSI CAL THERAPY	66.00		24. (
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		(*** Cost Center Deleted ***	114.00		25. (
6. 00	(chapter 21) Depreciation - NEW CAP REL		(NEW CAP REL COSTS-BLDG &	1.00	0	26. (
7.00	COSTS-BLDG & FIXT Depreciation - CAP REL		(FIXT *** Cost Center Deleted ***	2.00	0	27. (
	COSTS-MVBLE EQUIP Non-physician Anesthetist		(*** Cost Center Deleted ***	19.00		28.
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	(DOCCUPATI ONAL THERAPY	0.00 67.00	0	29. (30. (
D. 99	limitation (chapter 14) Hospice (non-distinct) (see		(ADULTS & PEDIATRICS	30.00		30. 9
1. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	(SPEECH PATHOLOGY	68.00		31. (
2.00	limitation (chapter 14) CAH HIT Adjustment for		(0.00	о	32. (
3. 00	Depreciation and Interest OTHER REV MEDICAL REPORT	В	-589	MEDICAL RECORDS & LIBRARY	16.00	0	33. (

Heal th Financia			RI VERVI EW			eu of Form CMS-2	
ADJUSTMENTS TO	EXPENSES			Provider CCN: 15-0059	Period: From 01/01/2016	Worksheet A-8	
					To 12/31/2016		
				Expense Classification o	n Worksheet A		[
				To/From Which the Amount is	s to be Adjusted		
Cos	st Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01 OTHER RE	V RADIOLOGY FILM	В	-557	RADI OLOGY-DI AGNOSTI C	54.00	0	33.0
33.02 OTHER RE	VENUES-OTHER	В	-2, 640	ADMI NI STRATI VE & GENERAL	5.00	0	33.0
REV-FI TN							
	VENUES ->PURCHASE	В	-25, 358	ADMI NI STRATI VE & GENERAL	5.00	0	33.0
DI SCOUNT							
	V ->VHA DIVIDENDS:	В	-3, 433	ADMI NI STRATI VE & GENERAL	5.00	0	33.0
OTHER							
	XPENSE INVESTMENT FEES			ADMI NI STRATI VE & GENERAL	5.00		
	HEALTH/INF CONT -	В	-110	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	33.0
OTHER RE			1 0/0		54.00		00.0
33. 07 RADI OLOG FOR LEGA	Y-OTHER REVENUE-CDS	В	-1,368	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 0
	E ->OTHER REVENUE	В	700	AMBULANCE SERVICES	95.00	0	33.0
	RY -> OTHER REVENUE	В		LABORATORY	60.00		
	WELLNESS- OTHER	B		EMPLOYEE BENEFITS DEPARTMEN			
REVENUE	WELLNESS- UTHER	В	-21, 354	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	34.00
	TING- OTHER REVENUE	В	-2 610	ADMI NI STRATI VE & GENERAL	5.00	0	36.0
	NEOUS INTEREST INCOME	B		ADMI NI STRATI VE & GENERAL	5.00		
	INCOME - BOND FUNDS	B		NEW CAP REL COSTS-BLDG &	1.00		
37.00 INTEREST	THEOME - DOND TONDS	b	-1, 517	FIXT	1.00	1	37.00
40.00 RENTAL I	NCOME - TCU	В	-125, 211	SKILLED NURSING FACILITY	44.00	0	40.0
	Y RELATIONS	Ā		ADMI NI STRATI VE & GENERAL	5.00		
	Y RELATIONS BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN			
44.00 CRNA		A		OPERATING ROOM	50.00		
	YING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		•
45.03 HAF EXPE		A		ADMI NI STRATI VE & GENERAL	5.00		
	ING - ENERGY REBATES	В		OPERATION OF PLANT	7.00		•
	RE-OTHER REVENUE	В		OUTPATI ENT	90.01		
	N OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		
	AIMED REFUNDS	В		ADMI NI STRATI VE & GENERAL	5.00		
	ACY REVENUE	В	-6, 136, 725		15.00		
	SALES PR DEDUCT	В		CAFETERIA	11.00		1
	Y-OTHER REVENUE-SILVER			RADI OLOGY-DI AGNOSTI C	54.00		
RECOV		5	102		01100		
	SERVICES -	В	-3,090	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	45.1
	->-OTHER		-,			- -	
	OVEMENT ->OTHER	В	-2,500	ADMI NI STRATI VE & GENERAL	5.00	0	45.1
REVENUE			,			- -	
45.16 OTHER RE	V PREMIER PROGRAM	В	-1, 389	CENTRAL SERVICES & SUPPLY	14.00	0	45.1
50.00 TOTAL (s	um of lines 1 thru 49)		-18, 147, 103				50.00
	r to Worksheet A,						
	, line 200.)						

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

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems	RI VERVI EW	HOSPITAL	In Lie	eu of Form CMS-2	2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0059	Period: From 01/01/2016	Worksheet A-8	-1
OFFICE COSTS			To 12/31/2016		
Line No.	Cost Center	Expense Items	Amount of	Amount	
			Allowable Cost	Included in	
				Wks. A, column	
				5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
HOME OFFICE COSTS:					
1.00 50.00	OPERATING ROOM	OPERATING ROOM	4, 049, 128	4, 472, 333	1.00
2.00 0.00			0	0	2.00
3.00 0.00			0	0	3.00
4.00 0.00			0	0	4.00
5.00 0		0	4, 049, 128	4, 472, 333	5.00

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

			Related Organization(s) and	/or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
Symbol (1)	Name	Ownershi p	Name	Ownershi p	
1.00	2.00	3.00	4.00	5.00	
 B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFLCE			

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:

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

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

C. Provider has financial interest in corporation, partnership, or other organization.

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

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

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

Health Financial Systems RIVE	ERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AN	ND HOME Provider CCN: 15-0059	Period:	Worksheet A-8-1	
OFFICE COSTS		From 01/01/2016 To 12/31/2016	Date/Time Prepared:	

			5/24/2017 3:54	l pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-423, 205	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-423, 205			5.00

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

nas not	been posteu to worksneet A,	cordinaris i and/or z, the amount arrowable should be thurcated in cordinaria of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

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

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

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

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

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

Health Financial Systems			RI VERVI EW HOSPI TAL			In Lieu of Form CMS-2552-10		
PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider CCN: 15-0059			Period: Worksheet A-8-2		3-2
						From 01/01/2016 To 12/31/2016		narod
						10 12/31/2010	5/24/2017 3:5	
	Wkst. A Line # Cost Center/Physician		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE & GENERAL	774) 177, 200		
2.00		OPERATING ROOM	1, 335, 001	1, 335, 001	(2.00
3.00		CARDIAC CATHETERIZATION	428, 445					3.00
4.00		ADULTS & PEDIATRICS	575, 618					4.00
5.00		RESPI RATORY THERAPY	310, 000				0	5.00
6.00		PHARMACY	199				0	6.00
7.00		ADMINISTRATIVE & GENERAL	100, 605			111,200		7.00
8.00		WOMEN'S CENTER	209					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, 750, 851			-	0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	0	0	(-	0	1.00
2.00		OPERATING ROOM	0	-		0 0	0	2.00
3.00		CARDIAC CATHETERIZATION	0	0			0	3.00
4.00		ADULTS & PEDIATRICS	0	0	(0	4.00
5.00		RESPI RATORY THERAPY	0	0	(0 0	0	5.00
6.00		PHARMACY	0	0	(0 0	0	6.00
7.00		ADMINISTRATIVE & GENERAL	0	0	(0 0	0	7.00
8.00		WOMEN'S CENTER	0	0	(0 0	0	8.00
9.00	0.00		0	0	(0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			0	0		0 0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	10.00		
1.00		2.00 ADMI NI STRATI VE & GENERAL	15.00	16.00 0	17.00	18.00		1.00
2.00		OPERATING ROOM		0				2.00
2.00		CARDIAC CATHETERIZATION		0				2.00
3.00 4.00		ADULTS & PEDIATRICS		0				
				, °				4.00
	5.00 65.00 RESPI RATORY THERAPY 6.00 15.00 PHARMACY 7.00 5.00 ADMI NI STRATI VE & GENERAL 8.00 76.02 WOMEN' S CENTER 9.00 0.00 0.00			0				5.00 6.00
				, °				
				0				7.00
				0				8.00
				0				9.00
10.00 0.00			0				10. 00 200. 00	
200.00	I	I	1 0	1 0	I I	2, 750, 851		200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2016	Worksheet B Part I	
				T	0 12/31/2016	Date/Time Pre 5/24/2017 3:5	
			CAPI TAL				
	Cost Center Description	Net Expenses	RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	· ·	for Cost	FI XT	BENEFITS		& GENERAL	
		Allocation (from Wkst A		DEPARTMENT			
		col. 7)					
		0	1.00	4.00	4A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	13, 177, 422	13, 177, 422				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 579, 893	65, 598	9, 645, 491			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	16, 989, 985				19, 131, 394	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	6, 108, 767 440, 481				1, 451, 328 64, 869	
9.00	00900 HOUSEKEEPI NG	1, 449, 452		106, 400		205, 439	
10.00	01000 DI ETARY	717, 799					•
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1,082,013		93, 235		173, 295	
13.00	01400 CENTRAL SERVICES & SUPPLY	671, 073 14, 311, 369		74, 354 86, 044		96, 361 1, 874, 021	13.00
15.00	01500 PHARMACY	12, 385, 349		312, 572			•
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 580, 539				228, 919	
17.00 23.00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	831, 627 257, 418				123, 807 36, 143	17.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	237,410	4, 147	10,032	217, 371		23.00
30.00	03000 ADULTS & PEDIATRICS	7, 462, 879				1, 344, 225	•
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	1, 914, 077 2, 294, 515				327, 090 364, 738	
41.00	04300 NURSERY	2, 294, 515	356, 655	100, 190 C		0	
44.00	04400 SKILLED NURSING FACILITY	1, 895, 508	247, 597	C	2, 143, 105	277, 037	•
F0.00	ANCI LLARY SERVI CE COST CENTERS	E 050 704	022.252	(15 7/0	7 200 710	042 757	50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 852, 706	832, 252 0	615, 760	7, 300, 718 0	943, 757 0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 311, 778	319, 214	203, 591	2, 834, 583	366, 424	•
55.00	05500 RADI OLOGY-THERAPEUTI C	949, 118		51, 290		153, 879	•
57.00 57.01	05700 CT SCAN 03630 ULTRA SOUND	290, 495		33, 590		41, 894 0	57.00 57.01
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	233, 088	-	22, 644	-	33, 058	•
59.00	05900 CARDI AC CATHETERI ZATI ON	890, 324		100, 065		137, 983	•
60.00	06000 LABORATORY	5, 517, 010	328, 845	320, 499	6, 166, 354	797, 118	
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	526, 315	0 48, 289		574, 604	0 74, 278	60.01 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	1, 146, 683		127, 586		171, 101	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	5, 894, 351 0		505, 980 C		827, 364 0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0		-	0	•
69.00	06900 ELECTROCARDI OLOGY	1, 026, 432	286, 549	112, 248	1, 425, 229	184, 238	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0 1, 083, 212	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1,003,212	0		1, 083, 212 0	140, 026 0	73.00
74.00	07400 RENAL DI ALYSI S	266, 341	14, 206	C	280, 547	36, 266	1
76.00	03020 OTHER ANCI LLARY	0	0	0	0	0	76.00
76. 01 76. 02	03140 CARDIAC REHAB 03070 WOMEN'S CENTER	1, 715, 227 502, 384		100, 212 55, 533		240, 151 100, 262	
76.03	03330 ENDOSCOPY	0	0	C		0	
~~~~~	OUTPATIENT SERVICE COST CENTERS	4 454 050		101.011	4 050 400	4/4 050	
90. 00 90. 01	09000 CLI NI C 09001 0UTPATI ENT	1, 151, 059 937, 141		101, 041 61, 925		161, 858 141, 066	
90.01 91.00	09100 EMERGENCY	2, 716, 139					•
91.01	09101 SHORT STAY	0	0	C	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
95.00	09500 AMBULANCE SERVICES	73, 538	0	7, 291	80, 829	10, 449	95.00
	SPECIAL PURPOSE COST CENTERS				1		1
118.00		126, 233, 507	12, 692, 930	6, 198, 882	122, 302, 406	13, 336, 814	118.00
190.00	NONREIMBURSABLE COST CENTERS	246, 144	126, 701	12, 254	385, 099	49.781	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	37, 573, 687	271, 674	3, 065, 028	40, 910, 389	5, 288, 394	192.00
	19201 FOUNDATI ON	170, 313		21, 156			192.01
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP	1, 233, 602 152		137, 362	1, 370, 964 152	177, 223	192.02 192.03
	19207 WESTFIELD SCHOOLS	920, 514	0	108, 105		132, 969	
192.05	19203 PRACTI CE MANAGEMENT	51, 504	0	93, 863	145, 367	18, 791	192.05
	19204 MOB - NOBLESVILLE SQUARE 19205 RIVERVIEW MEDICAL ARTS	344, 322 180, 069			344, 322 180, 069		192.06 192.08
	19205 RIVERVIEW MEDICAL ARTS	180, 089	0		0		192.08
	07950 WORKMED	0	0	C	0		194.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0059		Period: From 01/01/2016 To 12/31/2016			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL		
	0	1.00	4.00	4A	5.00		
194.0107951 MEALS ON WHEELS	174, 748	0	8, 84	1 183, 589	23, 732	194.01	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00   TOTAL (sum lines 118-201)	167, 128, 562	13, 177, 422	9, 645, 49	1 167, 128, 562	19, 131, 394	202.00	

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	RI VERVI EW			eriod: rom 01/01/2016	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pared:
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/24/2017 3:5 CAFETERI A	4 pm
	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	-
1.00       00100       NEW CAP REL COSTS-BLDG & FIXT         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       01100       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY	12, 678, 523 93, 670 59, 070 141, 711 292, 510 0 176, 311 273, 341 146, 113	660, 350 C C C C 4, 963 C C C C C	1, 853, 748 3, 745 52, 429 0 1, 872 46, 812 9, 362	1, 087, 490 0 0 0 0 0 0 0	1, 858, 814 21, 726 45, 240 105, 892 58, 880	13.00 14.00 15.00 16.00
17.00 01700 SOCIAL SERVICE 23.00 02300 PARAMED ED PRGM PHARMACY	77, 766			0	30, 617 2, 766	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,330			0	2,700	23.00
30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           41. 00         04100         SUBPROVI DER - I RF           43. 00         04300         NURSERY           44. 00         SKI LLED NURSI NG FACI LI TY           ANCI LLARY SERVI CE COST CENTERS	3, 620, 406 682, 524 634, 861 0 438, 055	48, 253 51, 592 0	91, 751 117, 966 0	547, 273 63, 583 262, 284 0 214, 350	387, 795 85, 281 87, 500 0 0	31.00 41.00 43.00
50. 00 05000 OPERATI NG ROOM	1, 472, 444	64, 091	228, 442	0	169, 127	50.00
52. 00         05200         DELI VERY ROOM & LABOR ROOM           54. 00         05400         RADI OLOGY-DI AGNOSTI C           55. 00         05500         RADI OLOGY-THERAPEUTI C           57. 00         05700         CT SCAN           57. 01         03630         ULTRA SOUND	0 564, 763 336, 103 0 0	38, 669	48, 684	0 0 0 0	0 68, 923 19, 373 13, 817 0	54.00 55.00 57.00
58. 00         05800         MAGNETI C         RESONANCE         I MAGI NG         (MRI )         59. 00         05900         CARDI AC         CATHETERI ZATI ON         60. 00         06000         LABORATORY         60. 01         06001         BLOOD         LABORATORY         63. 00         06300         BLOOD         STORI NG,         PROCESSI NG & TRANS.	0 136, 268 581, 802 0 85, 434			0 0 0 0	11, 312 31, 707 150, 984 0 0	59.00 60.00 60.01
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0 87, 280 0 0	0	0 5, 617	0 0 0 0	0 51,002 208,475 0 0	64.00 65.00 66.00
69. 0006900ELECTROCARDI OLOGY71. 0007100MEDI CAL SUPPLI ES CHARGED TO PATI ENTS72. 0007200IMPL. DEV. CHARGED TO PATI ENT73. 0007300DRUGS CHARGED TO PATI ENTS	506, 971 0 0 0	5, 667 C C	65, 537 0 0 0	0 0 0 0	42, 133 0 0 0	69.00 71.00 72.00 73.00
74. 00   07400  RENAL DI ALYSI S 76. 00   03020  OTHER ANCI LLARY	25, 133			0	0	
76. 01 03140 CARDI AC REHAB 76. 02 03070 WOMEN' S CENTER 76. 03 03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	74, 879 385, 139 0	3, 294		0 0 0	38, 227 27, 282 0	76. 01 76. 02
90. 00 09000 CLINIC 90. 01 09001 OUTPATIENT 91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 163, 105 758, 350 0	17, 940	22, 470	0 0 0	47, 766 29, 230 95, 688 0	90. 01 91. 00
95. 00 09500 AMBULANCE SERVICES	0	C	0	0	3, 558	95.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	11, 821, 345	1		1, 087, 490	1, 834, 301	
190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN         192.00       19200       PHYSI CLANS' PRI VATE OFFICES         192.01       19201       FOUNDATI ON         192.02       19202       CLI NI CS         192.03       19206       HOME HEALTH PARTNERSHI P         192.04       19207       WESTFI ELD SCHOOLS         192.05       19203       PRACTI CE MANAGEMENT         192.06       19204       MOB - NOBLESVI LLE SQUARE	224, 163 480, 654 152, 361 0 0 0 0 0 0 0 0	52, 089	0 37,449 0 0	0 0 0 0 0 0 0	0 10, 252 0 0 0 0 0 0	192. 02 192. 03 192. 04 192. 05 192. 06
192.08       19205       RIVERVIEW MEDICAL ARTS         193.00       19300       NONPAID       WORKERS         194.00       07950       WORKMED         194.01       07951       MEALS ON WHEELS         200.00       Cross Foot Adjustments         201.00       Negative Cost Centers         202.00       TOTAL (sum lines 118-201)	0 0 0 0 12, 678, 523	C C C C C C 660, 350	0 0 0 0 0 1,853,748	0 0 0 1, 087, 490	0 0 7, 168	192. 08 193. 00 194. 00 194. 01 200. 00 201. 00 202. 00

Health Financial Systems	RI VERVI EW H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	N: 15-0059 P F	eriod: rom 01/01/2016	Worksheet B Part I	
				o 12/31/2016		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCI AL SERVI CE	
	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
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT						5.00 7.00
8.00 00800 LAUNDRY & LI NEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A						10.00 11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	863, 514					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	16, 599, 474 0	14, 939, 882			14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	2, 214, 148		16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	1, 189, 934	
23. 00 02300 PARAMED ED PRGM PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	U	0	0	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	510, 262	0	0		961, 331	
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	112, 213 115, 132	0	0	125, 025 0	53, 112 104, 011	
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	0	8, 066	71, 480	44.00
50. 00 05000 OPERATI NG ROOM	0	0	0	778, 381	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0 0	16, 132 76, 628	0	54.00 55.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
57.01 03630 ULTRA SOUND 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57.01 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	84, 694	0	60.00
60. 01  06001 BLOOD LABORATORY 63. 00  06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	60. 01 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0	0	0 314, 578	0	65.00 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	0 32, 264	0	68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16, 599, 474	0	32, 204 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 PATI ENTS 74. 00 07400 RENAL DI ALYSI S	0	0	14, 939, 882 0	0	0	
76.00 03020 OTHER ANCI LLARY	0	0	0	0	0	76.00
76.01 03140 CARDIAC REHAB 76.02 03070 WOMEN'S CENTER	0	0	0	0	0	76.01 76.02
76. 03 03330 ENDOSCOPY	0	0	0	0	0	
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	o	0	0	0	0	90.00
90. 01 09001 OUTPATI ENT	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	125, 907	0	0	133, 091	0	91.00
91. 01 09101 SHORT STAY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0	0	0	0	91.01 92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	863, 514	16, 599, 474	14, 939, 882	2, 193, 983	1, 189, 934	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	100.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 0	0	0		190. 00 192. 00
192. 01 19201 FOUNDATI ON	0	0	0	0		192.01
192. 02 19202 CLI NI CS 192. 03 19206 HOME HEALTH PARTNERSHI P	0	0	0	20, 165 0		192. 02 192. 03
192.04 19207 WESTFIELD SCHOOLS	0	0 0	0	0	0	192.04
192. 05 19203 PRACTI CE MANAGEMENT 192. 06 19204 MOB - NOBLESVI LLE SQUARE	0	0	0	0		192. 05 192. 06
192. 08 19204 MOB - NOBLESVILLE SCOARE	0	0	0	0		192.08 192.08
193. 00 19300 NONPAI D WORKERS	0	0	0	0		193.00
194.0007950 WORKMED 194.0107951 MEALS ON WHEELS	0	0 O	0	0		194. 00 194. 01
200.00 Cross Foot Adjustments		_	-			200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0 863, 514	0 16, 599, 474	0 14, 939, 882	0 2, 214, 148		201.00
	000,011		,	_, _, , , , , 10	.,,	1 : 00

leal th Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	RIVERVIEW H	Provider C		ri od:	u of Form CMS-2552 Worksheet B
				om 01/01/2016	Part I
Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
	23.00	24.00	Adjustments 25.00	26.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 3.00 00800 LAUNDRY & LINEN SERVICE					1. 4. 5. 7. 8.
3. 00       00800 LAUNDRY & LINEN SERVICE         9. 00       00900 HOUSEKEEPING         10. 00       01000 DI ETARY         11. 00       01100 CAFETERIA         13. 00       01300 NURSING ADMINISTRATION         14. 00       01400 CENTRAL SERVICES & SUPPLY					8. 9. 10. 11. 13. 14.
15.00         01500         PHARMACY           16.00         01600         MEDI CAL         RECORDS & LI BRARY           17.00         01700         SOCI AL         SERVI CE           23.00         PARAMED ED PRGM PHARMACY	325, 842				15. 16. 17. 23.
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	0	19, 188, 156 4, 119, 136		19, 188, 156 4, 119, 136	30. 31.
41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	0 0	4, 559, 624 0 3, 304, 843	0 0 0	4, 559, 624 0 3, 304, 843	41. 43. 44.
ANCILLARY SERVICE COST CENTERS			-	1	
50. 00   05000   OPERATI NG ROOM 52. 00   05200   DELI VERY ROOM & LABOR ROOM 54. 00   05400 RADI 0LOGY-DI AGNOSTI C	0	10, 956, 960 0 3, 938, 178	0	10, 956, 960 0 3, 938, 178	50. 52. 54.
55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	0	1, 791, 066 379, 796	0	1, 791, 066 379, 796	55. 57.
57.01 03630 ULTRA SOUND 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0 301, 974	0 0	0 301, 974	57. 58.
59. 00 05900 CARDIAC CATHETERIZATION 50. 00 06000 LABORATORY	0	1, 390, 406 7, 846, 489		1, 390, 406 7, 846, 489	59. 60.
50. 01         06001         BLOOD         LABORATORY           53. 00         06300         BLOOD         STORI NG,         PROCESSI NG & TRANS.           54. 00         06400         I NTRAVENOUS         THERAPY	0	0 734, 316 0	0	0 734, 316	60. 63. 64.
55. 00 06500 RESPI RATORY THERAPY 56. 00 06600 PHYSI CAL THERAPY	0	1, 638, 601 7, 763, 806	0	1, 638, 601 7, 763, 806	65. 66.
57. 00 06700 0CCUPATI ONAL THERAPY 58. 00 06800 SPEECH PATHOLOGY 59. 00 06900 ELECTROCARDI OLOGY	0	0 0 2, 262, 039	0	0 0 2, 262, 039	67. 68. 69.
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	5 0 0	16, 599, 474 1, 223, 238	0	16, 599, 474 1, 223, 238	71.
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	325, 842 0	15, 265, 724 341, 946	0	15, 265, 724 341, 946	73. 74.
76. 00 03020 OTHER ANCI LLARY 76. 01 03140 CARDI AC REHAB 76. 02 03070 WOMEN' S CENTER	0	0 2, 248, 955 1, 332, 775		0 2, 248, 955 1, 332, 775	76. 76. 76.
76. 03 03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	0	0	0	0	76.
70. 00 09000 CLINIC 70. 01 09001 OUTPATIENT	0	1, 462, 617 1, 465, 067	0	1, 462, 617 1, 465, 067	90. 90.
91.00  09100 EMERGENCY 91.01  09101 SHORT_STAY 92.00  09200 OBSERVATION_BEDS_(NON-DISTINCT_PART)	0	5, 197, 355 0	0	5, 197, 355 0	91. 91. 92.
OTHER REI MBURSABLE COST CENTERS 75. 00 09500 AMBULANCE SERVI CES	0	94, 836	0	94, 836	95.
SPECIAL PURPOSE COST CENTERS INDEXIDENTIFICATION OF LINES 1-117)	325, 842	115, 407, 377	0	115, 407, 377	118.
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CIANS' PRI VATE OFFI CES	0	671, 753 46, 834, 512		671, 753 46, 834, 512	 190. 192.
192. 00 19200 PHTSICIANS PRIVATE OFFICES 192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	0	40, 834, 512 476, 082 1, 606, 036	0	40, 834, 312 476, 082 1, 606, 036	192. 192. 192.
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFIELD SCHOOLS	0	172 1, 161, 588	0 0	172 1, 161, 588	192. 192.
192. 05 19203 PRACTI CE MANAGEMENT 192. 06 19204 MOB – NOBLESVI LLE SQUARE	0 0	164, 375 388, 832	0	164, 375 388, 832	192. 192.
192. 08 19205 RI VERVI EW MEDI CAL ARTS 193. 00 19300 NONPAI D WORKERS	0	203, 346 0	0	203, 346 0	192. 193.
194.00 07950 WORKMED 194.01 07951 MEALS ON WHEELS	0	0 214, 489	0	0 214, 489	194. 194.

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/24/2017 3:5	
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM PHARMACY		Residents Cos	t		
			& Post			
			Stepdown			
			Adjustments			
	23.00	24.00	25.00	26.00		
201.00 Negative Cost Centers	0	0	)	0 0		201.00
202.00 TOTAL (sum lines 118-201)	325, 842	167, 128, 562		0 167, 128, 562		202.00

	Financial Systems	RI VERVI EW				eu of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	Fi	eriod: ^om 01/01/2016		
				Te	b 12/31/2016	Date/Time Pre 5/24/2017 3:5	
			CAPI TAL				
	Cost Center Description	Directly	RELATED COSTS NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	cost center bescription	Assigned New	FIXT	50510121	BENEFITS	& GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS		1.00	20	1.00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		(5.500	(5.500	(5.500		1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	65, 598 1, 043, 946	65, 598 1, 043, 946	65, 598 7, 466		4.00 5.00
7.00	00700 OPERATI ON OF PLANT	0	4, 901, 748		1, 474	79, 758	
8.00	00800 LAUNDRY & LINEN SERVICE	0	52, 944		57	3, 565	
9.00	00900 HOUSEKEEPING	0	33, 387	33, 387	724	11, 290	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	80, 098 165, 332	80, 098 165, 332	247 634	5, 926 9, 523	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	506	5, 296	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	99, 654	99, 654	585	102, 987	
15.00		0	154, 497	154, 497	2, 126	91, 304	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE		82, 586 43, 955		733 559		
23.00	02300 PARAMED ED PRGM PHARMACY	0			123		
	INPATIENT ROUTINE SERVICE COST CENTERS	-				L	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	2, 046, 319 385, 775		6, 051 1, 568	73, 872 17, 975	30.00 31.00
41.00	04100 SUBPROVIDER - IRF	0	358, 835	358, 835	1, 144		
43.00	04300 NURSERY	0	0	0	0	0	
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	247, 597	247, 597	0	15, 225	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	832, 252	832, 252	4, 189	51, 864	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	052,252	032, 232	4, 109	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	319, 214	319, 214	1, 385		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	189, 971	189, 971	349	8, 456	
57.00 57.01	05700 CT SCAN 03630 ULTRA SOUND	0	0	0	229 0	2, 302	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	154	1, 817	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	77, 021	77, 021	681	7, 583	
60.00		0	328, 845	328, 845	2, 180		
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	48, 289	48, 289	0	0 4, 082	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	49, 332	49, 332	868		
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	3, 442 0	45, 468	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	1
69.00	06900 ELECTROCARDI OLOGY	0	286, 549	286, 549	764	10, 125	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		0	/, 695	72.00 73.00
74.00	07400 RENAL DI ALYSI S	0	14, 206	14, 206	0	1, 993	
76.00	03020 OTHER ANCI LLARY	0	0	0	0	0	76.00
	03140 CARDI AC REHAB	0	42, 323	42, 323	682		
	03070 WOMEN' S CENTER 03330 ENDOSCOPY		217, 687 0	217, 687 0	378 0		
	OUTPATIENT SERVICE COST CENTERS		-	-		-	
		0	0	0	687	8, 895	
90. 01 91. 00	09001 OUTPATI ENT 09100 EMERGENCY		92, 190 428, 633	92, 190 428, 633	421 1, 715		
	09101 SHORT STAY		420,033	420, 033	0	24, 132	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
05 00					F0	E74	05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	50	574	95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	12, 692, 930	12, 692, 930	42, 171	732, 927	118.00
	NONREI MBURSABLE COST CENTERS	1					1.0-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	126, 701 271, 674	126, 701 271, 674	83 20, 832		190.00
	19200 PHYSICIANS PRIVATE OFFICES		271, 674 86, 117	86, 117	20, 832 144		192.00
	19202 CLI NI CS	0	0	0	934		192.02
	19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192.03
	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT		0		735 639		192.04 192.05
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE		0	0	039		192.05
192.08	19205 RIVERVIEW MEDICAL ARTS	0	0	0	0	1, 279	192.08
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 WORKMED 07951 MEALS ON WHEELS		0	0	0 60		194.00 194.01
		0	0	1 0	00	1, 304	1.2.0.01

Health Fina	ncial Systems	RI VERVI EW	RIVERVIEW HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider CCN: 15-0059		Peri od:	Worksheet B			
					From 01/01/2016 To 12/31/2016		norod.		
			_		10 12/31/2016	5/24/2017 3:5			
			CAPI TAL						
			RELATED COSTS						
	Cost Center Description	Di rectl y	NEW BLDG &	Subtotal		ADMI NI STRATI VE			
		Assigned New	FLXT		BENEFI TS	& GENERAL			
		Capi tal			DEPARTMENT				
		Related Costs							
		0	1.00	2A	4.00	5.00			
200.00	Cross Foot Adjustments				0		200.00		
201.00	Negative Cost Centers		0		0 0	0	201.00		
202.00	TOTAL (sum lines 118-201)	0	13, 177, 422	13, 177, 42	2 65, 598	1, 051, 412	202.00		

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2016	Worksheet B Part II	
			To			pared: 4 pm
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	4, 982, 980					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	36, 815		(0. (17			8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	23, 216 55, 696		68, 617 139	142, 106		9.00 10.00
11. 00 01100 CAFETERI A	114, 964		1, 941	0	292, 394	•
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	-	0	0	3, 418	•
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	69, 295 107, 430		69 1, 733	0	7, 116 16, 657	1
16.00 01600 MEDICAL RECORDS & LIBRARY	57, 426		347	0	9, 262	•
17. 00 01700 SOCIAL SERVICE	30, 564		0	0	4, 816	
23. 00 02300 PARAMED ED PRGM PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2,883	0	0	0	435	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 422, 911	29, 270	21, 693	71, 513	61, 000	30.00
31. 00 03100 I NTENSI VE CARE UNI T	268, 249			8, 309	13, 415	•
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	249, 516		4, 367 0	34, 274 0	13, 764 0	1
44.00 04400 SKILLED NURSING FACILITY	172, 167		3, 881	28, 010	0	•
	E 70 700	0.0(2	0 454		24.404	E0.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	578, 708		8, 456 0	0	26, 604 0	50.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	221, 966			0	10, 842	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	132, 097		347	0	3,047	55.00
57.00 05700 CT SCAN 57.01 03630 ULTRA SOUND	0		0	0	2, 173 0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-	69	Ö	1, 779	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	53, 557		0	0	4, 988	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	228, 663		2, 426	0	23, 750 0	60.00 60.01
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	33, 578		0	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	-	0	0	0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	34, 303		208 277	0	8, 023 32, 793	
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0	02,770	
68.00 06800 SPEECH PATHOLOGY	0	i i	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	199, 252	801	2, 426	0	6, 628 0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY	9, 878	0	0	0	0	
76. 01 03140 CARDI AC REHAB	29, 429	69	1, 386	0	6, 013	•
76. 02 03070 WOMEN' S CENTER	151, 369			0	4, 291	
76. 03 03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	0	0 0	0	0	0	76.03
90. 00 09000 CLINIC	0	126	0	0	7, 514	90.00
90. 01 09001 OUTPATI ENT	64, 104			0	4, 598	•
91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY	298, 051		5, 891 0	0	15, 052 0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			Ŭ	0	0	92.00
OTHER REI MBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	560	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4, 646, 087	85, 951	63, 211	142, 106	288, 538	118.00
NONREI MBURSABLE COST CENTERS	00.400					100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	88, 102 188, 909		208 3, 812	0		190.00 192.00
192. 01 19201 FOUNDATI ON	59, 882		0,012	0		192.01
192. 02 19202 CLI NI CS	0		1, 386	0		192.02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFIELD SCHOOLS	0	0	0	0		192.03 192.04
192. 05 19203 PRACTI CE MANAGEMENT	0	31	0	0		192.04
192. 06 19204 MOB - NOBLESVILLE SQUARE	0	0	0	О		192.06
192. 08 19205 RI VERVI EW MEDI CAL ARTS 193. 00 19300 NONPAI D WORKERS	0	0	0	0		192.08 193.00
194. 00 07950 WORKMED	0	0	0	0		194.00
194.01 07951 MEALS ON WHEELS	0	0	0	О	1, 127	194.01
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	_	0	0	0	200.00
202.00 TOTAL (sum Lines 118-201)	4, 982, 980	93, 381	68, 617	142, 106	292, 394	
			·			

Health Fi	nancial Systems	RI VERVI EW I	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	ON OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2016	Worksheet B	
					To 12/31/2016	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/24/2017 3:5 SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	17.00	
GE	ENERAL SERVICE COST CENTERS	10.00	11.00	10.00	10.00		
	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL						4.00 5.00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPI NG 1000 DI ETARY						9.00
	1000 CAFETERI A						10.00
	300 NURSING ADMINISTRATION	9, 220					13.00
	1400 CENTRAL SERVICES & SUPPLY	0	280, 408	070 74	-		14.00
	1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY	0	0	373, 74	7 0 162, 934		15.00 16.00
	1700 SOCIAL SERVICE	0	0		0 0	86, 698	
	2300 PARAMED ED PRGM PHARMACY	0	0		0 0	0	23.00
	IPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	5, 449	0		0 46,001	70, 042	30.00
	3100 I NTENSI VE CARE UNI T	1, 198	0		0 9, 200	3, 870	
	100 SUBPROVIDER - IRF	1, 229	0		0 0	7, 578	
	1300 NURSERY 1400 SKI LLED NURSI NG FACI LI TY	0	0		0 0 0 594	0 5, 208	
	ICI LLARY SERVICE COST CENTERS					0,200	11.00
	5000 OPERATING ROOM	0	0		0 57, 280	0	
	5200 DELIVERY ROOM & LABOR ROOM 5400 RADIOLOGY-DIAGNOSTIC	0	0		0 0 0 1, 187	0	
	5500 RADI OLOGY-THERAPEUTI C	0	0		0 5, 639	0	55.00
	5700 CT SCAN	0	0		0 0	0	57.00
	3630 ULTRA SOUND 5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57.01 58.00
	5900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
	5000 LABORATORY	0	0		0 6, 232	0	60.00
	5001 BLOOD LABORATORY	0	0		0 0	0	60. 01 63. 00
	5300 BLOOD STORING, PROCESSING & TRANS. 5400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00 06	5500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
	5600 PHYSI CAL THERAPY	0	0		0 23, 149	0	66.00
	5700 OCCUPATI ONAL THERAPY 5800 SPEECH PATHOLOGY	0	0			0	67.00 68.00
	5900 ELECTROCARDI OLOGY	0	0		0 2, 374	0	69.00
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	280, 408		0 0	0	
	7200 IMPL. DEV. CHARGED TO PATIENT 7300 DRUGS CHARGED TO PATIENTS	0	0	373, 74	0 0 7 0	0	
	7400 RENAL DI ALYSI S	0	Ō	0,0,7	0 0	0	74.00
	3020 OTHER ANCI LLARY	0	0		0 0	0	
	3140 CARDIAC REHAB 3070 WOMEN'S CENTER	0	0			0	
	3330 ENDOSCOPY	0	0		0 0	-	
	JTPATIENT SERVICE COST CENTERS				-		
	2000 CLINIC 2001 OUTPATIENT	0	0		0 0 0 0	0	
	2100 EMERGENCY	1, 344	0		0 9, 794	0	
	9101 SHORT STAY	0	0		0 0	0	
	2200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS						92.00
	2500 AMBULANCE SERVICES	0	0		0 0	0	95.00
	PECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117) DNREIMBURSABLE COST CENTERS	9, 220	280, 408	373, 74	7 161, 450	86, 698	118.00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.0019	200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	P201 FOUNDATION	0	0		0 0		192. 01 192. 02
	9202 CLINICS 9206 HOME HEALTH PARTNERSHIP	0	0		0 1,484 0 0		192.02
192.04 19	207 WESTFIELD SCHOOLS	0	Ö		0 0	0	192.04
		0	0		0 0		192.05
	9204 MOB - NOBLESVILLE SQUARE 9205 RIVERVIEW MEDICAL ARTS	0	0				192. 06 192. 08
193.0019	2300 NONPAID WORKERS	0	0		0 0	0	193.00
	7950 WORKMED	0	О		0 0		194.00
194.0107 200.00	7951 MEALS ON WHEELS Cross Foot Adjustments	0	0		0	0	194. 01 200. 00
201.00	Negative Cost Centers	0	О		o o		201.00
202.00	TOTAL (sum lines 118-201)	9, 220	280, 408	373, 74	7 162, 934	86, 698	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	RI VERVI EW H		CN: 15-0059 Per	In Lie	u of Form CMS-2552-1 Worksheet B
					om 01/01/2016	Part II Date/Time Prepared:
	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	5/24/2017 3:54 pm
		23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	1 1		1		
1.00 4.00 5.00 7.00 8.00 9.00 10.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY					1.0 4.0 5.0 7.0 8.0 9.0 10.0
11. 00 13. 00 14. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					11. 0 13. 0 14. 0
16. 00 17. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0.574				15. 0 16. 0 17. 0
23.00	02300 PARAMED ED PRGM PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	9, 574				23. 0
31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF		3, 854, 121 719, 779 698, 047	0	3, 854, 121 719, 779 698, 047	30. 0 31. 0 41. 0
	04300 NURSERY		098, 047		098, 047	41.0
	04400 SKILLED NURSING FACILITY		479, 455	0	479, 455	44.0
	ANCI LLARY SERVI CE COST CENTERS	1	1 5(0 41/		1 5(0 41/	FO 0
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM		1, 568, 416 0		1, 568, 416	50. 0 52. 0
	05400 RADI OLOGY-DI AGNOSTI C		582, 001	-	582, 001	54.0
	05500 RADI OLOGY-THERAPEUTI C		340, 661	0	340, 661	55.0
	05700 CT SCAN		4, 704	0	4, 704	57.0
	03630 ULTRA SOUND		0	0	0	57.0
	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERIZATI ON		3, 819 146, 239		3, 819 146, 239	58. 0 59. 0
	06000 LABORATORY		635, 902		635, 902	60.0
	06001 BLOOD LABORATORY		033, 702		0000, 702	60.0
	06300 BLOOD STORING, PROCESSING & TRANS.		85, 949	0	85, 949	63.0
	06400 I NTRAVENOUS THERAPY		C	0	0	64.0
	06500 RESPI RATORY THERAPY		102, 137		102, 137	65.0
	06600 PHYSI CAL THERAPY		105, 916		105, 916	66.0
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		U O		0	67.0 68.0
	06900 ELECTROCARDI OLOGY		508, 919		508, 919	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		280, 408		280, 408	71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		7, 695	5 O	7, 695	72.0
	07300 DRUGS CHARGED TO PATIENTS		373, 747		373, 747	73.0
	07400 RENAL DIALYSIS		26, 077	0	26, 077	74.0
	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB		93, 100		0 93, 100	76. 0 76. 0
	03070 WOMEN' S CENTER		381, 226		381, 226	76.0
76. 03	03330 ENDOSCOPY		C		0	76.0
	OUTPATIENT SERVICE COST CENTERS	1 1				
			17, 222		17, 222	90.0
	09001 OUTPATI ENT 09100 EMERGENCY		172, 434 797, 217		172, 434 797, 217	90. 0 91. 0
	09101 SHORT STAY		191,217		0	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		-	0	-	92.0
	OTHER REIMBURSABLE COST CENTERS	T		T		
95.00	09500 AMBULANCE SERVICES		1, 184	0	1, 184	95.0
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	11, 986, 375	0	11, 986, 375	118. 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		218, 946		218, 946	190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES		783, 261		783, 261	192. 0 192. 0
	19201 FOUNDATI ON 19202 CLI NI CS		149, 728 13, 576		149, 728 13, 576	192.0
	19206 HOME HEALTH PARTNERSHIP		13, 370	0	1	192.0
	19207 WESTFIELD SCHOOLS		8, 042	2 0	8, 042	192.0
	19203 PRACTI CE MANAGEMENT		1, 703		1, 703	192. 0
	19204 MOB - NOBLESVILLE SQUARE		2, 446		2, 446	192.0
	19205 RIVERVIEW MEDICAL ARTS		1, 279	0	1, 279	192.0
	19300 NONPAID WORKERS		Ŭ	0	0	193. 0
			0	)		110/ 0
194.00	07950 WORKMED 07951 MEALS ON WHEELS		0 2, 491	0	0 2, 491	194. 0 194. 0

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2016 To 12/31/2016		
Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	1 37 247 2017 3.3	
	23.00	24.00	25.00	26.00		
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	9, 574	13, 177, 422		0 13, 177, 422		202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	RI VERVI EW I	HOSPI TAL	CN: 15-0059	In Lie Period:	u of Form CMS-: Worksheet B-1	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio	n ADMI NI STRATI VE & GENERAL (ACCUM. COST)	5/24/2017 3:5 OPERATI ON OF PLANT (SQUARE FEET)	4 pm
		1.00	4.00	5A	5.00	7.00	
	GENERAL SERVICE COST CENTERS	402 542		1			1 1 00
11.00 13.00 14.00 15.00 16.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	492, 563 2, 452 39, 022 183, 224 1, 979 1, 248 2, 994 6, 180 0 3, 725 5, 775 3, 087	72, 026, 479 8, 195, 162 1, 618, 032 62, 621 794, 526 271, 073 696, 220 555, 231 642, 522 2, 334, 092 804, 601	-19, 131, 39	0         11, 227, 195           0         501, 811           0         1, 589, 239           0         834, 198           0         1, 340, 580           0         745, 427           0         14, 497, 067           0         12, 852, 418           0         1, 770, 874	6, 180 0 3, 725 5, 775 3, 087	8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	1, 643 155	613, 533 134, 654		0 957, 744 0 279, 597	1, 643 155	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	100	134, 034	1	217,371	100	20.00
31.00 41.00 43.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	76, 490 14, 420 13, 413 0 9, 255	6, 641, 995 1, 720, 871 1, 255, 937 0 0		0 10, 398, 667 0 2, 530, 304 0 2, 821, 540 0 0 2, 143, 105	76, 490 14, 420 13, 413 0 9, 255	31.00 41.00 43.00
	ANCILLARY SERVICE COST CENTERS						
$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 57.\ 01\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 60.\ 01\\ \end{array}$	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 03630 ULTRA SOUND 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	31, 109 0 11, 932 7, 101 0 0 2, 879 12, 292 0 1, 805	4, 598, 109 0 1, 520, 286 382, 998 250, 832 0 169, 090 747, 222 2, 393, 285 0 0		0 7, 300, 718 0 2, 834, 583 0 1, 190, 379 324, 085 0 255, 732 0 1, 067, 410 0 6, 166, 354 0 0 574, 604	31, 109 0 11, 932 7, 101 0 0 2, 879 12, 292 0 1, 805	55.00 57.00 57.01 58.00 59.00 60.00 60.01
	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
66.00 67.00 68.00 69.00 71.00 72.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT	1, 844 0 0 0 10, 711 0 0	952, 730 3, 778, 342 0 838, 198 0 0 0		0 1, 323, 601 0 6, 400, 331 0 0 0 0 1, 425, 229 0 0 1, 083, 212	0 0	66.00 67.00 68.00 69.00 71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 531	0		0 0	0 531	73.00
	03020 OTHER ANCI LLARY	0	0		0 280, 547 0 0	0	74.00 76.00
76. 01 76. 02	03140 CARDIAC REHAB 03070 WOMEN'S CENTER 03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	1, 582 8, 137 0	748, 317 414, 685 0		0 1, 857, 762 0 775, 604 0 0	1, 582 8, 137 0	76. 01 76. 02
	09000 CLI NI C	0	754, 507		0 1, 252, 100	0	90.00
91. 00 91. 01	09001 OUTPATI ENT 09100 EMERGENCY 09101 SHORT STAY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	3, 446 16, 022 0	462, 416 1, 882, 809 0		0 1, 091, 256 0 3, 396, 910 0 0	3, 446 16, 022 0	
95.00	09500 AMBULANCE SERVICES	0	54, 441		0 80, 829	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS	474, 453	46, 289, 337			249, 755	118.00
190.00 192.00 192.02 192.03 192.04 192.05 192.06	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 FOUNDATION 19202 CLINICS 19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE 19205 RIVERVIEW MEDICAL ARTS	4, 736 10, 155 3, 219 0 0 0 0 0 0 0	91, 508 22, 887, 739 157, 976 1, 025, 735 0 807, 258 700, 908 0 0		0 385, 099 0 40, 910, 389 0 277, 586 0 1, 370, 964 0 152 0 1, 028, 619 0 145, 367 0 344, 322 0 180, 069	10, 155 3, 219 0 0 0 0 0 0 0 0	190.00 192.00 192.01 192.02 192.03 192.03 192.04 192.05 192.06 192.08
193.00	19300 NONPAI D WORKERS	0	0		0 0	0	193.00
194.00	07950 WORKMED	0	0		0 0	0	194.00

Health Fir	ancial Systems	RI VERVI EW I	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-0059	Period:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016		pared: 4 pm
		CAPI TAL					
	Cost Center Description	RELATED COSTS NEW BLDG & FIXT	BENEFITS	Reconciliati	ADMI NI STRATI VE & GENERAL	PLANT	
		(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
			SALARI ES)		0001)		
		1.00	4.00	5A	5.00	7.00	
194.01079	51 MEALS ON WHEELS	0	66, 018		0 183, 589	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	13, 177, 422	9, 645, 491		19, 131, 394	12, 678, 523	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	26. 752765	0. 133916		0. 129269	47.331764	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		65, 598		1, 051, 412	4, 982, 980	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0. 000911		0. 007104	18. 602580	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	RI VERVI EW	HOSPI TAL Provider CC	N. 15 0050	In Lie Period:	u of Form CMS-2 Worksheet B-1	
CUST A	LLUCATION - STATISTICAL DASIS		Provider CC	F	From 01/01/2016		
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	5/24/2017 3:5 NURSI NG	
	cost center bescription	LINEN SERVICE	(HOURS OF	(MEALS	(MAN	ADMI NI STRATI ON	
		(POUNDS OF LAUNDRY)	SERVI CE)	SERVED)	HOURS)	(DI RECT	
						NRSING HRS)	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	73, 174					8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	0	990 2	81, 378	3		9.00 10.00
	01100 CAFETERI A	0	28	01, 370			11.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	(	12,749	385, 097	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	550 0	25	(	26, 547 62, 138	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	5	(	34, 551	0	
	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	0	0	(		0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		0		1, 023	0	23.00
	03000 ADULTS & PEDIATRICS	22, 936	313	40, 953		227, 559	
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	5, 347	49 63	4, 758 19, 62		50, 043 51, 345	
	04300 NURSERY	0	0	(	0 0	0	43.00
	04400 SKI LLED NURSI NG FACI LI TY	5, 307	56	16, 040	0 0	0	44.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	7, 102	122	(	99, 244	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0 0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	4, 285	26 5	(	0 40, 444 0 11, 368	0	54.00 55.00
	05700 CT SCAN	0	0	(	8, 108	0	57.00
	03630 ULTRA SOUND	0	0	(	0 0	0	57.01
	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	1	(	0 6, 638 0 18, 606	0	58.00 59.00
60.00	06000 LABORATORY	0	35	(	88, 598	0	60.00
	06001 BLOOD LABORATORY	0	0	(	0	0	60. 01 63. 00
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	(		0	64.00
	06500 RESPI RATORY THERAPY	0	3	(	29, 928	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	617	4	(	122, 334	0	66.00 67.00
	06800 SPEECH PATHOLOGY	0	0	(		0	68.00
	06900 ELECTROCARDI OLOGY	628	35	(	24, 724	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0 0	0	73.00
	07400 RENAL DIALYSIS 03020 OTHER ANCILLARY	0	0	(	0	0	74.00
	03140 CARDI AC REHAB	54	20	(	22,432	0	76.00
	03070 WOMEN' S CENTER	365	22	(	16, 009	0	
76.03	03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	0	0	(	0 0	0	76.03
	09000 CLI NI C	99	0	(	28, 029	0	
	09001 OUTPATI ENT 09100 EMERGENCY	1, 988	12	(	0 17, 152	0	90.01 91.00
	09100 EMERGENCY 09101 SHORT STAY	9,877	85 0	(	0 56, 150 0 0	56, 150 0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	(	2,088	0	95.00
	SPECIAL PURPOSE COST CENTERS						75.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	67, 352	912	81, 378	3 1, 076, 373	385, 097	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3	(	4, 162	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 772	55	(	0 0	0	192.00
	19201 FOUNDATI ON 19202 CLI NI CS	0 26	0 20	(	0 6, 016 0 0		192.01 192.02
	19206 HOME HEALTH PARTNERSHIP	0	0	(		0	192.03
	19207 WESTFIELD SCHOOLS	0	0	(			192.04
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE	24	0		0 וע ה (כ		192.05 192.06
192.08	19205 RI VERVI EW MEDI CAL ARTS	0	0	(		0	192.08
	19300 NONPALD WORKERS 07950 WORKMED	0	0	(			193.00 194.00
	07950 WORKMED 07951 MEALS ON WHEELS	0	0	(	4, 206		194.00
194.01							

Heal th Fi	nancial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALL	DCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016	Worksheet B-1	
					To 12/31/2016		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(HOURS OF	(MEALS		ADMI NI STRATI ON	
		(POUNDS OF	SERVI CE)	SERVED)	HOURS)		
		LAUNDRY)				(DI RECT	
						NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	660, 350	1, 853, 748	1, 087, 49	0 1, 858, 814	863, 514	202.00
	Part I)	-					
203.00	Unit cost multiplier (Wkst. B, Part I)	9. 024380	1, 872. 472727	13. 36344	0 1. 704150	2.242329	203.00
204.00	Cost to be allocated (per Wkst. B,	93, 381	68, 617	142, 10	6 292, 394	9, 220	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1. 276150	69. 310101	1.74624	6 0. 268065	0. 023942	205.00
Į.		1		1	1	1	

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	RI VERVI EW H	HOSPI TAL	CN: 15-0059 P	In Lie Period:	u of Form CMS- Worksheet B-1	
				rom 01/01/2016 o 12/31/2016		
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUI S. )	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCI AL SERVI CE (TI ME SPENT)	5/24/2017 3:5 PARAMED ED PRGM PHARMACY (ASSI GNED TI ME)	4 pm
	14.00	15.00	16.00	17.00	23.00	
GENERAL SERVICE COST CENTERS	1					
1.00       00100       NEW CAP REL COSTS-BLDG & FLXT         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVICE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       01100       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVICES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY	100 0 0	100 0	549			1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
17.00 01700 SOCIAL SERVICE	0	0	C	5, 377		17.00
23.00 02300 PARAMED ED PRGM PHARMACY	0	0	C	0	100	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	155	4 244	0	20.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	31		0	
41. 00 04100 SUBPROVI DER - I RF	0	0	C	470	0	
	0	0	C	0	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	2	323	0	44.00
50. 00 05000 OPERATI NG ROOM	0	0	193	0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	
54. 00  05400  RADI OLOGY-DI AGNOSTI C 55. 00  05500  RADI OLOGY-THERAPEUTI C	0	0	4	0	0	
57. 00 05700 CT SCAN	0	0	C		0	57.00
57.01 03630 ULTRA SOUND	0	0	C	0	0	57.01
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58.00
59. 00  05900  CARDI AC_CATHETERI ZATI ON 60. 00  06000  LABORATORY	0	0	21	0	0	59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	0	C		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	78		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68.00 69.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	100	0		0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	C	0	0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	100	C	0		73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY	0	0		0	0	
76. 01 03140 CARDI AC REHAB	0	0	C	0	0	
76.02 03070 WOMEN' S CENTER	0	0	C	0	0	
76. 03 03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	76.03
90. 00 09000 CLINIC	0	0	C	0	0	90.00
90. 01 09001 OUTPATI ENT	0	0	C	0	0	90.01
91.00 09100 EMERGENCY	0	0	33	0	0	
91.01 09101 SHORT STAY 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0		0	0	91.01 92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)	100	100	544	5, 377	100	118.00
NONREI MBURSABLE COST CENTERS	100	100	544	5,377	100	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.00
192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	0	0		0		192. 01 192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	0	C C	0		192.03
192.04 19207 WESTFIELD SCHOOLS	0	0	C	0		192.04
192. 05 19203 PRACTI CE MANAGEMENT 192. 06 19204 MOB - NOBLESVI LLE SQUARE	0	0		0		192. 05 192. 06
192. 08 19204 MOB - NOBLESVILLE SUDARE 192. 08 19205 RIVERVIEW MEDICAL ARTS	0	0		0		192.08
193. 00 19300 NONPAI D WORKERS	0	0	0	0 O	0	193.00
194. 00 07950 WORKMED	0	0	C	0		194.00
194.01 07951 MEALS ON WHEELS 200.00 Cross Foot Adjustments	0	0	C	0	0	194. 01 200. 00
	<u>   </u>		1	1	1	1-00.00

Heal th Fi	nancial Systems	RI VERVI EW HOSPI TAL			In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016		
Cost Center Description		CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE		
		SERVICES &	(COSTED	RECORDS &		PRGM PHARMACY	
		SUPPLY	REQUIS.)	LI BRARY	(TIME	(ASSI GNED	
		(COSTED	, ,	(TIME	SPENT)	TIME)	
		REQUIS.)		SPENT)	, , , , , , , , , , , , , , , , , , ,	,	
		14.00	15.00	16.00	17.00	23.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	16, 599, 474	14, 939, 882	2, 214, 14	8 1, 189, 934	325, 842	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	165, 994. 740000	149, 398. 820000	4, 033. 05646	6 221.300725	3, 258. 420000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	280, 408	373, 747	162, 93	4 86, 698	9, 574	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2, 804. 080000	3, 737. 470000	296. 78324	2 16. 123861	95.740000	205.00

	Systems RATIO OF COSTS TO CHARGES	RIVERVIEW	Provi der C	N. 15-0059	Peri od:	u of Form CMS-2 Worksheet C	2002 1
COMPORTATION OF 1				SN. 15 0057	From 01/01/2016	Part I	
					To 12/31/2016	Date/Time Pre	pared:
			Title	XVIII	Hospi tal	5/24/2017 3:5 PPS	4 pm
					Costs	1 113	
Cos	t Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)				5.00	
	ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	LTS & PEDIATRICS	19, 188, 156		19, 188, 1	56 0	19, 188, 156	30.00
	ENSIVE CARE UNIT	4, 119, 136		4, 119, 1		,	
	PROVIDER - IRF	4, 559, 624		4, 559, 6			
43.00 04300 NUR		0			0 0	0	43.00
44. 00 04400 SKI I	LLED NURSING FACILITY	3, 304, 843		3, 304, 8	43 0	3, 304, 843	44.00
	SERVICE COST CENTERS						
	RATING ROOM	10, 956, 960		10, 956, 9	60 0	10, 956, 960	
	VERY ROOM & LABOR ROOM	0			0 0	-	52.00
	I OLOGY-DI AGNOSTI C	3, 938, 178		3, 938, 1			
	I OLOGY-THERAPEUTI C	1, 791, 066		1, 791, 0		1, 791, 066	
57.00 05700 CT 3 57.01 03630 ULTI		379, 796		379, 7	76 U	379, 796 0	
	NETIC RESONANCE IMAGING (MRI)	301, 974		301, 9	0	301, 974	
	DI AC CATHETERI ZATI ON	1, 390, 406		1, 390, 4		1, 390, 406	
50. 00 06000 LAB		7, 846, 489		7, 846, 4		7, 846, 489	
	DD LABORATORY	0		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0	60.0
	DD STORING, PROCESSING & TRANS.	734, 316		734, 3	16 0	734, 316	
54.00 06400 I NTI	RAVENOUS THERAPY	0			0 0	0	64.00
55. 00 06500 RESI	PI RATORY THERAPY	1, 638, 601	C	1, 638, 6	0 0	1, 638, 601	65.00
	SI CAL THERAPY	7, 763, 806	C	7, 763, 8	0 0	7, 763, 806	66.00
	JPATIONAL THERAPY	0	C		0 0	0	
	ECH PATHOLOGY	0	C		0 0	0	
		2, 262, 039		2, 262, 0		2, 262, 039	
	I CAL SUPPLIES CHARGED TO PATIENTS L. DEV. CHARGED TO PATIENT	16, 599, 474 1, 223, 238		16, 599, 4 1, 223, 2		16, 599, 474 1, 223, 238	
	GS CHARGED TO PATIENT	15, 265, 724		15, 265, 7		15, 265, 724	
	AL DIALYSIS	341, 946		341, 9		341, 946	
	ER ANCILLARY	0		011, 7	0 0	0	
	DI AC REHAB	2, 248, 955		2, 248, 9	55 0	2, 248, 955	
76. 02 03070 WOMI	EN' S CENTER	1, 332, 775		1, 332, 7	75 0	1, 332, 775	76.0
76.03 03330 END		0			0 0	0	76.0
	T SERVICE COST CENTERS	1		-	1		
90.00 09000 CLII		1, 462, 617		1, 462, 6		.,	
0. 01 09001 0UTI		1, 465, 067		1, 465, 0		1, 465, 067	
91.00 09100 EMEI		5, 197, 355		5, 197, 3	55 O		
91.01 09101 SHO 92.00 09200 0BS	ERVATION BEDS (NON-DISTINCT PART)	0 2, 539, 269		2 520 2	0	2 520 260	
	MBURSABLE COST CENTERS	2, 339, 269		2, 539, 2	57	2, 539, 269	92.0
	JLANCE SERVICES	94, 836		94, 8	36 0	94, 836	95 0
	total (see instructions)	117, 946, 646	C				
	s Observation Beds	2, 539, 269	-	2, 539, 2		2, 539, 269	
	al (see instructions)	115, 407, 377	0				

	cial Systems OF RATIO OF COSTS TO CHARGES	RI VERVI EW I	Provi der CO	CN: 15-0059	Peri od:	u of Form CMS- Worksheet C	
					From 01/01/2016	Part I	
					To 12/31/2016	Date/Time Pre 5/24/2017 3:5	epared:
				XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30.00 03000	ADULTS & PEDIATRICS	25, 835, 508		25, 835, 50	)8		30. 00
31.00 03100	INTENSIVE CARE UNIT	5, 321, 468		5, 321, 46	8		31.00
41.00 04100	SUBPROVIDER - IRF	6, 300, 655		6, 300, 65	55		41.00
43.00 04300	NURSERY	0			0		43.00
	SKILLED NURSING FACILITY	2, 272, 104		2, 272, 10	)4		44.00
	LARY SERVICE COST CENTERS	I		1			_
	OPERATING ROOM	19, 925, 498	36, 546, 730			0.00000	
	DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	
	RADI OLOGY-DI AGNOSTI C	1, 560, 234	12, 303, 089			0. 000000	
	RADI OLOGY-THERAPEUTI C	111, 554	5,044,202			0. 000000	
	CT SCAN	1, 811, 161	9, 388, 039			0.00000	
	ULTRA SOUND MAGNETIC RESONANCE IMAGING (MRI)	0 345, 546	0 2, 980, 028		0.000000	0. 000000 0. 000000	
	CARDIAC CATHETERIZATION	5, 671, 231	10, 648, 537	16, 319, 76		0. 000000	
	LABORATORY	11, 498, 947	27, 651, 293			0. 000000	
	BLOOD LABORATORY	11, 490, 947	27,031,293		0 0. 000000	0. 000000	
	BLOOD STORING, PROCESSING & TRANS.	863, 176	629, 443			0.000000	
	I NTRAVENOUS THERAPY	0	0277110	., ., _, 0.	0 0.000000	0. 000000	
	RESPI RATORY THERAPY	5, 057, 289	1,061,555	6, 118, 84		0. 000000	
	PHYSI CAL THERAPY	9, 110, 663	11, 849, 741	20, 960, 40		0.00000	
67.00 06700	OCCUPATIONAL THERAPY	0	0		0 0.000000	0. 000000	67.00
	SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	68.00
	ELECTROCARDI OLOGY	2, 190, 648	10, 762, 463			0.00000	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 051, 137	24, 119, 901	49, 171, 03		0. 000000	
	IMPL. DEV. CHARGED TO PATIENT	943, 442	2, 965, 072			0. 000000	
	DRUGS CHARGED TO PATIENTS	11, 219, 227	27, 497, 490			0.00000	
	RENAL DIALYSIS	331, 571	13, 550	345, 12		0.00000	
	OTHER ANCI LLARY	0	0		0 0.00000	0.00000	
	CARDIAC REHAB	296, 596	6,041,581	6, 338, 17		0. 000000	
	WOMEN' S CENTER	12,077	4, 654, 019			0. 000000	
	ENDOSCOPY TIENT SERVICE COST CENTERS	0	0		0 0.000000	0. 000000	76.03
	CLINIC	60,000	4, 484, 954	4, 544, 95	0. 321811	0. 000000	90.00
	OUTPATI ENT	197, 174	4, 637, 617			0. 000000	
	EMERGENCY	3, 312, 153	20, 348, 370			0. 000000	
	SHORT STAY	0,012,100	20, 0.0, 0,0	20,000,02	0 0.000000	0. 000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	597, 780	2, 920, 361	3, 518, 14		0. 000000	
	REIMBURSABLE COST CENTERS		, .,				
	AMBULANCE SERVICES	0	0		0 0.000000	0.00000	95.00
200.00	Subtotal (see instructions)	139, 896, 839	226, 548, 035	366, 444, 87	4		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	139, 896, 839	226, 548, 035	366, 444, 87	4		202.00

	inancial Systems ION OF RATIO OF COSTS TO CHARGES	RIVERVIEW HO	Provider CCN: 15-0059	Peri od:	u of Form CMS-2552 Worksheet C
COMPUTAT	TUN OF RATIO OF COSTS TO CHARGES		Provider CCN. 15-0059	From 01/01/2016 To 12/31/2016	Part I Date/Time Prepare
			Title XVIII	Hospi tal	5/24/2017 3:54 pm PPS
	Cost Center Description	PPS Inpatient			110
		Ratio			
		11.00			
LN	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03	3000 ADULTS & PEDIATRICS				30.
31.00 03	3100 I NTENSI VE CARE UNI T				31.
41.00 04	4100 SUBPROVIDER - IRF				41.
	4300 NURSERY				43.
	4400 SKILLED NURSING FACILITY				44.
	ICI LLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 194024			50.
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.
	5400 RADI OLOGY - DI AGNOSTI C	0. 284072			54.
	5500 RADI OLOGY-THERAPEUTI C	0. 347392			55.
	5700 CT SCAN	0. 033913			57.
	3630 ULTRA SOUND	0. 000000			57.
		0. 090804			
	5800 MAGNETIC RESONANCE I MAGING (MRI)				58.
	5900 CARDI AC CATHETERI ZATI ON	0. 085198			59.
	5000 LABORATORY	0. 200420			60.
	5001 BLOOD LABORATORY	0. 000000			60.
	5300 BLOOD STORING, PROCESSING & TRANS.	0. 491965			63.
	5400 I NTRAVENOUS THERAPY	0. 000000			64.
	5500 RESPI RATORY THERAPY	0. 267796			65.
	5600 PHYSI CAL THERAPY	0. 370403			66.
	5700 OCCUPATIONAL THERAPY	0. 000000			67.
	5800 SPEECH PATHOLOGY	0. 000000			68.
	5900 ELECTROCARDI OLOGY	0. 174633			69.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 337586			71.
	7200 IMPL. DEV. CHARGED TO PATIENT	0. 312968			72.
	7300 DRUGS CHARGED TO PATIENTS	0. 394293			73.
	7400 RENAL DIALYSIS	0. 990800			74.
	3020 OTHER ANCI LLARY	0. 000000			76.
	3140 CARDI AC REHAB	0. 354827			76.
76.02 03	3070 WOMEN'S CENTER	0. 285630			76.
76.03 03	3330 ENDOSCOPY	0. 000000			76.
OU	JTPATIENT SERVICE COST CENTERS				
90.00 09	9000 CLINIC	0. 321811			90.
90.01 09	9001 OUTPATI ENT	0. 303026			90.
91.00 09	P100 EMERGENCY	0. 219664			91.
	9101 SHORT STAY	0. 000000			91.
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 721764			92.
	THER REIMBURSABLE COST CENTERS				721
	9500 AMBULANCE SERVICES	0.000000			95.
200.00	Subtotal (see instructions)				200.
201.00	Less Observation Beds				201.
201.00	Total (see instructions)				201.

		Provider C	^N· 15_0059	Peri od:	Worksheet C	
DMPUTATION OF RATIO OF COSTS TO CHARGES		riovider ci	314. 13-0037	From 01/01/2016	Part I	
				To 12/31/2016	Date/Time Pre	pared:
			e XIX	Hospi tal	5/24/2017 3:5 Cost	4 pm
				Costs	0031	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
D. 00 03000 ADULTS & PEDIATRICS	19, 188, 156		19, 188, 15	6 0	19, 188, 156	30.00
1. 00 03100 INTENSIVE CARE UNIT	4, 119, 136		4, 119, 13		4, 119, 136	
1. 00 04100 SUBPROVIDER - IRF	4, 119, 130		4, 119, 13		4, 119, 130	
3. 00 04300 NURSERY	4, 337, 024		4, 339, 02	0 0	4, 337, 024	43.00
4. 00 04400 SKI LLED NURSI NG FACI LI TY	3, 304, 843		3, 304, 84	13 0	3, 304, 843	
ANCI LLARY SERVICE COST CENTERS	0,001,010		0,001,01	0	0,001,010	11.00
D. 00 05000 0PERATING ROOM	10, 956, 960		10, 956, 96	0 0	10, 956, 960	50. OC
2.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 938, 178		3, 938, 17	78 0	3, 938, 178	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 791, 066		1, 791, 06	6 0	1, 791, 066	55.00
7.00 05700 CT SCAN	379, 796		379, 79	0	379, 796	57.00
7.01 03630 ULTRA SOUND	0			0 0	0	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	301, 974		301, 97		301, 974	
9. 00 05900 CARDIAC CATHETERIZATION	1, 390, 406		1, 390, 40		1, 390, 406	
D. 00 06000 LABORATORY	7, 846, 489		7, 846, 48	39 0	7, 846, 489	
D. 01 06001 BLOOD LABORATORY	0			0 0	0	60.01
3. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	734, 316		734, 31	6 0	734, 316	
4. 00 06400 I NTRAVENOUS THERAPY	0		1 (00 (0	0 0	0	
5. 00 06500 RESPIRATORY THERAPY	1, 638, 601	0	1, 638, 60		1, 638, 601	
6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 0CCUPATI ONAL THERAPY	7, 763, 806	0	7, 763, 80	0 0	7, 763, 806 0	
3. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
2. 00 06900 ELECTROCARDI OLOGY	2, 262, 039	0	2, 262, 03		2, 262, 039	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 599, 474		16, 599, 47		16, 599, 474	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 223, 238		1, 223, 23		1, 223, 238	
3. 00 07300 DRUGS CHARGED TO PATIENTS	15, 265, 724		15, 265, 72		15, 265, 724	
4. 00 07400 RENAL DIALYSIS	341, 946		341, 94		341, 946	
5. 00 03020 OTHER ANCI LLARY	0			0 0	0	
5. 01 03140 CARDI AC REHAB	2, 248, 955		2, 248, 95	5 0	2, 248, 955	76.01
6.02 03070 WOMEN'S CENTER	1, 332, 775		1, 332, 77	75 0	1, 332, 775	76.02
5. 03 03330 ENDOSCOPY	0			0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS			-			
D. 00 09000 CLINIC	1, 462, 617		1, 462, 61		.,	
D. 01 09001 OUTPATI ENT	1, 465, 067		1, 465, 06		1, 465, 067	
1. 00 09100 EMERGENCY	5, 197, 355		5, 197, 35		5, 197, 355	
1. 01 09101 SHORT STAY	0		0 500 -	0 0	0	1
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 539, 269		2, 539, 26	99	2, 539, 269	92.00
	04.00/		04.00		04.007	
5.00 09500 AMBULANCE SERVICES 00.00 Subtotal (see instructions)	94, 836	0	94, 83		,	
	117, 946, 646	0	117, 946, 64	6 0	117, 946, 646	I∠00. 00
01.00 Less Observation Beds	2, 539, 269		2, 539, 26		2, 539, 269	201 00

Health Financial Syste COMPUTATION OF RATIO C		RIVERVIEW	Provi der C	CN: 15-0059	Peri od:	u of Form CMS- Worksheet C	2002 1
					From 01/01/2016	Part I	
					To 12/31/2016	Date/Time Pre 5/24/2017 3:5	epared:
			Ti tl	e XIX	Hospi tal	Cost	, pill
			Charges				
Cost Cente	er Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTI	NE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30.00 03000 ADULTS & F	PEDI ATRI CS	25, 835, 508		25, 835, 50	)8		30. 00
31.00 03100 I NTENSI VE	CARE UNIT	5, 321, 468		5, 321, 46	58		31.00
41.00 04100 SUBPROVI DE	R – IRF	6, 300, 655		6, 300, 65	55		41.00
43.00 04300 NURSERY		0			0		43.00
44.00 04400 SKILLED NU		2, 272, 104		2, 272, 10	)4		44.00
ANCI LLARY SERVI		1		1	.1		_
50.00 05000 OPERATI NG		19, 925, 498	36, 546, 730			0.00000	
	ROOM & LABOR ROOM	0	0		0 0.00000	0.00000	
54.00 05400 RADI OLOGY-		1, 560, 234	12, 303, 089			0.00000	
55. 00 05500 RADI OLOGY-	THERAPEUTIC	111, 554	5,044,202			0.00000	
57.00 05700 CT SCAN 57.01 03630 ULTRA SOUM	D.	1, 811, 161 0	9, 388, 039 0		0. 033913 0. 000000	0.00000	
	RESONANCE IMAGING (MRI)	345, 546	2, 980, 028			0. 000000 0. 000000	
59.00 05900 CARDI AC CA		5, 671, 231	10, 648, 537			0. 000000	
60. 00 06000 LABORATORY		11, 498, 947	27, 651, 293			0.000000	
60.01 06001 BLOOD LABO		0	27,001,270		0 0.000000	0.000000	
	RING, PROCESSING & TRANS.	863, 176	629, 443			0.000000	
64.00 06400 I NTRAVENOU		0	0	.,, .	0 0.000000	0. 000000	
65. 00 06500 RESPI RATOR		5, 057, 289	1,061,555	6, 118, 84		0.00000	
66. 00 06600 PHYSI CAL 1	HERAPY	9, 110, 663	11, 849, 741	20, 960, 40	0. 370403	0. 000000	66.00
67.00 06700 0CCUPATION	IAL THERAPY	0	0		0 0.000000	0. 000000	67.00
68.00 06800 SPEECH PA		0	0		0 0.000000	0.00000	
69. 00 06900 ELECTROCAF		2, 190, 648	10, 762, 463			0. 000000	
	IPPLIES CHARGED TO PATIENTS	25, 051, 137	24, 119, 901			0. 000000	
	CHARGED TO PATIENT	943, 442	2, 965, 072			0.00000	
73.00 07300 DRUGS CHAF		11, 219, 227	27, 497, 490			0.00000	
74.00 07400 RENAL DIAL		331, 571	13, 550			0.00000	
76.00 03020 OTHER ANCI		0	0		0 0.00000	0.00000	
76.01 03140 CARDI AC RE		296, 596	6, 041, 581			0.00000	
76.02 03070 WOMEN'S CE 76.03 03330 ENDOSCOPY	INTER	12, 077 0	4, 654, 019			0.00000	
	CE COST CENTERS	0	0		0 0.000000	0.00000	/ /0.03
90. 00 09000 CLINIC	CE COST CENTERS	60,000	4, 484, 954	4, 544, 95	0. 321811	0. 000000	90.00
90. 01 09001 0UTPATI ENT	-	197, 174	4, 637, 617			0. 000000	
91.00 09100 EMERGENCY		3, 312, 153	20, 348, 370			0.000000	
91.01 09101 SHORT STAY	/	0	0		0 0.000000	0.00000	
	N BEDS (NON-DISTINCT PART)	597, 780	2, 920, 361	3, 518, 14		0.00000	
OTHER REI MBURSA	BLE COST CENTERS						
95.00 09500 AMBULANCE		0	0		0 0.000000	0.00000	95.00
	(see instructions)	139, 896, 839	226, 548, 035	366, 444, 87	74		200.00
	vation Beds						201.00
202.00 Total (see	e instructions)	139, 896, 839	226, 548, 035	366, 444, 87	74		202.00

	RIVERVIEW HC	ISPITAL	In Lie	u of Form CMS-25	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0059	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepa 5/24/2017 3:54	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
·	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
41.00 04100 SUBPROVIDER - IRF					41.00
43. 00 04300 NURSERY					43.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCI LLARY SERVI CE COST CENTERS	· · · · ·				
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0, 000000				55.00
57. 00 05700 CT SCAN	0.000000				57.00
57. 01 03630 ULTRA SOUND	0.000000				57.01
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0. 000000				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000				59.00
60. 00 06000 LABORATORY	0.000000				60.00
60. 01 06001 BLOOD LABORATORY	0.000000				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000				63.00
64. 00 06400 INTRAVENOUS THERAPY	0.000000				64.00
65. 00 06500 RESPIRATORY THERAPY					65.00
	0. 000000				
	0. 000000				66.00
67. 00 06700 OCCUPATIONAL THERAPY	0.000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000				69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
74.00 07400 RENAL DIALYSIS	0.000000				74.00
76.00 03020 OTHER ANCI LLARY	0.000000				76.00
76. 01 03140 CARDI AC REHAB	0.000000				76.01
76. 02 03070 WOMEN' S CENTER	0.000000				76.02
76. 03 03330 ENDOSCOPY	0.000000				76.03
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
90. 01 09001 OUTPATI ENT	0.000000				90.01
91.00 09100 EMERGENCY	0. 000000				91.00
91. 01 09101 SHORT STAY	0.000000				91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
OTHER REIMBURSABLE COST CENTERS	1				
95.00 09500 AMBULANCE SERVICES	0.000000				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)				2	202.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPI TAL COSTS	Provider C	F	Period: From 01/01/2016 Fo 12/31/2016	Date/Time Pre 5/24/2017 3:5	pared: 4 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTE						
30. 00 ADULTS & PEDIATRICS	3, 854, 121	0	3, 854, 121			
31.00 INTENSIVE CARE UNIT	719, 779		719, 779			
41.00 SUBPROVIDER - IRF	698, 047	0	698, 04			1
43.00 NURSERY	0		(	0 0	0.00	
44.00 SKILLED NURSING FACILITY	479, 455		479, 455			
200.00 Total (lines 30-199)	5, 751, 402		5, 751, 402	2 27, 891		200.00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	6,00	<u> </u>	-			
INPATIENT ROUTINE SERVICE COST CENTE		7.00				
30. 00 ADULTS & PEDIATRICS	5, 276	1, 328, 866	1			30,00
31. 00 I NTENSI VE CARE UNI T	1, 103					31.00
41. 00 SUBPROVIDER - IRF	4, 088	478, 460				41.00
43. 00 NURSERY	4,088	478, 400	1			41.00
44. 00 SKILLED NURSING FACILITY	3, 093	-				43.00
200.00 Total (lines 30-199)	13, 560		•			200.00
200.00/10101 (111165 30-199)	13, 500	2,490,312				1200. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0059	Period: From 01/01/2016 To 12/31/2016		pared: 4 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	Ŭ		
	26)	, ,	, i			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATI NG ROOM	1, 568, 416	56, 472, 228	0.0277	7, 905, 789	219, 567	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	52.00
54, 00 05400 RADI OLOGY-DI AGNOSTI C	582,001	13, 863, 323			30, 770	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	340, 661	5, 155, 756				•
57. 00 05700 CT SCAN	4, 704					•
57. 01 03630 ULTRA SOUND	0					•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 819	-				
59. 00 05900 CARDI AC CATHETERI ZATI ON	146, 239					
60. 00 06000 LABORATORY	635, 902					
60. 01 06001 BLOOD LABORATORY	035, 402		0.0000		0	•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	85, 949	-				
			0.0000			
	102 127	u u u u u u u u u u u u u u u u u u u			0	
65. 00 06500 RESPI RATORY THERAPY	102, 137					
66.00 06600 PHYSI CAL THERAPY	105, 916					
67.00 06700 OCCUPATI ONAL THERAPY	0	-	0.00000		-	67.00
68.00 06800 SPEECH PATHOLOGY	0	-	0.00000		•	
69. 00 06900 ELECTROCARDI OLOGY	508, 919					•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	280, 408					
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 695					•
73.00 07300 DRUGS CHARGED TO PATIENTS	373, 747					•
74.00 07400 RENAL DIALYSIS	26,077	345, 121				•
76.00 03020 OTHER ANCI LLARY	0	-			0	76.00
76. 01 03140 CARDI AC REHAB	93, 100	6, 338, 177			2, 147	76.01
76.02 03070 WOMEN'S CENTER	381, 226	4, 666, 096			686	76.02
76. 03 03330 ENDOSCOPY	0	0	0.0000	0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	17, 222	4, 544, 954	0.00378	43, 091	163	90.00
90. 01 09001 OUTPATI ENT	172, 434	4, 834, 791	0. 03566	5 57, 626	2, 055	90.01
91.00 09100 EMERGENCY	797, 217	23, 660, 523	0. 03369			
91. 01 09101 SHORT STAY	0	C	0.0000	0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	510,035	3, 518, 141			0	92.00
OTHER REIMBURSABLE COST CENTERS		, .,,		-		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	6, 743, 824	326, 715, 139		37, 826, 699	621, 944	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 4 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
41. 00 04100 SUBPROVIDER – IRF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0			0	44.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	15, 302					30.00
31.00 03100 INTENSIVE CARE UNIT	2, 379					31.00
41.00 04100 SUBPROVIDER - IRF	5, 964			8 0		41.00
43. 00 04300 NURSERY	0	0.00		0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	4, 246	0.00	3, 09	3 0		44.00
200.00 Total (lines 30-199)	27, 891		13, 56	0 0		200.00

APPORT ID NUMENT OF LINATIENT AUGURATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider         C/R: 15-0059 From 01/07/2016         Period: Prom 01/07/2016         Peri	Health Financial Systems	RI VERVI EW H	IOSPI TAL		In Lie	u of Form CMS-:	2552-10
Cost Center Description         Non-Physician         Nursing School         Allied Health         Total Cost         Total Cost           4NCLLLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (DPEATING ROM)         0         0         0         0         0         0         5.00           50.00         05200 (DELIVERY ROW & LABOR ROM)         0         0         0         0         0         5.00         5.00         52.00         0         0         0         0         52.00         5.00         52.00         0         0         0         0         0         0         0         0         52.00         50.00         52.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td>RVICE OTHER PASS</td> <td></td> <td></td> <td>From 01/01/2016</td> <td>Part IV Date/Time Pre</td> <td>pared: 4 pm</td>		RVICE OTHER PASS			From 01/01/2016	Part IV Date/Time Pre	pared: 4 pm
Amesthetist Cost         Medical Education Cost         (sm of col 1 through col 4)           50:00         DS000 (PERATING ROOM         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							
Image: Cost         Education Cost         Education Cost         through col. (4)           50.00         05000 (PERATING ROM 052.00         05200 (DELIVERY ROM & LABOR ROM 052.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	Cost Center Description	Non Physician N	lursi ng School	Allied Health	All Other	Total Cost	
ANCILLARY SERVICE COST CENTERS         -         4)           50:00         CS000 OPERATING ROOM         0         0         0         50:00           50:00         CS000 OPERATING ROOM         0         0         0         0         50:00           50:00         CS000 OPERATING ROOM         0         0         0         0         50:00           50:00         DS200 PADI LOCY-DI AGNOSTIC         0         0         0         0         55:00           50:00         DS200 RADI LOCY-THERAPEUTIC         0         0         0         0         57:00         57:00         57:00         57:01         0         0         0         0         0         57:01         58:00         0         0         0         0         0         0         0         58:00         58:00         0         59:00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		Anestheti st			Medi cal	(sum of col 1	
Incidit LARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		Cost			Education Cost	through col.	
ANCILLARY SERVICE COST CENTERS         Image: Cost of Centers           60         00         00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							
50. 00         050.00         0PERATING ROM         0         0         0         0         0         0         50.00         0         0         50.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></t<>		1.00	2.00	3.00	4.00	5.00	
52:00         05:00         05:00         05:00         05:00         0         0         0         0         52:00         05:00         05:00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							
54.00       S400       RADIOLOCY-DIAGNOSTIC       0       0       0       55.00         55.00       S500       RADIOLOCY-THERAPEUTIC       0       0       0       0       55.00         57.00       DS700       CT SCAN       0       0       0       0       57.01         58.00       DS600       ARDIAC CATHETERIZATION       0       0       0       0       58.00         59.00       OS900       LABORATORY       0       0       0       0       0       0       60.00         60.01       BLOOD LABORATORY       0       0       0       0       0       0       0       60.00         63.00       HADOL INTRAVENUS THERAPY       0       0       0       0       64.00         64.00       OG000 INTRAVENUS THERAPY       0       0       0       0       64.00         65.00       OBG00 RESPI RATORY THERAPY       0       0       0       0       64.00         65.00       OBG00 RESPI RATORY THERAPY       0       0       0       0       64.00         66.00       OG700 OCUPATIONAL THERAPY       0       0       0       0       67.00         67.00       OCOO <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0	0		0 0	0	
55:00       05500       RADIOLOGY-THERAPEUTIC       0       0       0       0       55:00         57:00       05700 CT SCAN       0       0       0       0       0       57:01         58:00       05800 MAGNETIC RESONANCE I MAGING (MRI)       0       0       0       0       58:00         59:00       05900 CARDIA CATHERIZATION       0       0       0       0       0       58:00         60:01       06000       LABORATORY       0       0       0       0       0       60:01         63:00       BLOOD LABORATORY       0       0       0       0       0       60:01         63:00       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0       64:00       0       64:00       0       64:00       0       0       0       0       64:00       0       0       0       0       66:00       0       66:00       0       0       0       0       0       0       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       66:00       67:00       0       0       0       0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
57.00       05700       CT SCAN       0       0       0       0       57.01         57.01       03630       ULTRA SOUND       0       0       0       0       57.01         58.00       05800       MAGNETI C RESONANCE I MAGING (MRI)       0       0       0       0       58.00         59.00       CARDI AC CATHETERIZATION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
57. 01       03630       ULTRA SOUND       0       0       0       57. 01         58. 00       05800       MAGNETI C RESONANCE I MAGING (MRI )       0       0       0       0       58. 00         59. 00       05000       ARDIAC CATHETERI ZATION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td>55. 00 05500 RADI OLOGY-THERAPEUTI C</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>55.00</td>	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0       0       58.00         59.00       05900       CARDI AC CARDI AC CATHETERI ZATI ON       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>57.00</td>		0	0		0 0	0	57.00
59.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	57.01 03630 ULTRA SOUND	0	0		0 0	0	57.01
60.00       06000       LABORATORY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
60.00       06000       LABORATORY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60.01       06001       BLOOD LABORATORY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>•</td>		0	0		0 0	0	•
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0       63.00         64.00       06400       INTRAVENUUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPIRATORY THERAPY       0       0       0       0       64.00         65.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       66.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       67.00       68.00       0       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       72.00       73.00 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>		0	0		0 0		
64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06500       RESPI RATORY THERAPY       0       0       0       0       66.00         66.00       06700       0CUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       OTOO       DELECTROCARDIOLOGY       0       0       0       0       71.00         071.00       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       71.00       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       74.00       74.00       0       0       0       74.00       74.00       74.00       0       0       74.00       74.00       0       0       0       74.00       74.00       74.00       74.00       76.01       76.03       76.03       76.03       76.03       76.03       76.03       76.03       76.03		0	0		0 0		•
65.00       06500       RESPI RATORY THERAPY       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       0       0       66.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         71.00       OTIO       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       74.00         74.00       O7400       REANCI LLARY       0       0       0       0       76.00       76.00         76.01       03140       CARDI AC REHAB       0       0       0       0       76.02         76.02       03370       ENDOSCOPY       0       0       0       0		0	0			-	
66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       74.00         74.00       07400       RENAL DI ALYSIS       0       0       0       0       74.00         76.01       03140       CARDIA C REHAB       0       0       0       0       76.01         76.02       03707       WOMEN'S CENTER       0       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       0       0       0       <		0	0				
67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       68.00         69.00       CECTROCARDI OLOGY       0       0       0       0       68.00         69.00       ELECTROCARDI OLOGY       0       0       0       0       69.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       71.00       0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENT       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       72.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         76.01       03140       CARDI AC REHAB       0       0       0       0       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       0       76.02         76.03       03333       ENDOSCOPY       0       0       0       0       0       90.01         00       09000       CLI NI C		0	0			-	
68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         71.00       O7100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0       0       0       72.00       73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       325,842       0       325,842       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         76.01       03140       CARGEH ANCI LLARY       0       0       0       0       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       0       76.02         70.00       09000       CLINIC       0       0       0       0       0       90.00         76.03       03330       ENDOSCOPY       0       0       0       0       90.01       90.01		0	0				
69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       0       0       0       0       0       71.00       71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       71.00       72.00       72.00       73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       72.00       73.00       73.00       73.00       73.00       73.00       73.00       07300       RENAL DI ALYSI S       0       0       0       0       72.00       73.00       74.00       0       0       0       0       74.00       74.00       0       0       0       74.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.01       76.01       76.02       76.02       76.02       76.02       76.03       76.02       76.03       76.03       76.02       76.02       76.02       76.03       76.03       76.02       76.03       76.03       76.02       76.03       76.03       76.02       76.03       76.03       76.03       76.03       76.04       76.02       76.03       76.03       76.03		0	0			-	
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       325,842       0       325,842       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       76.01         76.01       03140       CARDI AC REHAB       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.03         90.00       09000       CLI NI C       0       0       0       0       90.00         91.01       90101       EMERGENCY       0       0       0       0       90.01         91.01       90101       EMERGENCY       0       0       0       0       91.01 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td>		0	0			-	
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       325,842       0       325,842       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       0       74.00         76.00       03200       OTHER ANCI LLARY       0       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       0       0       0       76.01         76.02       03070       WMEN' S CENTER       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.02         00.00       09000       CLI NI C       0       0       0       0       90.00         90.01       09001       OUTPATI ENT       0       0       0       0       90.01         90.01       09000       CLI NI C       0       0       0       0       90.01         91.01       9000       UUTPATI ENT       0       0       0       0       90.01		0	0			-	
73.00       07300       DRUGS CHARGED TO PATIENTS       0       325,842       0       325,842       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       0       0       0       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.02         76.03       03300       ENDUSCOPY       0       0       0       0       76.02         70.00       09000       CLI NI C       0       0       0       0       90.00         90.01       09001       OUTPATI ENT       0       0       0       0       90.01         91.01       94001       EMERGENCY       0       0       0       0       91.00         91.01       09100       EMERGENCY       0       0       0       0       91.00         91.01       09100		0	0			-	
74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       0       0       0       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.02         76.04       09000       CLI NI C       0       0       0       0       76.03         0000       09000       CLI NI C       0       0       0       0       90.00         90.01       09001       OUTPATI ENT       0       0       0       0       90.01         91.00       OPO00       EMERGENCY       0       0       0       0       91.00         91.00       09100       EMERGENCY       0       0       0       0       91.00         92.00       OSERVATI ON BEDS (NON-DI STI NCT PART)		0	U				
76.00       03020       OTHER ANCI LLARY       0       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       0       0       0       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       0       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.03         01000       CLI NI C       0       0       0       0       0       90.00         90.00       09001       OUTPATI ENT       0       0       0       90.01       90.01         91.00       09002       CLI NI C       0       0       0       0       90.01         91.01       09100       ENERGENCY       0       0       0       91.00       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       0       0       0       92.00         0THER REI MBURSABLE COST CENTERS       95.00       0       950.0       95.00       95.00		0	U				
76. 01       03140       CARDI AC REHAB       0       0       0       0       76. 01         76. 02       03070       WOMEN'S CENTER       0       0       0       0       76. 02         76. 03       03330       ENDOSCOPY       0       0       0       0       0       76. 02         76. 03       03330       ENDOSCOPY       0       0       0       0       0       76. 03         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       90. 00         90. 00       09000       CLI NI C       0       0       0       0       90. 00         90. 01       09001       OUTPATI ENT       0       0       0       0       90. 01         91. 00       09100       EMERGENCY       0       0       0       0       91. 01         91. 01       09101       SHORT STAY       0       0       0       0       91. 01         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       0       92. 00         0THER REI MBURSABLE COST CENTERS       95. 00       09500       AMBULANCE SERVICES       95. 00       95. 00 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td>•</td>		0	0		0 0		•
76. 02         03070         WOMEN'S CENTER         0         0         0         0         0         76. 02           76. 03         03330         ENDOSCOPY         0         0         0         0         0         0         0         0         0         0         0         76. 03           0UTPATI ENT SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>		0	0		0 0	-	
76.03         03330         ENDOSCOPY         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	-				
OUTPATI ENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0         0         0         0         0         90.00           90. 01         09000 UTPATI ENT         0         0         0         0         0         90.00           90. 01         09000 UTPATI ENT         0         0         0         0         90.01           91. 00         09100 EMERGENCY         0         0         0         0         91.00           91. 01         09101 SHORT STAY         0         0         0         0         91.01           92. 00         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         0         0         0         92.00           0THER REI MBURSABLE COST CENTERS         95.00         950.0         950.0         950.0         950.0         950.0		0					
90.00       09000       CLINIC       0       0       0       0       0       0       90.00         90.01       09001       OUTPATIENT       0       0       0       0       0       90.01         91.00       09100       EMERGENCY       0       0       0       0       0       91.00         91.01       09101       SHORT STAY       0       0       0       0       91.01         92.00       0BSERVATION BEDS (NON-DISTINCT PART)       0       0       0       0       92.00         OTHER REIMBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES       95.00       95.00		0	0		0 0	0	76.03
90.01         09001         OUTPATIENT         0         0         0         0         0         0         90.01           91.00         09100         EMERGENCY         0         0         0         0         0         91.00           91.01         09101         SHORT STAY         0         0         0         0         0         91.01           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         0         0         92.00           0THER         REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00         950.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01         95.01		1		1			
91.00         09100         EMERGENCY         0         0         0         0         91.00           91.01         09101         SHORT STAY         0         0         0         0         0         91.01           92.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         0         0         0         92.00           0THER         REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00         950.00 <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td>		0	-			-	
91. 01         09101         SHORT STAY         0         0         0         0         0         91. 01           92. 00         09200         0BSERVATI ON BEDS (NON-DISTINCT PART)         0         0         0         0         0         0         92.00           0THER         REI MBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVICES         95. 00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00 <t< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>-</td><td></td></t<>		0	C		0 0	-	
92. 00         09200         0BSERVATION         BEDS (NON-DISTINCT PART)         0         0         0         0         0         92. 00           OTHER REIMBURSABLE COST CENTERS         0         0         0         0         0         0         0         95. 00         9500         AMBULANCE SERVICES         95. 00         95. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950. 00         950.		0	0				
OTHER REIMBURSABLE COST CENTERS       95.00         95.00       09500       AMBULANCE SERVICES       95.00	91.01  09101 SHORT STAY	0	0			0	91.01
95.00 09500 AMBULANCE SERVICES 95.00		0	0		0 0	0	92.00
				1			
200.00           Total (lines 50-199)         0         0         325, 842         0         325, 842         200.00							
	200.00   Total (lines 50-199)	0	C	325, 84	2 0	325, 842	200.00

APPORT IO NUMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-0059 Period 10/10/2016 To 12/31/2016         Period : Port J/10/2016 Period 10/2012016         Period : Port J/10/2016 S2/20/2016         Period : Port J/10/2016         Port J/10/2016         Period : Port J/10/2016         Period : Port J/10/2016         Port J/10/2016         Period : Port J/10/2016         Port J/10/2016         Port J/10/2016         Period : Port J/10/2016         Port J/10	Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
Interview         Total         Total         Total         Total         Deterting         Detering         Detering<	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C	CN: 15-0059			
Cost Center Description         Total Outpatient (Col. 2, 3)         Total Outpatient (Col. 2, 4)         Total (Col. 2, 4)         Total (Col. 2, 4)         Total (Col. 2, 4)         Total (Col. 2, 5)         Total (Col. 2, 5) <tht< td=""><td>THROUGH COSTS</td><td></td><td></td><td></td><td></td><td></td><td>nored.</td></tht<>	THROUGH COSTS						nored.
Cost Center Description         Title VIII         Hospital         PPS           Cost Center Description         Total Outpatient (Cost (sum of col. 2, 3 and 4)         Total (Sum of col. 2, 3 and 4)         Total					10 12/31/2010	5/24/2017 3.5	a nm
Cost Center Description         Total Outpatient (Cost (sum of cost (sum of c			Title	XVIII	Hospi tal	PPS	
Outpatient col:         Crom Wkst.         Col.	Cost Center Description	Total					
Cost (sum of)         Part I, col.         (col.         5, -°col.         to         Charges           ANCILLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           50.00         05000 (PERATING ROM         0         56,472,228         0.000000         0.000000         0.000000         55,00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00							
Col.         2, 3 and 4)         8)         7)         (col.         6, et ol. 7)         7           50.00         05000 (PERTING ROM         0         56, 472, 228         0.000000         0.000000         7, 905, 789         50.00           52.00         05200 (DELIVERY NOM & LABOR ROM         0         56, 472, 228         0.000000         0.000000         732, 944         54.00           55.00         05500 (RADI OLGGY - THERAPEUTI C         0         55, 756         0.000000         0.000000         0.000000         732, 944         54.00           57.00         05700 (T SCAN         0         11, 199, 200         0.000000         0.000000         13, 981         55.00           57.00         05500 (ARDI ALC CATHETERI ZATI ON         0         16, 319, 756         0.000000         0.000000         2, 431, 480         59.00           59.00         05900 (ARDI ALC CATHETERI ZATI ON         0         16, 319, 758         0.0000000         2, 431, 480         59.00           60.00         06000 (LABORATORY         0         0         0.0000000         0.0000000         2, 431, 480         59.00           61.00         06000 INTRAVENUS THERAPY         0         0         0.0000000         0.000000         0.0000000         2, 431, 430 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
4)         7)         7)           ANCILLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           50.00         05000         OPERATI NG ROOM         0         56.472,228         0.000000         0.000000         7.905,789         50.00           52.00         05200         DELI VERY ROM & LABOR ROOM         0         13.863,323         0.000000         0.000000         7.905,789         50.00           51.00         DS500 RADI DLOCY-DI AGNOSTI C         0         13.863,323         0.000000         0.000000         1.981         55.00           57.00         DS700 CT SCAN         0         11,199,200         0.000000         0.000000         0.000000         1.981         55.00           58.00         DG800 MARTI C RESONANCE I MAGI NG (MRI )         0         3.352,574         0.000000         0.000000         4.783,173         60.00           60.01         D6000 LABORATORY         0         39,150,240         0.000000         0.000000         4.63.00           61.00         DABORATORY         0         0         0.000000         0.000000         2.64.01         63.00           65.00         DG500 KESPI RATORY THERAPY         0         0.0000000         0.000000						g	
ACLILLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         0         56.00         0.000000         0.000000         7,905,789         50.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         0         0.000000         0.000000         7,905,789         50.00           54.00         OS400 RADI LOCY-THERAPEUTI C         0         13,863,323         0.000000         0.000000         31,941         55.00           57.00         OS700 CT SCAN         0         11.199,200         0.000000         0.000000         57.01           58.00         DS00 MAGNETIC CE RESONANCE IMAGING (MRI)         0         3,325,574         0.000000         0.000000         57.01           59.00         DS900 CARDI AC CATHETERI ZATI ON         0         16,319,768         0.000000         0.000000         4,783,173         60.00           60.01         IBLODD LABORATORY         0         0         0.000000         0.000000         26,441,483         59.00           61.00         DG500 RESPI RATORY THERAPY         0         0         0.000000         0.000000         26,440         30.00000         0.000000         26,440         30.0100           65.00         DG500 RESPI RATORY THERAPY				,			
50. 00         05000   DEELATI NC ROOM         0         56. 472, 228         0.000000         0.000000         7, 905, 789         50. 00           52. 00         05200 DELL VERY ROOM & LABOR ROOM         0         0.000000         0.000000         0.000000         7, 905, 789         50. 00           54. 00         05400 RADI OLOGY-DI AGNOSTI C         0         13, 863, 323         0.000000         0.000000         732, 944         54. 00           55. 00         0500 CT SCAN         0         11, 199, 200         0.000000         0.000000         856, 269         57. 00           57. 01         33630 ULTRA SOUND         0         0         0.000000         0.000000         0.000000         149, 589         58. 00           59. 00         05900 CARDI AC CATHETRI ZATI ON         0         16, 319, 768         0.000000         0.000000         2, 431, 480         59. 00           60. 01         60001 BLODD LABORATORY         0         39, 150, 240         0.000000         0.000000         2, 404         63. 00           61. 01         65000 INTRING, PROCESSI NG & TRANS.         0         1, 492, 619         0.000000         0.000000         2, 403, 238         65. 00           65. 00         05500 RESPI RATORY THERAPY         0         0.000000			7.00	8.00		10.00	
52.00         DELIVERY ROOM & LABOR ROOM         0         0.000000         0.000000         0.000000         732.944         54.00           54.00         05400 RADIOLOGY-THERAPEUTIC         0         13,863,323         0.000000         0.000000         732.944         54.00           57.00         05500 RADIOLOGY-THERAPEUTIC         0         51,555,756         0.000000         0.000000         0.000000         31,941         55.00           57.00         05300 RADIOLOGY-THERAPEUTIC         0         51,555,756         0.000000         0.000000         35,027         57.00         57.00         57.00         57.00         57.01         57.00         57.00         57.00         57.00         57.00         57.01         57.00         57.01         57.00         57.01         57.00         57.01         57.00         57.01         57.00         57.01         57.00         57.00         57.01         57.00         57.01         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         50.00         50.00         50.00         50.00         50.00         50.00         56.0	ANCI LLARY SERVI CE COST CENTERS						
54.00       0s400       RADIOLOGY-DIASNOSTIC       0       13.863.323       0.000000       0.000000       732.944       54.00         55.00       05500       RADIOLOGY-THERAPEUTIC       0       55.00       0.000000       0.000000       31.981       55.00         57.00       05700       CT SCAN       0       11.199.200       0.000000       0.000000       0.5000       55.00         57.01       03630       UTRA SOUND       0       0.325.574       0.000000       0.000000       149.599       58.00         59.00       0S900       CARDIAC CATHETERIZATION       0       16.319.768       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       60.01         60.00       060001       BLODD LABGRATORY       0       0       0.000000       0.000000       0.000000       60.01         63.00       06300       RESPI RATORY THERAPY       0       0       0.000000       0.000000       0.000000       64.00         64.00       06400       INTARVINUS THERAPY       0       0.960,404       0.000000       0.000000       2.403,238       65.00         65.00       06500       RESPI RATORY THERAPY       0       0.000000       0.000000	50. 00 05000 OPERATI NG ROOM	0	56, 472, 228	0.00000	0.000000	7, 905, 789	50.00
55.00         05500         RADIOLOGY-THERAPEUTIC         0         5, 155, 756         0.000000         0.000000         31, 981         55.00           57.00         05700         CT SCAN         0         11, 199, 200         0.000000         0.000000         0.000000         157.01           58.00         05800         MAGNETIC RESONANCE I MAGING (MRI)         0         3, 325, 574         0.000000         0.000000         2.431, 480         59.00           59.00         OSOO CARDIA C. CATHETERIZITION         16, 319, 758         0.000000         0.000000         2.431, 480         59.00           60.01         06001         BLODD LABORATORY         0         39, 150, 240         0.000000         0.000000         4.783, 173         60.00           63.00         BLODD STORING, PROCESSING & TRANS.         1, 492, 619         0.000000         0.000000         2.403, 238         65.00           65.00         06500 RESPI RATORY THERAPY         0         6.118, 844         0.000000         0.000000         2.403, 238         65.00           66.00         OCUPATI ONAL THERAPY         0         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         67.00         68.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0.00000	0. 000000	0	52.00
57.00       CT SCAN       0       11, 199, 200       0.000000       0.000000       856, 289       57. 01         57.01       03630       ULTRA SOUND       0       0.000000       0.000000       0.000000       67. 01         58.00       05800       MAGNETI C. RESONANCE I MAGING (MRI )       0       3, 325, 574       0.000000       0.000000       2, 431, 480       59. 00         60.00       06001       LABORATORY       0       39, 150, 240       0.000000       0.000000       4, 783, 173       60. 01         60.01       06001       BLOOD STORI NG, PROCESSI NG & TRANS.       0       1, 492, 619       0.000000       0.000000       259, 440       63. 00         64.00       06400       INTRAVENUS THERAPY       0       0       0.000000       0.000000       2433, 238       65. 00         65.00       06500       PESPI RATORY THERAPY       0       0       0.000000       0.000000       2403, 238       65. 00         66.00       06600       PHYSI CAL THERAPY       0       0       0.000000       0.000000       2403, 238       65. 00         67.00       06700       CCUPATI ONAL THERAPY       0       0       0.000000       0.000000       0.000000       0.000000 <td< td=""><td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td><td>0</td><td>13, 863, 323</td><td>0.00000</td><td>0. 000000</td><td>732, 944</td><td>54.00</td></td<>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	13, 863, 323	0.00000	0. 000000	732, 944	54.00
57. 01       0330       ULTRA SOUND       0       0.00000       0.000000       149,589       57. 01         58. 00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       3,325,574       0.000000       0.000000       149,589       58. 00         60. 00       06000       CARDIAC CATHETERIZATION       0       16,319,768       0.000000       0.000000       2,431,480       59. 00         60. 01       06000       LABORATORY       0       39,150,240       0.000000       0.000000       4,783,173       60. 00         63.00       06300       BLODD STORING, PROCESSING & TRANS.       0       1,492,619       0.000000       0.000000       259,440       63. 00         64.00       06400       INTRAVENOUS THERAPY       0       6,118,844       0.000000       0.000000       2,93,238       65. 00         65.00       06500       RESPI RATORY THERAPY       0       0       0.000000       0.000000       2,93,238       65. 00         66.00       06600       PHYSI CAL THERAPY       0       0       0.000000       0.000000       67. 00         67.00       0       0.000000       0.000000       0.000000       0.000000       1,022,030       69. 00         67.00 </td <td>55. 00 05500 RADI OLOGY-THERAPEUTI C</td> <td>0</td> <td>5, 155, 756</td> <td>0. 00000</td> <td>0. 000000</td> <td>31, 981</td> <td>55.00</td>	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	5, 155, 756	0. 00000	0. 000000	31, 981	55.00
57.01       0330       ULTRA SOUND       0       0.00000       0.000000       149,589       58.00         58.00       05800       CARDIAC CATHETERIZATION       0       16,319,758       0.000000       0.000000       2,431,480       59.00         60.01       06000       LABORATORY       0       39,150,240       0.000000       0.000000       4,783,173       60.00         60.01       06000       DS000 STORING, PROCESSING & TRANS.       0       0.000000       0.000000       0.000000       2,934,460       63.00         64.00       06400       INTRAVENUS THERAPY       0       0       0.000000       0.000000       2,944,463.00         65.00       06500       RSPI RATORY THERAPY       0       6,118,844       0.000000       0.000000       2,943,238       65.00         66.00       06400       PHYSI CAL THERAPY       0       0       0.000000       0.000000       2,943,238       65.00         67.00       05000       SPECE HATHORY THERAPY       0       0       0.000000       0.000000       2,943,238       65.00         69.00       SPECH PATHOLOGY       0       0       0.000000       0.000000       1,022,030       69.00         71.00       07100 ME	57.00 05700 CT SCAN	0	11, 199, 200	0.00000	0. 000000	856, 289	57.00
59.00       05900       CARDI AC CATHETERI ZATI ON       0       16, 319, 768       0.000000       0.000000       2, 431, 480       59.00         60.00       06000       LABORATORY       0       39, 150, 240       0.000000       0.000000       4, 783, 173       60.00         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       1, 492, 619       0.000000       0.000000       2, 431, 480       63.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0.000000       0.000000       2, 403, 238       65.00         65.00       06500       RESPI RATORY THERAPY       0       6, 118, 844       0.000000       0.000000       2, 403, 238       65.00         66.00       06600       PHYSI CAL THERAPY       0       20, 960, 404       0.000000       0.000000       0.000000       67.00         0       0.000000       0.000000       0.000000       0.000000       0.000000       68.00         69.00       06800       SPECH PATHOLOGY       0       12, 953, 111       0.000000       0.000000       9, 18, 977       71.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       3, 908, 514       0.000000       0.0000000       1, 72.00       73.00	57.01 03630 ULTRA SOUND	0			0. 000000		
60.00       06000       LABORATORY       0       39, 150, 240       0.000000       0.000000       4, 783, 173       60.00         60.01       BLOOD LABORATORY       0       0       0.000000       0.000000       259, 440       63.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0.000000       0.000000       259, 440       64.00         65.00       06500       RESPI RATORY THERAPY       0       6, 118, 844       0.000000       0.000000       2, 403, 238       65.00         66.00       06500       RESPI RATORY THERAPY       0       6, 118, 844       0.000000       0.000000       923, 021       66.00         67.00       06700       OCUPATI ONAL THERAPY       0       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.00000	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 325, 574	0.00000	0. 000000	149, 589	58.00
60.01         06001         BLOOD         LABORATORY         0         0         0.000000         0.000000         0.000000         0.000000         259,440         63.00           63.00         BLOOD         STORING, PROCESSING & TRANS.         0         1,492,619         0.000000         0.000000         0.000000         0.000000         0.64.00           64.00         OfAdol INTRAVENOUS THERAPY         0         6.118,844         0.000000         0.000000         2,403,238         65.00           66.00         O6600         PHYSI CAL THERAPY         0         6.118,844         0.000000         0.000000         0.000000         2,403,238         65.00           66.00         O6500         RESPI RATORY THERAPY         0         0         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	16, 319, 768	0.00000	0. 000000	2, 431, 480	59.00
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       1,492,619       0.000000       0.000000       259,440       63.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0.000000       0.000000       2,403,238       65.00         65.00       06500       PESPIRATORY THERAPY       0       20,960,404       0.000000       0.000000       2,403,238       65.00         66.00       06600       PHYSI CAL THERAPY       0       20,960,404       0.000000       0.000000       20,930,21       66.00         67.00       0CCUPATI ONAL THERAPY       0       0       0.000000       0.000000       0       67.00         68.00       06900       CLCUPATI ONAL THERAPY       0       0       0.000000       0.000000       68.00         0       0.6900       ELECTROCARDI OLOGY       0       12,953,111       0.000000       0.000000       95,175       72.00         73.00       07300       DRUCS CHARGED TO PATI ENT       325,842       38,716,717       0.008416       0.08416       4,175,708       73.00         76.00       03202       OTHER ANCI LLARY       0       0       0.000000       0.000000       168,382       74.00	60. 00 06000 LABORATORY	0	39, 150, 240	0.00000	0. 000000	4, 783, 173	60.00
64.00       06400       INTRAVENOUS THERAPY       0       0.000000       0.000000       2,403,238       65.00         65.00       06500       RESPI RATORY THERAPY       0       6,118,844       0.000000       0.000000       2,403,238       65.00         66.00       06500       RESPI RATORY THERAPY       0       20,960,404       0.000000       0.000000       923,021       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0.000000       0.000000       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0.000000       0.000000       0.000000       1,022,030       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       49,171,038       0.000000       0.000000       895,175       72.00         73.00       07300       DRUSC CHARGED TO PATIENTS       325,842       38,716,717       0.008416       4,175,708       73.00         74.00       03020       OTHER ANCI LLARY       0       0       0.000000       0.000000       168,382       74.00         76.01       03140       CARDIA C REHAB       0       6,338,177       0.000000       0.000000       8,401       76.02	60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0. 000000	0	60.01
64.00       06400       INTRAVENOUS THERAPY       0       0.000000       0.000000       2,403,238       65.00         65.00       06500       RESPI RATORY THERAPY       0       6,118,844       0.000000       0.000000       2,403,238       65.00         66.00       06500       RESPI RATORY THERAPY       0       20,960,404       0.000000       0.000000       923,021       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0.000000       0.000000       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0.000000       0.000000       0.000000       1,022,030       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       49,171,038       0.000000       0.000000       895,175       72.00         73.00       07300       DRUSC CHARGED TO PATIENTS       325,842       38,716,717       0.008416       4,175,708       73.00         74.00       03020       OTHER ANCI LLARY       0       0       0.000000       0.000000       168,382       74.00         76.01       03140       CARDIA C REHAB       0       6,338,177       0.000000       0.000000       8,401       76.02	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 492, 619	0. 00000	0. 000000	259, 440	63.00
66.00       06600       PHYSI CAL THERAPY       0       20,960,404       0.000000       0.000000       923,021       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0.000000       0.000000       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0.000000       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       12,953,111       0.000000       0.000000       9,118,997       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       49,171,038       0.000000       0.000000       995,175       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       325,842       38,716,717       0.000000       0.000000       168,332       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0.000000       168,322       74.00         76.01       03140       CREHAB       0       6,338,177       0.000000       0.000000       168,322       74.00         76.02       03070       WOMEN'S CENTER       0       4,664,996       0.000000       0.000000       166.02         76.03 <td></td> <td>0</td> <td></td> <td></td> <td>0. 000000</td> <td>0</td> <td>64.00</td>		0			0. 000000	0	64.00
67.00       06700       0CCUPATI ONAL THERAPY       0       0       0.000000       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0.000000       0.000000       1,022,030       68.00         69.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       12,953,111       0.000000       0.000000       9,118,997       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       3,908,514       0.000000       0.000000       995,175       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       325,842       38,716,717       0.008416       0.000000       168,382       74.00         76.00       03020       OTHEA ANCI LLARY       0       0       0.000000       0.000000       168,382       74.00         76.01       03140       CARDI AC REHAB       0       6,338,177       0.000000       0.000000       146,172       76.01         76.02       03070       WOMEN'S CENTER       0       4,666,096       0.000000       0.000000       146,172       76.01         76.03       03330       ENDISCOPY       0       0       0.000000       0.000000       76.02       0.000000       0.	65. 00 06500 RESPI RATORY THERAPY	0	6, 118, 844	0.00000	0. 000000	2, 403, 238	65.00
67.00       06700       0CCUPATI ONAL THERAPY       0       0       0.000000       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0.000000       0.000000       1,022,030       68.00         69.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       12,953,111       0.000000       0.000000       9,118,997       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       3,908,514       0.000000       0.000000       995,175       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       325,842       38,716,717       0.008416       0.000000       168,382       74.00         76.00       03020       OTHEA ANCI LLARY       0       0       0.000000       0.000000       168,382       74.00         76.01       03140       CARDI AC REHAB       0       6,338,177       0.000000       0.000000       146,172       76.01         76.02       03070       WOMEN'S CENTER       0       4,666,096       0.000000       0.000000       146,172       76.01         76.03       03330       ENDISCOPY       0       0       0.000000       0.000000       76.02       0.000000       0.	66. 00 06600 PHYSI CAL THERAPY	0	20, 960, 404	0.00000	0. 000000	923, 021	66.00
69.00       06900       ELECTROCARDIOLOGY       0       12,953,111       0.000000       0.000000       1,022,030       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       49,171,038       0.000000       0.000000       9,118,997       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       3,908,514       0.000000       0.000000       895,175       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       325,842       38,716,717       0.008416       4,175,708       73.00         74.00       07400       RENAL DIALYSIS       0       345,121       0.000000       0.000000       0       76.00         76.01       03140       CARDIAC REHAB       0       6,338,177       0.000000       0.000000       146,172       76.01         76.02       03070       WOMEN'S CENTER       0       4,666,096       0.000000       0.000000       8,401       76.02         70.00       OPOOD       CLI NI C       0       4,544,954       0.000000       0.000000       90.00         90.01       OPTOTI ENT SERVI CE COST CENTERS       0       4,834,791       0.000000       0.000000       57,626       90.01	67.00 06700 OCCUPATI ONAL THERAPY	0			0. 000000	0	67.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       49, 171, 038       0.000000       0.000000       9, 118, 997       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0       3, 908, 514       0.000000       0.000000       895, 175       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       325, 842       38, 716, 717       0.008416       4, 175, 708       73.00         74.00       07400       RENAL DI ALYSI S       0       345, 121       0.000000       0.000000       168, 382       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0.000000       0.000000       0.000000       166, 382       74.00         76.01       03140       CARDI AC REHAB       0       6, 338, 177       0.000000       0.000000       146, 172       76.01         76.02       03070       WOMEN'S CENTER       0       4, 564, 096       0.000000       0.000000       84, 401       76.02         76.03       03330       ENDOSCOPY       0       0       0.000000       0.000000       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00 <td< td=""><td>68.00 06800 SPEECH PATHOLOGY</td><td>0</td><td>o c</td><td>0.00000</td><td>0. 000000</td><td>0</td><td>68.00</td></td<>	68.00 06800 SPEECH PATHOLOGY	0	o c	0.00000	0. 000000	0	68.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       49, 171, 038       0.000000       0.000000       9, 118, 997       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0       3, 908, 514       0.000000       0.000000       895, 175       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       325, 842       38, 716, 717       0.008416       0.000000       168, 382       74.00         74.00       07400       RENAL DI ALYSI S       0       345, 121       0.000000       0.000000       168, 382       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0.000000       166, 382       76.01         76.01       03140       CARDI AC REHAB       0       6, 338, 177       0.000000       0.000000       146, 172       76.01         76.02       03070       WOMEN'S CENTER       0       4, 566, 096       0.000000       0.000000       84, 017       76.02         76.03       03330       ENDOSCOPY       0       0       0.000000       0.000000       76.03         90.00       09000       CLI NI C       0       4, 544, 954       0.000000       0.000000       57, 626	69. 00 06900 ELECTROCARDI OLOGY	0	12, 953, 111	0.00000	0. 000000	1, 022, 030	69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       325,842       38,716,717       0.008416       0.008416       4,175,708       73.00         74.00       07400       RENAL DI ALYSI S       0       345,121       0.000000       0.000000       168,382       74.00         76.00       03202       OTHER ANCI LLARY       0       0       0.000000       0.000000       168,382       74.00         76.01       03140       CARDI AC REHAB       0       6,338,177       0.000000       0.000000       146,172       76.01         76.02       03070       WOMEN'S CENTER       0       4,666,096       0.000000       0.000000       8,01       76.02         03330       ENDSCOPY       0       0       0.000000       0.000000       76.03         00.00       09000       CLI NI C       0       4,544,954       0.000000       0.000000       43,091       90.00         90.01       09001       OUTPATI ENT       ENT SERVI CE COST CENTERS       0       4,834,791       0.000000       0.000000       57,626       90.01         91.00       09101       SHORT STAY       0       0       0.000000       0.000000       1,714,173       91.00         92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49, 171, 038	0.00000	0. 000000		
74.00       07400       RENAL DI ALYSI S       0       345, 121       0.000000       0.000000       168, 382       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0.000000       0.000000       0       76.00         76.01       03140       CARDIA C REHAB       0       6, 338, 177       0.000000       0.000000       146, 172       76.01         76.02       03070       WOMEN'S CENTER       0       4, 666, 096       0.000000       0.000000       8, 401       76.02         76.03       03330       ENDOSCOPY       0       0       0.000000       0.000000       76.03         00TPATI ENT SERVICE COST CENTERS       0       4, 544, 954       0.000000       0.000000       43, 091       90.00         90.00       09000       CLINIC       0       4, 834, 791       0.000000       0.000000       57, 626       90.01         91.00       09101       BUTPATI ENT       0       4, 834, 791       0.000000       0.000000       1, 714, 173       91.00         91.01       09101       SHORT STAY       0       0       0.000000       0.000000       92.00       09200       DESERVATI ON BEDS (NON-DI STI NCT PART)       0       0.000000	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 908, 514	0.00000	0. 000000	895, 175	72.00
76.00         03020         OTHER ANCI LLARY         0         0         0.000000         0.000000         0         76.00         76.00           76.01         03140         CARDI AC REHAB         0         6,338,177         0.000000         0.000000         146,172         76.01           76.02         03070         WOMEN'S CENTER         0         4,666,096         0.000000         0.000000         8,401         76.02           76.03         03330         ENDOSCOPY         0         0         0.000000         0.000000         0         0.000000         0         76.03           00         09000         CLI NI C         0         4,544,954         0.000000         0.000000         43,091         90.00           90.00         09001         OUTPATI ENT         0         4,834,791         0.000000         0.000000         57,626         90.01           91.00         09100         ENEGENCY         0         23,660,523         0.000000         1,714,173         91.01           92.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         3,518,141         0.000000         0.000000         0         92.00           01HER         REI MBURSABLE COST CENTERS         9	73.00 07300 DRUGS CHARGED TO PATIENTS	325, 842	38, 716, 717	0. 00841	6 0.008416	4, 175, 708	73.00
76.00         03020         OTHER ANCI LLARY         0         0         0.000000         0.000000         76.00           76.01         03140         CARDI AC REHAB         0         6,338,177         0.000000         0.000000         146,172         76.01           76.02         03070         WOMEN'S CENTER         0         4,666,096         0.000000         0.000000         8,401         76.02           76.03         03330         ENDOSCOPY         0         0         0.000000         0.000000         0         76.03           0017PATIENT SERVICE COST CENTERS         0         4,544,954         0.000000         0.000000         43,091         90.00           90.00         09001         0UTPATIENT         0         4,834,791         0.000000         0.000000         57,626         90.01           91.01         09101         ENGERCY         0         23,660,523         0.000000         1,714,173         91.01           92.00         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         3,518,141         0.000000         0.000000         0         92.00           01HER REIMBURSABLE COST CENTERS         0         000000         0.000000         0         92.00         0         0.000000	74.00 07400 RENAL DIALYSIS	0	345, 121	0.00000	0. 000000	168, 382	74.00
76.02         03070         WOMEN'S CENTER         0         4,666,096         0.000000         0.000000         8,401         76.02           76.03         0330         ENDOSCOPY         0         0         0.000000         0.000000         0.000000         0         76.03           OUTPATI ENT SERVICE COST CENTERS         0         4,544,954         0.000000         0.000000         43,091         90.00           90.00         09001         OUTPATI ENT         0         4,544,954         0.000000         0.000000         57,626         90.01           91.01         09100         EMERGENCY         0         23,660,523         0.000000         0.000000         1,714,173         91.00           91.01         O9101 SHORT STAY         0         0         0.000000         0.000000         0.000000         0         91.01           92.00         02200 (DBSERVATI ON BEDS (NON-DI STI NCT PART)         0         3,518,141         0.000000         0.000000         0         92.00           95.00         09500 AMBULANCE SERVICES         95.00         95.00	76.00 03020 OTHER ANCI LLARY	0			0. 000000	0	76.00
76.02         03070         WOMEN'S CENTER         0         4,666,096         0.000000         0.000000         8,401         76.02           76.03         03330         ENDOSCOPY         0         0         0.000000         0.000000         0.000000         76.03           0UTPATIENT SERVICE COST CENTERS         0         4,544,954         0.000000         0.000000         43,091         90.00           90.00         09001         0UTPATIENT         0         4,544,954         0.000000         0.000000         57,626         90.01           90.01         09100         EMERGENCY         0         23,660,523         0.000000         0.000000         1,714,173         91.00           91.01         09101         Stort STAY         0         0         0.000000         0.000000         0.000000         0.000000         91.01           92.00         02200 (DBSERVATION BEDS (NON-DI STINCT PART)         0         3,518,141         0.000000         0.000000         0         92.00           95.00         09500         AMBULANCE SERVICES         95.00         95.00	76. 01 03140 CARDI AC REHAB	0	6, 338, 177	0. 00000	0. 000000	146, 172	76.01
OUTPATI ENT         SERVI CE         COST         CENTERS           90. 00         09000         CLI NI C         0         4, 544, 954         0. 000000         0.000000         43,091         90. 00           90. 01         09000         OUTPATI ENT         0         4, 834, 791         0. 000000         0. 000000         57, 626         90. 01           91. 00         09100         EMERGENCY         0         23, 660, 523         0. 000000         0. 000000         1, 714, 173         91. 00           91. 01         09101         STARY         0         0         0. 000000         0. 000000         91. 01           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         3, 518, 141         0. 000000         0. 000000         92. 00           0THER RELIMBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVI CES         95. 00         95. 00	76. 02 03070 WOMEN' S CENTER	0	4, 666, 096	0.00000			76.02
90. 00         09000         CLI NI C         0         4, 544, 954         0. 00000         0. 00000         43, 091         90. 00           90. 01         09001         0UTPATI ENT         0         4, 834, 791         0. 000000         0. 000000         57, 626         90. 01           91. 00         09101         EMERGENCY         0         23, 660, 523         0. 000000         0. 000000         1, 714, 173         91. 00           91. 01         09101         SHORT STAY         0         0         0         0. 000000         0. 000000         0         91. 01           92. 00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0         3, 518, 141         0. 000000         0. 000000         0         92. 00           OTHER RELIMBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVICES         95. 00         95.00         95.00	76. 03 03330 ENDOSCOPY	0	0	0.00000	0. 000000	0	76.03
90. 01         09001         0UTPATI ENT         0         4, 834, 791         0. 00000         0. 000000         57, 626         90. 01           91. 00         09100         EMERGENCY         0         23, 660, 523         0. 000000         0. 000000         1, 714, 173         91. 00           91. 01         09101         SHORT STAY         0         0         0. 000000         0. 000000         0         91. 01           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         3, 518, 141         0. 000000         0. 000000         0         92. 00           0THER         REI MBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVICES         95. 00         95.00         95.00	OUTPATIENT SERVICE COST CENTERS				•		
91.00       09100       EMERGENCY       0       23, 660, 523       0.000000       0.000000       1, 714, 173       91.00         91.01       09101       SHORT STAY       0       0       0.000000       0.000000       0       91.01         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       3, 518, 141       0.000000       0.000000       0       92.00         0THER REIMBURSABLE COST CENTERS       0       09500       AMBULANCE SERVICES       95.00       95.00       95.00       95.00	90. 00 09000 CLINIC	0	4, 544, 954	0.00000	0.00000	43, 091	90.00
91. 01         09101         SHORT STAY         0         0         0.000000         0.000000         0         91. 01           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         3, 518, 141         0.000000         0         92.00         92.00           0THER         REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00	90. 01 09001 OUTPATI ENT	0	4, 834, 791	0.00000	0. 000000	57, 626	90.01
91.01       09101       SHORT STAY       0       0       0.000000       0.000000       0       91.01         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0       3,518,141       0.000000       0.000000       0       92.00         0THER REIMBURSABLE COST CENTERS       0       09500       AMBULANCE SERVICES       95.00       95.00	91. 00 09100 EMERGENCY	0					
92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         3,518,141         0.000000         0         92.00           0THER REIMBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00	91.01 09101 SHORT STAY	0	0	0.00000	0. 000000		
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 518, 141	0.00000	0. 000000	0	
	OTHER REIMBURSABLE COST CENTERS					-	1
200. 00 Total (Lines 50-199) 325, 842 326, 715, 139 37, 826, 699 200. 00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00   Total (lines 50-199)	325, 842	326, 715, 139			37, 826, 699	200.00

lealth Financial Systems		RI VERVI EW F	IOSPI TAL			In Lieu	u of Form CMS	-2552-1
APPORTIONMENT OF INPATIENT/OUTPAT THROUGH COSTS	IENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-0059		eriod: com 01/01/2016 o 12/31/2016	Worksheet D Part IV Date/Time Pr 5/24/2017 3:	
				XVIII		Hospi tal	PPS	
Cost Center Descripti	on	Inpati ent	Outpati ent	Outpati ent	:			
		Program	Program	Program				
		Pass-Through	Charges	Pass-Throug				
		Costs (col. 8		Costs (col.				
		x col. 10)	40.00	x col. 12)				
ANCI LLARY SERVI CE COST CENT	500	11.00	12.00	13.00				_
50. 00 05000 OPERATING ROOM	EKS	0	7, 319, 812		0			50.00
52.00 05200 DELIVERY ROOM & LABOR	DOOM	0	7, 319, 812		0			52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	KUUW	0	3, 339, 739		0			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0	2,077,580		0			55.00
57. 00 05700 CT SCAN		0	2,077,380		0			57.00
57. 01 03630 ULTRA SOUND		0	2, 992, 214		0			57.0
58. 00 05800 MAGNETIC RESONANCE IM	ACINC (MDL)	0	721, 785		0			57.0
59. 00 05900 CARDI AC CATHETERI ZATI		0	4, 435, 780		0			59.00
50. 00 06000 LABORATORY	UN	0			0			60.0
		0	3, 038, 708		0			
		0	0		0			60.0
53. 00 06300 BLOOD STORING, PROCES	SING & TRANS.	0	321, 458		-			63.0
54.00 06400 INTRAVENOUS THERAPY		0	0		0			64.00
55. 00 06500 RESPI RATORY THERAPY		0	340, 001		0			65.0
66.00 06600 PHYSI CAL THERAPY		0	49, 327		0			66.0
57.00 06700 OCCUPATIONAL THERAPY		0	0		0			67.0
58.00 06800 SPEECH PATHOLOGY		0	0		0			68.0
59. 00 06900 ELECTROCARDI OLOGY		0	3, 145, 286		0			69.0
71.00 07100 MEDICAL SUPPLIES CHAR		0	5, 396, 201		0			71.0
72.00 07200 IMPL. DEV. CHARGED TO		0	1, 655, 351		0			72.0
73.00 07300 DRUGS CHARGED TO PATI	ENTS	35, 143	8, 030, 757	67, 5				73.0
74.00 07400 RENAL DIALYSIS		0	0		0			74.0
76.00 03020 OTHER ANCI LLARY		0	0		0			76.0
76.01 03140 CARDI AC REHAB		0	2, 324, 953		0			76.0
76.02 03070 WOMEN'S CENTER		0	281, 646		0			76. 0
76. 03 03330 ENDOSCOPY		0	0		0			76. 0
OUTPATIENT SERVICE COST CEN	ITERS	r						
90. 00 09000 CLI NI C		0	1, 202, 517		0			90.00
90. 01 09001 OUTPATI ENT		0	2,064,370		0			90.0
91.00 09100 EMERGENCY		0	3, 713, 939		0			91.00
91.01 09101 SHORT STAY		0	0		0			91. 0 ⁻
92.00 09200 OBSERVATION BEDS (NON		0	942, 100		0			92. 0
OTHER REIMBURSABLE COST CEN	ITERS							
95.00 09500 AMBULANCE SERVICES								95.00
200.00   Total (lines 50-199)		35, 143	53, 393, 524	67, 5	87			200.00

lealth Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	RI VERVI EW D VACCI NE COST	Provider C	CN: 15-0059	Period:	u of Form CMS-2 Worksheet D	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
				llooni tol	5/24/2017 3:5 PPS	4 pm
			2 XVIII	Hospi tal		
Cost Center Description	Cost to Charge	PPS Reimbursed	Charges Cost	Cost	Costs PPS Services	
cost center bescription	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(300 11131.)	
	Part I, col. 9	· · ·	Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	·					
50.00 05000 OPERATING ROOM	0. 194024	7, 319, 812	)	0 0	1, 420, 219	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 284072	3, 339, 739		0 0	948, 726	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 347392	2, 077, 580		0 0	721, 735	55.00
57.00 05700 CT SCAN	0. 033913	2, 992, 214	Ļ	0 0	101, 475	57.00
57. 01 03630 ULTRA SOUND	0. 000000	0		0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 090804	721, 785		0 0	65, 541	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 085198	4, 435, 780		0 0	377, 920	59.00
50. 00 06000 LABORATORY	0. 200420	3, 038, 708	8	0 0	609, 018	60.00
50. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 491965	321, 458	8	0 0	158, 146	63.00
54.00 06400 INTRAVENOUS THERAPY	0. 000000	0	)	0 0	0	64.00
55. 00 06500 RESPI RATORY THERAPY	0. 267796	340, 001		0 0	91, 051	65.00
56. 00 06600 PHYSI CAL THERAPY	0. 370403	49, 327	7	0 0	18, 271	66.00
57.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
58.00 06800 SPEECH PATHOLOGY	0. 000000		)	0 0	0	68.00
59. 00 06900 ELECTROCARDI OLOGY	0. 174633			0 0	549, 271	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 337586			0 0	1, 821, 682	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 312968			0 0	518, 072	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 394293		7, 10	08 15, 832	3, 166, 471	
74. 00 07400 RENAL DI ALYSI S	0. 990800			0 0	0	74.00
76.00 03020 OTHER ANCI LLARY	0. 000000		)	0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0. 354827			0 0	824, 956	•
76.02 03070 WOMEN'S CENTER	0. 285630			0 0	80, 447	76.02
76. 03 03330 ENDOSCOPY	0. 000000	0	)	0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
20. 00 09000 CLINIC	0. 321811			0 0	386, 983	90.00
20. 01 09001 OUTPATI ENT	0. 303026			0 0	625, 558	
91.00 09100 EMERGENCY	0. 219664			0 0	815, 819	
91.01 09101 SHORT STAY	0. 000000			0 0	0	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 721764	942, 100	1	0 0	679, 974	92.00
OTHER REIMBURSABLE COST CENTERS	0.000000		-			05 65
	0. 000000			0		95.00
95.00 09500 AMBULANCE SERVICES		F0 000 F0.		1 4 5 0 0 0	10 004 005	1000 00
200.00 Subtotal (see instructions)		53, 393, 524	7, 10		13, 981, 335	
		53, 393, 524	7, 10	08 15, 832 0 0	13, 981, 335	200. 00 201. 00

	Financial Systems ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	RI VERVI EW VACCI NE COST	Provi der C	CN: 15-0059	Peri od:	u of Form CMS- Worksheet D	2002 10
					From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	enared
					10 12/01/2010	5/24/2017 3:5	54 pm
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
	D5000 OPERATING ROOM	0	0				50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0					52.00
	D5400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
	D5700 CT SCAN	0	0				57.00
	D3630 ULTRA SOUND	0	0				57.00
	D5800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	0	0				60.00
	06001 BLOOD LABORATORY	0	0				60.01
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	06400 I NTRAVENOUS THERAPY		0				64.00
	06500 RESPIRATORY THERAPY	0	0				65.00
	06600 PHYSI CAL THERAPY	0	0				66.00
	06700 OCCUPATI ONAL THERAPY	0	0				67.00
	06800 SPEECH PATHOLOGY	0	0				68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	2,803	6, 242				73.00
74.00	07400 RENAL DIALYSIS	0	0				74.00
76.00	03020 OTHER ANCI LLARY	0	0				76.00
76.01	D3140 CARDI AC REHAB	0	0				76.01
76.02	D3070 WOMEN'S CENTER	0	0				76.02
76.03	D3330 ENDOSCOPY	0	0				76.03
C	DUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0				90.00
90.01	09001 OUTPATI ENT	0					90.01
	09100 EMERGENCY	0					91.00
	09101 SHORT STAY	0					91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	THER REIMBURSABLE COST CENTERS	1					
	09500 AMBULANCE SERVI CES	0					95.00
200.00	Subtotal (see instructions)	2,803	6, 242				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
000 00	Only Charges	0.000					
202.00	Net Charges (line 200 +/- line 201)	2,803	6, 242				202.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
				From 01/01/2016		
		Component	CCN: 15-T059	To 12/31/2016	Date/Time Pre 5/24/2017 3:5	pared:
		Ti +L c	e XVIII	Subprovider -	PPS	4 pili
		in the		IRF	115	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	U U	· · ·	
	26)	,	, i			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		_				
50.00 05000 OPERATING ROOM	1, 568, 416	56, 472, 228			7, 895	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	582,001	13, 863, 323	0. 04198	82, 894	3, 480	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	340, 661	5, 155, 756	0.06607	74 117	8	55.00
57.00 05700 CT SCAN	4, 704	11, 199, 200	0.00042	20 75, 521	32	57.00
57.01 03630 ULTRA SOUND	0	0	0.0000	0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 819	3, 325, 574	0.00114	18, 003	21	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	146, 239	16, 319, 768	0.00896	70, 718	634	59.00
60. 00 06000 LABORATORY	635, 902			13 794, 504	12, 905	60,00
60. 01 06001 BLOOD LABORATORY	0		0.0000		0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	85, 949	1, 492, 619			1, 109	•
64. 00 06400 I NTRAVENOUS THERAPY	0		0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	102, 137	6, 118, 844				65.00
66. 00 06600 PHYSI CAL THERAPY	105, 916					66.00
67.00 06700 OCCUPATI ONAL THERAPY	0				0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	508, 919	12, 953, 111			2, 694	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	280, 408					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	7, 695					•
73. 00 07300 DRUGS CHARGED TO PATIENTS	373, 747				8, 438	
74. 00 07400 RENAL DIALYSIS	26, 077				6, 076	•
76.00 03020 OTHER ANCI LLARY	20,077				0,0,0	76.00
76. 01 03140 CARDI AC REHAB	93, 100	,			-	76.01
76. 02 03070 WOMEN'S CENTER	381, 226				86	76.02
76. 03 03330 ENDOSCOPY	0					76.02
OUTPATIENT SERVICE COST CENTERS			0.00000	0	<u> </u>	/0.00
90. 00 09000 CLINIC	17, 222	4, 544, 954	0.00378	6, 952	26	90.00
90. 01 09001 0UTPATI ENT	172, 434					
91. 00 09100 EMERGENCY	797, 217				2,040	
91. 01 09101 SHORT STAY	0		0.00000		2,040	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
072.00 07200 003ERVATION BEDS (NON-DISTINCT PART)	0	5, 510, 141	0.0000	0	0	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	6, 233, 789	326, 715, 139		7, 026, 494	75, 738	
200.00   10tul (11103 00-177)	0,200,709	1 520, 113, 137	I	1, 020, 494	1 15,150	1200.00

Heal th	Financial Systems	RIVERVIEW H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUG	GH COSTS		Component	CCN: 15-T059	From 01/01/2016 To 12/31/2016		narod
			component	CCN. 15-1059	10 12/31/2010	5/24/2017 3:5	4 nm
			Title	XVIII	Subprovider -	PPS	- p
					' I RF		
	Cost Center Description	Non Physician N	ursing School	Allied Healt	h All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00	05000 OPERATING ROOM	0	C		0 0		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
57.00	05700 CT SCAN	0	0		0 0	0	57.00
57.01	03630 ULTRA SOUND	0	C		0 0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	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 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	1
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0			0 0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	325, 8		325, 842	
74.00	07400 RENAL DIALYSIS	0	0	525,0		323, 042	1
74.00	03020 OTHER ANCI LLARY	0	0			0	
76.01	03140 CARDI AC REHAB	0	0			0	1
76.02	03070 WOMEN' S CENTER	0	0		0 0	-	
	03330 ENDOSCOPY	0	0			-	
70.05	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0	0	70.03
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.00 90.01	09001 OUTPATI ENT	0	0		0	0	
90.01 91.00	09100 EMERGENCY	0				0	
91.00 91.01	09101 SHORT STAY	0				0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	1	<u> </u>	0	72.00
95.00							95.00
200.00		0	C	325, 8	42 0	325, 842	
200.00		I U	U	1 323, 0	42  U	J 323, 042	1200.00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN 15 0050		u of Form CMS-2	2002-1
	RVICE UTHER PAS	S Provider C	UN: 15-0059	Period: From 01/01/2016	Worksheet D Part IV	
HROUGH COSTS		Component (	CCN: 15-T059	To 12/31/2016		pared.
		componente			5/24/2017 3:5	4 pm
		Ti tl e	e XVIII	Subprovider -	PPS	
Cost Center Description	Total	Total Charges	Patio of Cos	I RF t Outpatient	Inpati ent	
Cost Center Description	Outpatient	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	$(col. 5 \div col$		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	charges	
	4)	0)	,,	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS			•			
0.00 05000 OPERATI NG ROOM	0	56, 472, 228	0.0000		284, 264	50.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0. 000000	0	52.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	13, 863, 323	0.0000	0. 000000	82, 894	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	5, 155, 756	0.0000	0. 000000	117	55.00
7.00 05700 CT SCAN	0	11, 199, 200	0.0000	0. 000000	75, 521	57.00
7.01 03630 ULTRA SOUND	0	0	0.0000	0. 000000	0	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 325, 574	0.0000	0. 000000	18, 003	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	16, 319, 768	0.0000	0. 000000	70, 718	59.0
0. 00 06000 LABORATORY	0	39, 150, 240	0.0000	0. 000000	794, 504	60.00
0.01 06001 BLOOD LABORATORY	0	0	0.0000	0. 000000	0	60. 0 [.]
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 492, 619	0.0000	0. 000000	19, 252	63.00
4.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	0. 000000	0	64.0
5. 00 06500 RESPI RATORY THERAPY	0	6, 118, 844	0.0000	0. 000000	516, 947	65.0
6. 00 06600 PHYSI CAL THERAPY	0	20, 960, 404	0.0000	0. 000000	3, 439, 553	66.0
7.00 06700 OCCUPATIONAL THERAPY	0	0	0.0000	0. 000000	0	67.0
8.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0. 000000	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	12, 953, 111	0. 00000	0. 000000	68, 559	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49, 171, 038	0.0000	0. 000000	559, 383	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 908, 514	0.0000	0. 000000	32, 189	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	325, 842	38, 716, 717	0. 00841	0. 008416	874, 131	73.0
4.00 07400 RENAL DIALYSIS	0	345, 121	0.00000	0. 000000	80, 414	74.0
6.00 03020 OTHER ANCI LLARY	0	0	0.0000	0. 000000	0	76.0
6. 01 03140 CARDI AC REHAB	0	6, 338, 177	0.00000	0. 000000	21, 368	76.0
6.02 03070 WOMEN'S CENTER	0	4, 666, 096	0.0000	0. 000000	1, 047	76.0
6. 03 03330 ENDOSCOPY	0	0	0.0000	0. 000000	0	76.0
OUTPATIENT SERVICE COST CENTERS						1
0. 00 09000 CLINIC	0	4, 544, 954	0.0000	0. 000000	6, 952	90.0
0. 01 09001 OUTPATI ENT	0	4, 834, 791	0.0000	0. 000000	20, 124	90.0
1.00 09100 EMERGENCY	0	23, 660, 523	0.0000	0. 000000	60, 554	91.0
1.01 09101 SHORT STAY	0	0	0.0000	0. 000000	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 518, 141	0.0000	0. 000000	0	92.0
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES						95.00
00.00 Total (lines 50-199)	325, 842	326, 715, 139			7, 026, 494	200.00

Heal th	Financial Systems	RIVERVIEW H	OSPI TAL		. In L	ieu of Form CMS-2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-0059	Peri od:	Worksheet D
THROUG	H COSTS		Component	CCN: 15-T059	From 01/01/20 To 12/31/20	
			Title	e XVIII	Subprovider - IRF	- PPS
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
		Program	Program	Program		
		Pass-Through	Charges	Pass-Throug		
		Costs (col. 8		Costs (col.	9	
		x col. 10)		x col. 12)		
		11.00	12.00	13.00		
	ANCI LLARY SERVI CE COST CENTERS	-		1	-1	
	05000 OPERATI NG ROOM	0	C		0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	C		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	C	)	0	55.00
	05700 CT SCAN	0	C	)	0	57.00
	03630 ULTRA SOUND	0	C		0	57.01
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0	59.00
60.00	06000 LABORATORY	0	C		0	60.00
60. 01	06001 BLOOD LABORATORY	0	C		0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	C	)	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	C	)	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C	)	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	)	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C	)	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C	)	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C	)	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,357	C		0	73.00
74.00	07400 RENAL DIALYSIS	0	C		0	74.00
76.00	03020 OTHER ANCILLARY	0	C		0	76.00
	03140 CARDI AC REHAB	0	C		0	76.01
76.02	03070 WOMEN'S CENTER	0	C		0	76. 02
76.03	03330 ENDOSCOPY	0	C	)	0	76.03
	OUTPATIENT SERVICE COST CENTERS			_		
	09000 CLI NI C	0	C	)	0	90.00
90.01	09001 OUTPATI ENT	0	C		0	90.01
91.00	09100 EMERGENCY	0	C		0	91.00
91.01	09101 SHORT STAY	0	C		0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES					95.00
200.00	Total (lines 50-199)	7,357	C		0	200.00

Health Financial Systems	RI VERVI EW HC	SPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA	RY SERVICE OTHER PASS	Provider CC		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016	Part IV	
		Component C	CN: 15-5669	To 12/31/2016	Date/Time Pre 5/24/2017 3:5	epared:
		Titlo	XVIII	Skilled Nursing	PPS	14 pili
		nue	AVIII	Facility	FFJ	
Cost Center Description	Non Physician Nu	irsing School	Allied Healt		Total Cost	
obst benter beschiption	Anesthetist	a strig benoor	ni i i cu noui ti	Medi cal	(sum of col 1	
	Cost			Educati on Cost	•	
	0031				4)	
	1.00	2.00	3,00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
57. 01 03630 ULTRA SOUND	0	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0	0	
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS		0		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	INTS 0	0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	325, 84	2 0	325, 842	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	
76.00 03020 OTHER ANCI LLARY	0	0		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0	0		0 0	0	76.01
76.02 03070 WOMEN' S CENTER	0	0		0 0	0	76.02
76. 03 03330 ENDOSCOPY	0	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	· · ·					1
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 OUTPATI ENT	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
91.01 09101 SHORT STAY	0	0		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART) 0	О		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	325, 84	2 0	325, 842	200.00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN. 15 0050	Period:	u of Form CMS-2 Worksheet D	2552-1
PPORTIONMENT OF INPATIENT/OUTPATIENT ANGILLARY SET HROUGH COSTS	RVICE UTHER PASS	S Provider C	CN: 15-0059	From 01/01/2016	Part IV	
HKUUGH CUSIS		Component	CCN: 15-5669	To 12/31/2016	Date/Time Pre	pared:
		•			5/24/2017 3:5	4 pm
		Title	e XVIII	Skilled Nursing	PPS	
	Tatal	Total Charges		Facility t Outpatient	Inpati ent	
Cost Center Description	Total Outpatient	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and		7)	$(col. 6 \div col.$	chai ges	
	4)	0)	,,	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS						
0. 00 05000 OPERATING ROOM	0	56, 472, 228	0.0000	0.00000	0	50. 0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0. 000000	0	52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0				28, 756	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0				0	
7.00 05700 CT SCAN	0				0	57.0
7.01 03630 ULTRA SOUND	0				0	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 325, 574			0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0		1		4, 137	59.0
0. 00 06000 LABORATORY	0	39, 150, 240	1		1,002,662	60. C
0.01 06001 BLOOD LABORATORY	0				0	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 492, 619	0.0000	0. 000000	0	63. C
4.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	0. 000000	0	64.0
5. 00 06500 RESPI RATORY THERAPY	0	6, 118, 844	0.0000	0. 000000	236, 361	65. C
6. 00 06600 PHYSI CAL THERAPY	0	20, 960, 404	0.00000	0. 000000	1, 355, 490	66.0
7.00 06700 OCCUPATIONAL THERAPY	0	0	0.0000	0. 000000	0	67. C
8.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0. 000000	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	12, 953, 111	0.00000	0. 000000	0	69. C
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49, 171, 038	0.0000	0. 000000	45, 724	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 908, 514	0.0000	0. 000000	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	325, 842	38, 716, 717	0. 00841	6 0.008416	859, 419	73. C
4.00 07400 RENAL DIALYSIS	0	345, 121	0.00000	0. 000000	0	74.0
6.00 03020 OTHER ANCILLARY	0	0	0.0000	0. 000000	0	76.0
6. 01 03140 CARDI AC REHAB	0	6, 338, 177	0.0000	0. 000000	21, 382	76.0
6.02 03070 WOMEN'S CENTER	0	4, 666, 096	0.0000	0. 000000	31	76.0
6. 03 03330 ENDOSCOPY	0	0	0.0000	0. 000000	0	76. C
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	4, 544, 954	0.0000	0.00000	13	90.0
0. 01 09001 OUTPATI ENT	0	4, 834, 791	0.00000	0. 000000	0	90.0
1.00 09100 EMERGENCY	0	23, 660, 523	0.00000		0	91. C
1.01 09101 SHORT STAY	0	0	0.0000	0. 000000	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 518, 141	0.0000	0. 000000	0	92.0
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES						95.0
00.00 Total (lines 50-199)	325, 842	326, 715, 139			3, 553, 975	200.0

THROUGH COSTS         From 01/01/2016         Part           Component CCN: 15-5669         To         12/31/2016         Date/	heet D IV Time Prepared: 2017 3:54 pm PPS
Component CCN: 15-5669     To     12/31/2016     Date/5/24/5/24/       Title XVIII     Skilled Nursing Facility       Cost Center Description     Inpatient Program Program Program Program Program Program Program Pass-Through Costs (col. 8 x col. 10)     Date/5/24/       11.00     12.00     13.00	Time Prepared: 2017 3:54 pm
Title XVIIISkilled Nursing FacilityCost Center DescriptionInpatient ProgramOutpatient ProgramOutpatient ProgramProgram Pass-Through Costs (col. 8 x col. 10)Program Pass-Through Costs (col. 9 x col. 12)Facility	
Cost Center DescriptionInpatient ProgramOutpatient ProgramOutpatient ProgramPass-Through Costs (col. 8Charges Costs (col. 9 X col. 10)Pass-Through Costs (col. 9 X col. 12)	
ProgramProgramProgramPass-ThroughChargesPass-ThroughCosts (col. 8Costs (col. 9x col. 10)x col. 12)11.0012.0013.00	
Pass-Through Costs (col. 8 x col. 10)         Charges Costs (col. 9 x col. 12)         Pass-Through Costs (col. 9 x col. 12)           11.00         12.00         13.00	
Costs (col.         8         Costs (col.         9           x col.         10)         x col.         12)           11.00         12.00         13.00	
x col. 10)         x col. 12)           11.00         12.00         13.00	
11.00 12.00 13.00	
ANCLELARY SERVICE COST CENTERS	
	F0.00
50. 00 05000 OPERATING ROOM 0 0 0	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 0 0 0	52.00
54. 00   05400   RADI 0LOGY-DI AGNOSTI C 0 0 0	54.00
55. 00   05500  RADI OLOGY-THERAPEUTI C 0 0 0	55.00
57. 00 05700 CT SCAN 0 0 0	57.00
57. 01 03630 ULTRA SOUND 0 0	57.01
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0	59.00
60. 00 06000 LABORATORY 0 0 0	60.00
60. 01 06001 BLOOD LABORATORY 0 0 0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0	64.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0	65.00
66.00 06600 PHYSI CAL THERAPY 0 0 0	66.00
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 7,233 0 0	73.00
74. 00 07400 RENAL DI ALYSI S 0 0 0	74.00
76.00 03020 OTHER ANCI LLARY 0 0 0	76.00
76. 01 03140 CARDI AC REHAB 0 0 0	76.01
76. 02 03070 WOMEN'S CENTER 0 0 0	76.02
76. 03 03330 ENDOSCOPY 0 0 0	76.03
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0 0	90.00
90. 01 09001 OUTPATI ENT 0 0	90.01
91. 00 09100 EMERGENCY 0 0 0	91.00
91. 01 09101 SHORT STAY 0 0 0	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0	92.00
OTHER REIMBURSABLE COST CENTERS	
95.00 O9500 AMBULANCE SERVICES	95.00
200.00   Total (lines 50-199) 7,233 0 0	200.00

	Financial Systems RIVERVIEW HOS ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period: From 01/01/2016	u of Form CMS-2 Worksheet D-1	
		Title XVIII	To 12/31/2016 Hospi tal	Date/Time Pre 5/24/2017 3:5 PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		<b>I</b>		
00	Inpatient days (including private room days and swing-bed days			15, 302	1.
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		ivate room days,	15, 302 0	2
00	do not complete this line.	ad dave)	-	10 077	4
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	13, 277 0	5
00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	n davs) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	- ·		5, 276	9
	newborn days)	0			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)	5 .	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI> through December 31 of the cost reporting period	K only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13
	Medically necessary private room days applicable to the Progra			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	5		0.00	
	reporting period				
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	19, 188, 156 0	21 22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	na period (line	0	24
	7 x line 19) Swing-bed cost applicable to NF type services after December 3			0	
	x line 20)		, per lou (i ne o		
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		0 19, 188, 156	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- TTHE 28)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lir		/	0.00	
	Private room cost differential adjustment (line 3 x line 35)	-		0	36
	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	19, 188, 156	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		I	1 252 0/	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 253. 96 6, 615, 893	
	Medically necessary private room cost applicable to the Progra			0, 013, 075	
				0	

OMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Peric	od:   Worksheet D-1 01/01/2016	1
		12/31/2016 Date/Time Pre 5/24/2017 3:5	
Cast Caster Description		ospital PPS	
Cost Center Description	Inpatient CostInpatient DaysDiem (col. 1 ÷	ogram Days Program Cost (col. 3 x col.	
	col. 2)           1.00         2.00         3.00	4.00 5.00	+
2.00 NURSERY (title V & XIX only)	0 0 0.00	0 0	) 42.
Intensive Care Type Inpatient Hospital Units			
3. 00 INTENSIVE CARE UNIT 4. 00 CORONARY CARE UNIT	4, 119, 136 2, 379 1, 731. 46	1, 103 1, 909, 800	0 43. 44.
5. 00 BURN INTENSIVE CARE UNIT			44.
5. 00 SURGICAL INTENSIVE CARE UNIT			46.
7. 00 OTHER SPECIAL CARE (SPECIFY)			47.
Cost Center Description		1.00	-
3.00 Program inpatient ancillary service cost (Wk	st. D-3, col. 3, line 200)	9, 887, 267	7 48.
9.00 Total Program inpatient costs (sum of lines		18, 412, 960	) 49.
PASS THROUGH COST ADJUSTMENTS			1 50
0.00 Pass through costs applicable to Program inp (111)	atient routine services (from Wkst. D, sum of F	Parts I and 1,662,590	50.
	atient ancillary services (from Wkst. D, sum of	Parts II 657, 087	51.
and IV)			
2.00  Total Program excludable cost (sum of lines 3.00  Total Program inpatient operating cost exclu	50 and 51) ding capital related, non-physician anesthetist	2, 319, 677 and 16, 093, 283	
medical education costs (line 49 minus line		, and 10, 093, 283	5 53.
TARGET AMOUNT AND LIMIT COMPUTATION			
4.00 Program di scharges		0	
5.00 Target amount per discharge 5.00 Target amount (line 54 x line 55)		0.00	) 55. ) 56.
	ng cost and target amount (line 56 minus line		
3.00 Bonus payment (see instructions)	<u> </u>	0	
	porting period ending 1996, updated and compour	nded by the 0.00	59.
market basket 0.00 Lesser of lines 53/54 or 55 from prior year	cost report undated by the market basket	0.00	60.
	s 55, 59 or 60 enter the lesser of 50% of the a		
	n expected costs (lines 54 x 60), or 1% of the	target	
amount (line 56), otherwise enter zero (see 2.00 Relief payment (see instructions)	nstructions)	0	62.
3.00 Allowable Inpatient cost plus incentive paym	ent (see instructions)		
PROGRAM INPATIENT ROUTINE SWING BED COST			
4.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through December 31 of the cost reporting pe	eriod (See 0	64.
	ts after December 31 of the cost reporting peri	od (See 0	65.
instructions)(title XVIII only)			
	ne costs (line 64 plus line 65)(title XVIII onl	y). For 0	66.
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient routir	e costs through December 31 of the cost reporti	ng period 0	67.
(line 12 x line 19)			
	e costs after December 31 of the cost reporting	period 0	) 68.
(line 13 x line 20) 9.00  Total title V or XIX swing-bed NF inpatient	coutine costs (line 67 + line 68)	0	69.
PART III - SKILLED NURSING FACILITY, OTHER N	· · ·	0	<u> </u>
0.00 Skilled nursing facility/other nursing facil			70.
1.00 Adjusted general inpatient routine service of			71.
<ol> <li>Program routine service cost (line 9 x line</li> <li>Medically necessary private room cost applic</li> </ol>			72.
4.00 Total Program general inpatient routine serv			74.
	routine service costs (from Worksheet B, Part I	I, column	75.
26, line 45) 6.00 Per diem capital-related costs (line 75 ÷ li	ne 2)		76.
6.00  Per diem capital-related costs (line 75 ÷ li 7.00  Program capital-related costs (line 9 x line	•		77.
3.00 Inpatient routine service cost (line 74 minu			78.
9.00 Aggregate charges to beneficiaries for exces	• • •	70)	79.
0.00 Total Program routine service costs for comp 1.00 Inpatient routine service cost per diem limi	arison to the cost limitation (line 78 minus li tation	ne /9)	80.
2.00 Inpatient routine service cost per drem finn			82.
. 00 Reasonable inpatient routine service costs (			83.
1.00 Program inpatient ancillary services (see in			84.
5.00 Utilization review - physician compensation			85.
6.00 Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS			86.
7.00 Total observation bed days (see instructions		2, 025	5 87.
8.00 Adjusted general inpatient routine cost per 9.00 Observation bed cost (line 87 x line 88) (se	· · · · · · · · · · · · · · · · · · ·	1, 253. 96	
	A THE PERCENT OFFICE	2, 539, 269	1 89.

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1		
				From 01/01/2016 To 12/31/2016		pared: 4 pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	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, 854, 121	19, 188, 156	0. 20085	9 2, 539, 269	510, 035	90.00	
91.00 Nursing School cost	0	19, 188, 156	0.00000	0 2, 539, 269	0	91.00	
92.00 Allied health cost	0	19, 188, 156	0.00000	0 2, 539, 269	0	92.00	
93.00 All other Medical Education	0	19, 188, 156	0. 00000	0 2, 539, 269	0	93.00	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Peri od:	Worksheet D-1	
		Component CCN: 15-T059	From 01/01/2016 To 12/31/2016	Date/Time Prep 5/24/2017 3:54	
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS			5.0(4	
	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			5, 964 5, 964	1
	Private room days (excluding private room days, excluding swing Private room days (excluding swing-bed and observation bed d		ivate room davs	5, 964	
00	do not complete this line.		rvato room dayo,	0	ľ
00	Semi-private room days (excluding swing-bed and observation	bed days)		5, 964	4
00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private r	nom dave) after December	21 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	oom days) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Brogram (oveluding	swing bod and	4, 088	9
	newborn days)		Swing-bed and	4,000	`
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instru		-		
	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
. 00	through December 31 of the cost reporting period		c room days)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar				
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
	SWING BED ADJUSTMENT			0	
	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31 o	f the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
	reporting period			0100	
	Total general inpatient routine service cost (see instructio	·		4, 559, 624	
. 00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost report	ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reportin	a period (line 6	0	23
. 00	x line 18)		g period (inte o	0	20
. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swime had and any include to NE type any include Star December			0	0
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 Of the cost reporting	period (inne 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 559, 624	27
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		<u>,</u>		
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	ed and observation bed ch	arges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)	·		0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)		+:>	0.00	
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l		tions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	30
	General inpatient routine service cost net of swing-bed cost		fferential (line	4, 559, 624	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			764 50	20
	Adjusted general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x lin			764. 52 3, 125, 358	
	Medically necessary private room cost applicable to the Prog			0, 120, 300	
. 00 1					

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	RI VERVI EW HO		CN: 15-0059	Peri od:	eu of Form CMS- Worksheet D-1	
			CCN: 15-T059	From 01/01/2016 To 12/31/2016	Date/Time Pre	epare
		Title	e XVIII	Subprovider -	5/24/2017 3:5 PPS	54 pm
Cost Contor Description	Total	Total	Average Der	IRF Program Days	Drogram Cost	
Cost Center Description	Inpatient Costlr	npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	) 42.
Intensive Care Type Inpatient Hospital U	-		<u> </u>	50 0		/ 42.
B. OO INTENSIVE CARE UNIT	0	C	0.	0 00	C	
. OO CORONARY CARE UNIT . OO BURN INTENSIVE CARE UNIT						44
. 00 SURGICAL INTENSIVE CARE UNIT						46
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			2, 334, 869	9 48
.00 Total Program inpatient costs (sum of li	nes 41 through 48)(se	e instructio	ons)		5, 460, 227	49
PASS THROUGH COST ADJUSTMENTS 00 Pass through costs applicable to Program	innationt routing s	prvicos (from	wket D cu	n of Parts L and	478, 460	50
			n wkst. D, Su		470,400	
.00 Pass through costs applicable to Program	n inpatient ancillary	services (fr	rom Wkst. D, s	sum of Parts II	83, 095	5 51
and IV) .00 Total Program excludable cost (sum of li	nes 50 and 51)				561, 555	5 52
3.00 Total Program inpatient operating cost e		ated, non-phy	ysician anestl	netist, and	4, 898, 672	
medical education costs (line 49 minus l	ine 52)					_
TARGET AMOUNT AND LIMIT COMPUTATION						54
. 00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					0	
.00 Difference between adjusted inpatient op .00 Bonus payment (see instructions)	erating cost and tar	get amount (I	ine 56 minus	line 53)		
00 Lesser of lines 53/54 or 55 from the cos	t reporting period e	nding 1996, ι	updated and co	ompounded by the		
market basket						
0.00 Lesser of lines 53/54 or 55 from prior y 1.00 If line 53/54 is less than the lower of				the amount by	0.00	
which operating costs (line 53) are less						
amount (line 56), otherwise enter zero (	see instructions)					
<ul><li>2.00 Relief payment (see instructions)</li><li>3.00 Allowable Inpatient cost plus incentive</li></ul>	payment (see instruc	tions)				
PROGRAM INPATIENT ROUTINE SWING BED COST					-	
4.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	e costs through Decem	per 31 of the	e cost reporti	ng period (See	0	64
5.00 Medicare swing-bed SNF inpatient routine	e costs after Decembe	- 31 of the d	cost reporting	g period (See	0	65
instructions)(title XVIII only)						
5.00 Total Medicare swing-bed SNF inpatient r CAH (see instructions)	outine costs (line 6	1 plus line 6	55)(title XVI	l only). For	C	) 66
7.00 Title V or XIX swing-bed NF inpatient ro	outine costs through I	December 31 d	of the cost re	eporting period	0	67
(line 12 x line 19)						
3.00 Title V or XIX swing-bed NF inpatient ro (line 13 x line 20)	outine costs after De	cember 31 of	the cost repo	orting period	C	68
2.00 Total title V or XIX swing-bed NF inpati	ent routine costs (li	ne 67 + line	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTH						
<ul> <li>00 Skilled nursing facility/other nursing f</li> <li>00 Adjusted general inpatient routine servi</li> </ul>				)		70
. 00 Program routine service cost (line 9 x l			_,			72
. 00 Medically necessary private room cost ap		•	,			73
1.00 Total Program general inpatient routine 5.00 Capital-related cost allocated to inpati	-			Part II. column		74
26, line 45)						
. 00 Per diem capital -related costs (line 75						76
.00 Program capital-related costs (line 9 x .00 Inpatient routine service cost (line 74	· · · · · · · · · · · · · · · · · · ·					77
. 00 Aggregate charges to beneficiaries for e		ovider record	(st			79
.00 Total Program routine service costs for	•	st limitatior	ו (line 78 mi)	nus line 79)		80
.00 Inpatient routine service cost per diem .00 Inpatient routine service cost limitatio						81
00 Reasonable inpatient routine service cost rum tarte		)				83
.00 Program inpatient ancillary services (se	e instructions)					84
.00 Utilization review - physician compensat .00 Total Program inpatient operating costs						85
D. 00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		Jugn 65)				-  °°
7.00 Total observation bed days (see instruct	i ons)				0	
8.00 Adjusted general inpatient routine cost 9.00 Observation bed cost (line 87 x line 88)		ine 2)			0.00	
. of Longer Agricult new cost (THE 0/ X THE 08)	(SEE THELTUCETURE)				1 0	) 89

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
		Component (		To 12/31/2016		
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	698, 047	4, 559, 624	0. 15309	3 0	0	90.00
91.00 Nursing School cost	0	4, 559, 624	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 559, 624	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 559, 624	0. 00000	0 0	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-5669	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre	
		Ti tle XVIII	Skilled Nursing	5/24/2017 3: 54 PPS	
	Cost Center Description		Facility		
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			4, 246	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line.		ivate room days,	4, 246 0	2. 3.
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	4, 246 0	
00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc reporting period			0	7
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable t newborn days)	0 . 0	Ū.	3, 093	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of	ctions)		0	
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)			
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	5 . 51	5 /	0	
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	year, enter 0 on this lin	e)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0 0	
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	f the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18
	Medicaid rate for swing-bed NF services applicable to service reporting period	C		0.00	
	Medicaid rate for swing-bed NF services applicable to service reporting period		he cost	0.00	
00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ing period (line	3, 304, 843 0	
00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	g period (line 6	0	23
00	Swing-bed cost applicable to NF type services through December 7 x line 19) $$			0	
00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	
00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 3, 304, 843	
00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)	Line 28)		0	
00 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IINE 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	3, 304, 843	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			
00	Adjusted general inpatient routine service cost per diem (see				38
. 00		- /			
	Program general inpatient routine service cost (line 9 x line	e 38)			39

alth Financial Systems DMPUTATION OF INPATIENT OPERATING COST	RI VERVI EW	Provider C	CN: 15-0059	Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-5669	From 01/01/2016 To 12/31/2016	Date/Time Pre	eparec
		Title	XVIII	Skilled Nursing	5/24/2017 3:5 PPS	54 pm
				Facility		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.0
3. 00 INTENSIVE CARE UNIT	5					43.
4. 00 CORONARY CARE UNI T						44.
5. 00 BURN INTENSIVE CARE UNIT						45.
5. 00 SURGI CAL I NTENSI VE CARE UNI T 7. 00 OTHER SPECI AL CARE (SPECI FY)						46. 47.
Cost Center Description						47.
3.00 Program inpatient ancillary service cost (W	ket D 2 col 2	Line 200)			1.00	48.
3.00  Program inpatient ancillary service cost (W 9.00  Total Program inpatient costs (sum of lines			ns)			40. 49.
PASS THROUGH COST ADJUSTMENTS						
D. 00 Pass through costs applicable to Program in [111]	patient routine	services (from	Wkst. D, su	m of Parts I and		50.0
1.00 Pass through costs applicable to Program in	patient ancillar	y services (fr	om Wkst. D,	sum of Parts II		51.
and IV)						
2.00 Total Program excludable cost (sum of lines 3.00 Total Program inpatient operating cost excl		lated non nhu	cician anost	botist and		52. 53.
medical education costs (line 49 minus line		rated, non-phy	Si ci all'alles t	netist, and		55.
TARGET AMOUNT AND LIMIT COMPUTATION						
4.00 Program discharges 5.00 Target amount per discharge						54. 55.
5.00 Target amount (line 54 x line 55)						56.
7.00 Difference between adjusted inpatient opera	ting cost and ta	rget amount (I	ine 56 minus	line 53)		57.
B. 00 Bonus payment (see instructions)	-	-				58.
2.00 Lesser of lines 53/54 or 55 from the cost r	eporting period	endi ng 1996, u	pdated and c	ompounded by the		59.
market basket 0.00 Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the m	arket basket			60.
1.00   fline 53/54 is less than the lower of lin	es 55, 59 or 60	enter the less	er of 50% of	the amount by		61.
which operating costs (line 53) are less th		s (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (see 2.00 Relief payment (see instructions)	mstructrons)					62.
3.00 Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)				63.
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine co	ata through Dooo	mbor 21 of the	aget report	ing pariod (Cao		64.
4.00 Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through bece		cost report	ing period (see		04.
5.00 Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reportin	g period (See		65.
instructions)(title XVIII only) 5.00  Total Medicare swing-bed SNF inpatient rout	ino costa (lino	64 plus lips 6	E) (+; +  o X)/I			66.
CAH (see instructions)	The costs (The	04 prus rifie o	5)(title XVI	ri oniy). Toi		00.
7.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost r	eporting period		67.
(line 12 x line 19) 3.00 Title V or XIX swing-bed NF inpatient routi	no coste aftor D	ocombor 21 of	the cost ron	orting poriod		68.
(line 13 x line 20)	ne costs arter b	ecember 31 01	the cost rep	or tring period		00.
9.00 Total title V or XIX swing-bed NF inpatient						69.
PART III - SKILLED NURSING FACILITY, OTHER I D. 00 Skilled nursing facility/other nursing faci				)	3, 304, 843	70.
1.00 Adjusted general inpatient routine service				)	3, 304, 843	
2.00 Program routine service cost (line 9 x line					2, 407, 406	72.
3.00 Medically necessary private room cost appli	U U	•	ne 35)		0	
4.00  Total Program general inpatient routine ser 5.00  Capital-related cost allocated to inpatient	•		orksheet B	Part II. column	2, 407, 406 0	
26, line 45)		55515 (110m W				
5.00 Per diem capital -related costs (line 75 ÷ I					0.00	
7.00 Program capital-related costs (line 9 x lin 3.00 Inpatient routine service cost (line 74 min					0	
9.00 Aggregate charges to beneficiaries for exce		rovi der record	s)		0	
0.00 Total Program routine service costs for com	parison to the c			nus line 79)	0	80.
I.00 Inpatient routine service cost per diem lim		<b>`</b>			0.00	
<ol> <li>2.00  Inpatient routine service cost limitation (</li> <li>3.00  Reasonable inpatient routine service costs</li> </ol>		· .			0 2, 407, 406	
4.00 Program inpatient ancillary services (see i	•	-,			1, 136, 749	
5.00 Utilization review - physician compensation	(see instructio				0	85.
5.00 Total Program inpatient operating costs (su		rough 85)			3, 544, 155	86.
PART IV - COMPUTATION OF OBSERVATION BED PA 7.00 Total observation bed days (see instruction					0	87.
8.00 Adjusted general inpatient routine cost per		line 2)				88.
	ee instructions)					89.

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2016	Worksheet D-1	
		Component (	CCN: 15-5669	To 12/31/2016		
		Ti tl e	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	0	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 HOS ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period: From 01/01/2016	u of Form CMS-2 Worksheet D-1	
			To 12/31/2016	Date/Time Pre 5/24/2017 3:5	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				1
00	Inpatient days (including private room days and swing-bed days			15, 302	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		rivate room days	15, 302 0	
	do not complete this line.		rvate room aays,		
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		er 31 of the cost	13, 277 0	4
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	316	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 21 of the east separating period (see instrum		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of	nly (including private r	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progra			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	C		0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period			0.00	
	Medicaid rate for swing-bed NF services applicable to services reporting period	0		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		the cost	0.00	
. 00 . 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December 5 x line 17)	·	ing period (line	19, 188, 156 0	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	g period (line 8	0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 19, 188, 156	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)		-	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 min		ctions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 19, 188, 156	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see			1, 253. 96	38
	Program general inpatient routine service cost (line 9 x line	-		396, 251	
	Medically necessary private room cost applicable to the Progra			0	
	Total Program general inpatient routine service cost (line 39	+ iine 40)		396, 251	1 47

NIPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0059	Peri od:	u of Form CMS- Worksheet D-	
					From 01/01/2016 To 12/31/2016		epare
						5/24/2017 3:5	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center beschiption	Inpatient Costlr				(col. 3 x col.	
				col. 2)		4)	
00		1.00	2.00	3.00	4.00	5.00	1 40
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	0 00	<u> </u>	42
00	INTENSIVE CARE UNIT	4, 119, 136	2, 379	1, 731.	46 0	(	5 43
. 00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	+
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			312, 213	
. 00	Total Program inpatient costs (sum of lines 4	11 through 48)(s	ee instructio	ns)		708, 464	49
00	PASS THROUGH COST ADJUSTMENTS			What D av			
. 00	Pass through costs applicable to Program inpa	atient routine so	ervices (Trom	WKST. D, SU	n or Parts I and		50
. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51
	and IV)	5		-			
. 00	Total Program excludable cost (sum of lines 5						52
8. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		ated, non-phy	sıcıan anestl	netist, and	(	53
	TARGET AMOUNT AND LIMIT COMPUTATION	JZ J					
. 00	Program di scharges					(	54
. 00	Target amount per discharge					0.00	55
. 00	Target amount (line 54 x line 55)						56
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ıne 56 minus	line 53)		) 57 ) 58
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period e	nding 1996 u	ndated and co	omnounded by the		
. 00	market basket	boi tring period ei	nuring 1770, u		shipounded by the	0.00	
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, upda	ated by the m	arket basket		0.00	0 60
. 00	If line 53/54 is less than the lower of lines					(	) 61
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% o	f the target		
. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)					0 62
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				0 63
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64
. 00	instructions)(title XVIII only)	te after December	r 21 of the e	act reporting	a pariod (Saa		0 65
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)			ost reportinț	g period (see		00
. 00	Total Medicare swing-bed SNF inpatient routir	ne costs (line 64	4 plus line 6	5)(title XVI	I only). For	0	66 (
	CAH (see instructions)				•		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through I	December 31 o	f the cost re	eporting period	(	) 67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost ren	orting period		68 10
. 00	(line 13 x line 20)			the cost rep	bi ting period		
. 00	Total title V or XIX swing-bed NF inpatient r	routine costs (li	ine 67 + line	68)		0	) 69
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	
. 00	Skilled nursing facility/other nursing facili	2			)		70
. 00 . 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ne /0 ÷ i i ne	2)			71
. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient r	routine service (	costs (from W	orksheet B, I	Part II, column		75
00	26, line 45)	2)					-,
. 00 . 00	Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	,	ovider record	s)			79
00	Total Program routine service costs for compa	arison to the co			nus line 79)		80
00	Inpatient routine service cost per diem limit						81
00	Inpatient routine service cost limitation (li		\ \				82
. 00 . 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		)				83
. 00	Utilization review - physician compensation (		s)				85
. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	5 THROUGH COST					
	Total observation bed days (see instructions)	)				2, 025	
7.00 8.00	Adjusted general inpatient routine cost per o	11 om (11 07	11			1, 253. 96	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Pre 5/24/2017 3:5	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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, 854, 121	19, 188, 156	0. 20085	9 2, 539, 269	510, 035	90.00
91.00 Nursing School cost	0	19, 188, 156	0.00000	0 2, 539, 269	0	91.00
92.00 Allied health cost	0	19, 188, 156	0.00000	0 2, 539, 269	0	92.00
93.00 All other Medical Education	0	19, 188, 156	0. 00000			93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period:	Worksheet D-1	
		Component CCN: 15-T059	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/24/2017 3:54	
		Title XIX	Subprovider - IRF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		4		
00	INPATIENT DAYS				
00 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			5,964	1
00	Private room days (excluding private room days, excluding swing Private room days (excluding swing-bed and observation bed d		ivate room days	5, 964 0	
00	do not complete this line.		rvate room days,	0	ľ
00	Semi-private room days (excluding swing-bed and observation			5, 964	4
00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private r	nom davs) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	com days) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	swing_bed and	74	9
00	newborn days)		Swillig bed and	7 4	'
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days)	0	10
	through December 31 of the cost reporting period (see instru				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
	through December 31 of the cost reporting period	<u> </u>	3 ,	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
	after December 31 of the cost reporting period (if calendar				
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		I		
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	cos after December 21 of	the cost	0.00	10
. 00	reporting period	ces al tel December 31 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructio	nc)		4, 559, 624	21
2.00	Swing-bed cost applicable to SNF type services through Decem		ing period (line	4, 559, 624	
	5 x line 17)		ing poir ou (inite	0	
8.00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reportin	g period (line 6	0	23
00	x line 18)		an and dias	0	
. 00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	er 31 of the cost reporti	ng period (iine	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)	1 3			
o. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 559, 624	27
. 00	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		al gooy	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost		fferential (line	4, 559, 624	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	IUSTMENTS			-
. 00	Adjusted general inpatient routine service cost per diem (se			764.52	38
	Program general inpatient routine service cost (line 9 x lin			56, 574	
. 00	Medically necessary private room cost applicable to the Prog	ram (line 14 x line 35)		0	
. 00	Total Program general inpatient routine service cost (line 3	9 + line 40)		56, 574	1 11

	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW HC		CN: 15-0059	In Lie Period:	u of Form CMS- Worksheet D-1	
				CCN: 15-T059	From 01/01/2016 To 12/31/2016	Date/Time Pre	epared
			Titl	e XIX	Subprovider - IRF	5/24/2017 3:5 Cost	54 pm
	Cost Center Description	Total Inpatient CostIr	Total npatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	0	21 00 C				) 42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.		C C	) 43.
4.00	CORONARY CARE UNIT	0	L.	0.	00 0		44.
	BURN INTENSIVE CARE UNIT						45.
5.00	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.
7.00	Cost Center Description						47.
3. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1.00	5 48.
	Total Program inpatient costs (sum of lines			ons)		91, 169	
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine se	ervices (from	Wkst D su	n of Parts L and	C	50.
5.00							00.
1.00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	C	51.
2.00	Total Program excludable cost (sum of lines !	50 and 51)				c	52.
3. 00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	vsician anest	netist, and	C	53.
	Program discharges					C	
6.00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and targ	aet amount (I	ine 56 minus	line 53)		
3.00	Bonus payment (see instructions)		,			C	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period er	nding 1996, ι	pdated and c	ompounded by the	0.00	) 59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report, upda	ated by the m	arket basket		0.00	60.
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see	s 55, 59 or 60 er n expected costs	nter the less	er of 50% of		C	
2. 00 8. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme		tions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	e cost report	ng period (See	C	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	- 31 of the c	ost reportin	n period (See	c c	) 65.
	instructions)(title XVIII only)						
6. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line 64	l plus line 6	5)(title XVI	ll only). For	C	) 66.
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through [	December 31 c	of the cost r	eporting period	C	67.
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of	the cost rep	orting period	C	68.
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					c	69.
0. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID routi	ne service d	ost (line 37	)		70.
. 00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71.
2.00 8.00	Program routine service cost (line 9 x line Medically necessary private room cost applica		(line 14 x li	ne 35)			73.
4.00	Total Program general inpatient routine servi	ce costs (line 7	72 + line 73)	ŗ			74.
5.00	Capital-related cost allocated to inpatient 1 26, line 45)	routine service o	costs (from V	lorksheet B,	Part II, column		75.
00	Per diem capital related costs (line 75 ÷ lin Program capital related costs (line 0 × line						76.
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.
. 00	Aggregate charges to beneficiaries for excess		ovider record	ls)			79.
0. 00	Total Program routine service costs for compa		st limitation	n (line 78 mi	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						81. 82.
2.00	Reasonable inpatient routine service cost ilmitation (il		)				82.
4.00	Program inpatient ancillary services (see ins						84.
5.00	Utilization review - physician compensation						85.
6.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86.
7.00	Total observation bed days (see instructions)					C	87.
	Adjusted general inpatient routine cost per o	•	ine 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	e instructions)				I C	) 89.

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1	
		Component (		To 12/31/2016		
		Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	698, 047	4, 559, 624	0. 15309	3 0	0	90.00
91.00 Nursing School cost	0	4, 559, 624	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 559, 624	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 559, 624	0. 00000	0 0	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-0059	Peri od:	Worksheet D-3	. –
			From 01/01/2016 To 12/31/2016	Date/Time Pre	par
				5/24/2017 3:5	4 p
	Titl€	XVIII	Hospi tal	PPS	_
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient	
		10 charges		Program Costs (col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2100	0100	
. 00 03000 ADULTS & PEDI ATRI CS			8, 261, 049		30
. 00 03100 I NTENSI VE CARE UNI T			2, 502, 569		3
. 00 04100 SUBPROVIDER - IRF			0		4
. 00 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS					
. 00 05000 OPERATING ROOM		0. 19402		1, 533, 913	
. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2840		208, 209	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 34739	92 31, 981	11, 110	5
. 00 05700 CT SCAN		0. 0339		29, 039	
. 01 03630 ULTRA SOUND		0.0000		0	-
. OO  05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 09080		13, 583	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08519		207, 157	
. 00 06000 LABORATORY		0. 20042		958, 644	
. 01 06001 BLOOD LABORATORY		0.0000		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 49196		127, 635	
. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
. 00 06500 RESPI RATORY THERAPY		0. 26779		643, 578	
. 00 06600 PHYSI CAL THERAPY		0. 37040		341, 890	
. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
. 00 06800 SPEECH PATHOLOGY		0.0000		0	-
. 00 06900 ELECTROCARDI OLOGY		0. 17463		178, 480	
. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 33758		3, 078, 446	
. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0.31290		280, 161	
. 00 07300 DRUGS CHARGED TO PATIENTS		0.39429		1, 646, 452	
. 00 07400 RENAL DI ALYSI S		0. 99080		166, 833	
. 00 03020 OTHER ANCI LLARY . 01 03140 CARDI AC REHAB		0.0000		0 51 0((	1 .
		0.35482		51,866	
. 02  03070  WOMEN' S CENTER . 03  03330  ENDOSCOPY		0. 28563		2, 400 0	
OUTPATIENT SERVICE COST CENTERS		0.0000		0	1 /
. 00 09000 CLINIC		0. 3218	43, 091	13, 867	90
. 01 09001 0UTPATI ENT		0. 30302		17, 462	
. 00 09100 EMERGENCY		0. 21960		376, 542	
. 01 09101 SHORT STAY		0.0000		0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 72176		0	
OTHER REIMBURSABLE COST CENTERS		0.7217	0	0	1 ''
. 00 09500 AMBULANCE SERVICES					9
0.00 Total (sum of lines 50-94 and 96-98)			37, 826, 699	9, 887, 267	
1.00 Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0	.,,	20
2.00 Net Charges (line 200 minus line 201)	/		37, 826, 699		202

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-0059	Peri od:	Worksheet D-3	3
	omponent	CCN: 15-T059	From 01/01/2016 To 12/31/2016	Date/Time Pre	naro
	Jiiponent	CCN. 15-1059	10 12/31/2010	5/24/2017 3:5	
	Titl€	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
D. 00 03000 ADULTS & PEDIATRICS			0		30
1. 00   03100   NTENSI VE CARE UNI T			0		31
1. 00 04100 SUBPROVIDER - IRF			4, 380, 852		41
3. 00 04300 NURSERY			4, 500, 052		43
ANCI LLARY SERVICE COST CENTERS		1		1	
D. 00 05000 OPERATING ROOM		0. 1940	24 284, 264	55, 154	50
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2840		-	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 3473		41	
7. 00 05700 CT SCAN		0. 0339		2, 561	57
7. 01 03630 ULTRA SOUND		0.0000			
. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 09080	18, 003	1, 635	5 58
2. 00 05900 CARDIAC CATHETERIZATION		0. 0851	70, 718	6, 025	59
0. 00 06000 LABORATORY		0. 2004	20 794, 504	159, 234	60
0. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60   60
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4919	55 19, 252	9, 471	63
I. 00 06400 I NTRAVENOUS THERAPY		0.0000	0 00	0	64
5. 00 06500 RESPI RATORY THERAPY		0. 2677	96 516, 947	138, 436	65
6. 00 06600 PHYSI CAL THERAPY		0. 37040		1, 274, 021	66
2. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	67
3. 00 06800 SPEECH PATHOLOGY		0.0000	0 00	-	
P. 00 06900 ELECTROCARDI OLOGY		0. 1746			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3375			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3129			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3942		344, 664	
. 00 07400 RENAL DIALYSIS		0. 9908			
0. 00 03020 OTHER ANCI LLARY		0.0000			
0. 01 03140 CARDI AC REHAB		0. 3548			
5. 02 03070 WOMEN'S CENTER		0. 2856		299	
5. 03 03330 ENDOSCOPY		0.0000	0 00	0	0 76
OUTPATI ENT SERVI CE COST CENTERS		0.2210	11 ( 052	2 2 2 7	7 90
0. 00   09000  CLI NI C 0. 01   09001  0UTPATI ENT		0. 3218			
. 00  09100 EMERGENCY		0. 3030			
. 01  09101  SHORT STAY		0.2198			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7217			
OTHER REIMBURSABLE COST CENTERS		0.72170	0	0	4 72
5. 00 09500 AMBULANCE SERVICES		1			95
0.00 Total (sum of lines 50-94 and 96-98)			7, 026, 494	2, 334, 869	
01.00 Less PBP Clinic Laboratory Services-Program only charges (1	ine 61)		7, 020, 494		200
02.00 Net Charges (line 200 minus line 201)			7, 026, 494		201

: 15-0059	Peri od:	eu of Form CMS- Worksheet D-3	
	From 01/01/2016		
N: 15-5669	To 12/31/2016	Date/Time Pre 5/24/2017 3:5	
(VIII	Skilled Nursing		
atio of Cos	Facility t Inpatient	I npati ent	
To Charges	Program	Program Costs	
ro onarges	Charges	$(col \cdot 1 \times col \cdot$	
	onar ges	2)	
1.00	2.00	3.00	
	C	D	30.
	C		31.
	C	D	41.
			43.
		-	
0. 19402		-	
0.00000			
0. 28407			
0.34739			
0. 03391		-	
0.00000			
0.09080		-	
0. 08519			
0. 20042		2 200, 954	
0.00000		-	
0. 49196			
0.00000		-	
0. 26779			
0.37040			
0.00000			
0.00000			
0. 17463		-	
0. 33758		1 15, 436	
0. 31296		۲ ۲	
0. 39429		9 338, 863	
0.99080		-	
0.00000		-	
0. 35482			
0. 28563			
0.00000	00 C	0 0	76.
0.00101	1		
0. 32181			
0. 30302			
0.21966			
0.00000			
0. 72176	64 C	00	92.
		1	OF
	2 552 075	1 1 2 4 7 4 0	95.
	-		201.
		0	3, 553, 975 1, 136, 749 0 3, 553, 975

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider C	CN: 15-0059	Peri od:	Worksheet D-3	<b>;</b>
			From 01/01/2016	Data (Time Dres	
			To 12/31/2016	Date/Time Pre 5/24/2017 3:5	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	+
. 00 03000 ADULTS & PEDI ATRI CS			433, 973		30
. 00 03100 I NTENSI VE CARE UNI T			104, 711		31
. 00 04100 SUBPROVI DER – I RF			0		41
. 00 04300 NURSERY			0		43
ANCI LLARY SERVICE COST CENTERS		1			1
. 00 05000 OPERATING ROOM		0. 1940	24 297, 287	57, 681	50
. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 00	0	52
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2840	72 14, 811	4, 207	54
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 3473	92 0	0	55
. 00 05700 CT SCAN		0. 0339	13 31, 707	1, 075	57
. 01 03630 ULTRA SOUND		0.0000		0	57
. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 09080	04 0	0	58
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0851	98 51, 836	4, 416	59
. 00 06000 LABORATORY		0. 20042		29, 195	60
. 01 06001 BLOOD LABORATORY		0.0000		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4919		7, 495	
. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
. 00 06500 RESPI RATORY THERAPY		0. 2677		13, 957	
. 00 06600 PHYSI CAL THERAPY		0. 37040		3, 161	
. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
. 00 06800 SPEECH PATHOLOGY		0.0000		0	
. 00 06900 ELECTROCARDI OLOGY		0. 1746		4, 187	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.3375		94, 802	
. 00 07200 I MPL. DEV. CHARGED TO PATIENT . 00 07300 DRUGS CHARGED TO PATIENTS		0. 3129		0 75, 339	
. 00 07400 RENAL DIALYSIS		0. 9908		4, 823	
. 00  03020  OTHER ANCI LLARY		0.0000		4, 823	
. 01   03140 CARDI AC REHAB		0. 3548		299	
. 02 03070 WOMEN'S CENTER		0. 2856		0	
. 03 03330 ENDOSCOPY		0.0000		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	1 '`
. 00 09000 CLINIC		0. 3218	11 0	0	90
. 01 09001 OUTPATI ENT		0. 3030		783	
. 00 09100 EMERGENCY		0. 2196		10, 793	
. 01 09101 SHORT STAY		0.0000		0	91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7217	64 0	0	92
OTHER REIMBURSABLE COST CENTERS					
. 00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50-94 and 96-98)			1, 170, 500	312, 213	
1.00 Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0		201
2.00 Net Charges (line 200 minus line 201)			1, 170, 500		202

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr	ovider C	CN: 15-0059	Period:	Worksheet D-3	}
	moonent	CCN: 15-T059	From 01/01/2016 To 12/31/2016	Date/Time Pre	naro
	inponent	CCN. 15-1057	10 12/31/2010	5/24/2017 3:5	
	Ti tl	e XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
1.00 04100 SUBPROVIDER - IRF			90, 644		41.
3. 00 04300 NURSERY			0		43.
ANCI LLARY SERVI CE COST CENTERS		1		1	
0. 00 05000 OPERATING ROOM		0. 19402			
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2840			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 34739			
7. 00 05700 CT SCAN		0.0339		-	
7. 01 03630 ULTRA SOUND		0.0000			
8. 00  05800  MAGNETI C RESONANCE I MAGI NG (MRI) 9. 00  05900  CARDI AC CATHETERI ZATI ON		0.09080		-	
9. 00  05900  CARDI AC CATHETERI ZATI ON 0. 00  06000  LABORATORY		0. 08519 0. 20042			
0. 00 06000 LABORATORY		0. 20042			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 49196			
4. 00 06400 I NTRAVENOUS THERAPY		0. 00000			
5. 00 06500 RESPIRATORY THERAPY		0. 26779			
6. 00 06600 PHYSI CAL THERAPY		0. 37040			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 00000			
8. 00 06800 SPEECH PATHOLOGY		0.0000			
9. 00 06900 ELECTROCARDI OLOGY		0. 17463	33 0	0	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 33758	6, 849	2, 312	2 71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 31296	58 0	0	72.
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 39429	93 19, 875	7, 837	73.
4. 00 07400 RENAL DI ALYSI S		0. 99080		-	
6. 00 03020 OTHER ANCI LLARY		0.0000			
6. 01 03140 CARDI AC REHAB		0. 35482			
6. 02 03070 WOMEN' S CENTER		0. 28563			
6. 03 03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS		0.0000	0 00	0	76.
0.00 09000 CLINIC		0. 3218	11 0	0	90.
0. 00   09000   CETNIC 0. 01   09001   OUTPATI ENT		0. 3218			
1. 00 09100 EMERGENCY		0. 2196			
1. 01 09101 SHORT STAY		0. 00000		-	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 72176			
OTHER REIMBURSABLE COST CENTERS		0.7217		. 0	1 1
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50-94 and 96-98)			100, 499	34, 595	200.
01.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201.
02.00 Net Charges (line 200 minus line 201)	,		100, 499		202.

	Financial Systems RIVERVIEW HOS	Provider CCN: 15-0059	Peri od: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/24/2017 3:5	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1 (	(see	0 0	
. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	13, 170, 532	1. 0
. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or di scharges occurri ng	prior to October	0	1.0
. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1.0
. 00 . 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			245, 594 0	2.0
. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	
. 00 . 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	0 99.47	3.0 4.0
. 00	Indirect Medical Education Adjustment	<b>X</b> 1 1		//. +/	0
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	1 5		0.00	
. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)			0.00	6.0
. 00 . 01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR §412.105(1		0. 00 0. 00	
. 00	If the cost report straddles July 1, 2011 then see instructio Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	thic and osteopathic pro		0.00	8. 0
. 01	The amount of increase if the hospital was awarded FTE cap slithe cost report straddles July 1, 2011, see instructions.	ots under section 5503 o	of the ACA. If	0.00	8. C
. 02	The amount of increase if the hospital was awarded FTE cap slunder section 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8. C
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	(see	0.00	9.0
0. 00 1. 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recor	-ds	0.00 0.00	10. C
2.00	Current year allowable FTE (see instructions)				12.0
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	ar ended on or after Sep	otember 30, 1997,	0. 00 0. 00	
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.0
6.00	Adjustment for residents in initial years of the program				16.0
7.00	Adjustment for residents displaced by program or hospital clo	sure			17. (
8.00	Adjusted rolling average FTE count	、 、		0.00	
9.00 0.00	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)	).		0. 000000 0. 000000	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
2.00	IME payment adjustment (see instructions)			0	
2. 01	IME payment adjustment - Managed Care (see instructions)			0	22. (
3. 00	Indirect Medical Education Adjustment for the Add-on for Secti Number of additional allopathic and osteopathic IME FTE resid		Sec. 412.105	0.00	23. 0
4.00	(f)(1)(iv)(C ). IME FTE Resident Count Over Cap (see instructions)			0.00	
5.00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see		25.0
6.00 7.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
8.00	IME add-on adjustment amount (see instructions)			0	
8. 01	IME add-on adjustment amount - Managed Care (see instructions	)		0	
9. 00 9. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
0 00	Disproportionate Share Adjustment Percentage of SSL recipient patient days to Medicare Part A p	atient dave (coo inctave	stions)	TO C	20 1
0. 00 1. 00	Percentage of SSI recipient patient days to Medicare Part A p. Percentage of Medicaid patient days (see instructions)	attent udys (see instruc		2.87 15.19	
2.00	Sum of Lines 30 and 31			15. 19	
2.00 3.00	Allowable disproportionate share percentage (see instructions	)		4.48	
	Disproportionate share adjustment (see instructions)	-		147, 510	

AL CUL	Financial Systems RIVERVIEW H ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet E	2002
ALCOL			From 01/01/2016 To 12/31/2016	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/24/2017 3:5 PPS	4 pr
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		-		
5.00	Total uncompensated care amount (see instructions)			5, 977, 483, 147	
5.01	Factor 3 (see instructions)	ton zono on this line)	0. 000083987	0. 000082658	
5. 02	Hospital uncompensated care payment (If line 34 is zero, en (see instructions)	iter zero on this line)	538, 031	494, 085	35
5.03	Pro rata share of the hospital uncompensated care payment am	nount (see instructions)	402, 788	124, 537	35
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35.	03)	527, 325		36
	Additional payment for high percentage of ESRD beneficiary d				
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40
1 00	652, 682, 683, 684 and 685 (see instructions)	(00 (04 (05 (			
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (See	0		41
1. 01	Total ESRD Medicare covered and paid discharges excluding MS	-DRGs 652 682 683 684	0		41
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	82, 683, 684 an 685. (see	0		43
4 00	instructions)	Leveline 41 divided by 7	0,000000		
4.00	Ratio of average length of stay to one week (line 43 divided days)	i by line 41 divided by 7	0.000000		44
5.00	Average weekly cost for dialysis treatments (see instruction	ls)	0.00		45
6.00	Total additional payment (line 45 times line 44 times line 4	·	0		46
7.00	Subtotal (see instructions)		14, 090, 961		47
B. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)				
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instruction	15)		14, 090, 961	49
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			1, 155, 386	
1.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51
2.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	
3.00	Nursing and Allied Health Managed Care payment			0	
4.00 4.01	Special add-on payments for new technologies			1, 588 0	
4.01 5.00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	
6.00	Cost of physicians' services in a teaching hospital (see int	-		0	56
7.00	Routine service other pass through costs (from Wkst. D, Pt.		nrough 35).	0	
8.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		35, 143	58
9.00	Total (sum of amounts on lines 49 through 58)			15, 283, 078	
0.00	Primary payer payments			2, 208	
1.00 2.00	Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	is The 60)		15, 280, 870 1, 554, 196	
2.00 3.00	Coinsurance billed to program beneficiaries			38, 899	
4.00	Allowable bad debts (see instructions)			171, 750	
5.00	Adjusted reimbursable bad debts (see instructions)			111, 638	
6.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		65, 516	66
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			13, 799, 413	6
	Credits received from manufacturers for replaced devices for			0	
8.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	. (For SCH see instructions	5)	0	
8. 00 9. 00	ATHER AD INCTMENTS (SEE INSTRUCTIONS) (SPECIEV)			0	
8.00 9.00 0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			. 0	
8.00 9.00 0.00 0.50	RURAL DEMONSTRATION PROJECT			0	1 /1
7.00 8.00 9.00 0.00 0.50 0.88 0.89	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	structions)		0	
8.00 9.00 0.00 0.50	RURAL DEMONSTRATION PROJECT	tructions)		0 0 0	70
8.00 9.00 0.00 0.50 0.88 0.89	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		0	70 70
8.00 9.00 0.00 0.50 0.88 0.89 0.90 0.91 0.91	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	structions)		0 0 0 0	70 70 70 70
8.00 9.00 0.00 0.50 0.88 0.89 0.90 0.91	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	structions)		0 0 0	70 70 70 70 70 70

	Financial Systems RIVERVIEW HO				u of Form CMS-2	2552-1
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 5/24/2017 3:54	
		Title	XVIII	Hospi tal	PPS	
			FFY	′ (уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.96
	the corresponding federal year for the period prior to 10/1)					
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.97
70.00	the corresponding federal year for the period ending on or af	ter 10/1)			0	70.00
	Low Volume Payment-3				150 750	70.98
	HAC adjustment amount (see instructions)	(0 % 70)			152, 752	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			13, 673, 951	
	Sequestration adjustment (see instructions) Interim payments				273, 479 13, 362, 872	
	Tentative settlement (for contractor use only)				13, 302, 872	73.00
	Balance due provider (Program) (line 71 minus lines 71.01, 72	and 72)			37,600	
	Protested amounts (nonallowable cost report items) in accorda				2, 136, 270	
75.00	CMS Pub. 15-2, chapter 1, §115.2	nce with			2, 130, 270	/5.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			I		
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)	1		0	90.00
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
	The rate used to calculate the time value of money (see instr				0.00	94.00
	Time value of money for operating expenses (see instructions)				0	95.00
	Time value of money for capital related expenses (see instruc				0	96.00
ı			•	Prior to 10/1	On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.000000000	0.000000000	
	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions	)		0	0	104.00

	Financial Systems		RI VERVI EW	Provi der C		Period:	u of Form CMS-2 Worksheet E	
					F	From 01/01/2016 Fo 12/31/2016	Part A Exhibi Date/Time Pre	pare
				Title	XVIII	Hospi tal	5/24/2017 3:5 PPS	4 pm
		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)	
	1	0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0	(	0 0	0	1
01	payments DRG amounts other than outlier payments for discharges	1.01	0	0	(	ס	0	1
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	13, 170, 532	0		13, 170, 532	13, 170, 532	1
3	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1. 03	O	0	(	D	0	1
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1. 04	0	0		0	0	1
00	October 1 Outlier payments for discharges (see instructions)	2.00	245, 594	0	(	245, 594	245, 594	2
)1	Outlier payments for	2.02	0	0	(	0 0	0	2
00	discharges for Model 4 BPCI Operating outlier	2.01	0	0	(	0 0	0	3
00	reconciliation Managed care simulated payments	3.00	0	0	(	0 0	0	4
	Indirect Medical Education Adju		· ·		1	1		1
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0.00000	0.000000		5
0	IME payment adjustment (see instructions)	22.00	0	0		0	0	6
1	IME payment adjustment for managed care (see instructions)	22.01	0	0	(	0 0	0	6
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ction 422 of t	he MMA	- H		
0	IME payment adjustment factor	27.00	0. 000000	0.00000	0.00000	0. 000000		7
0	(see instructions) IME adjustment (see	28.00	о	0	(	0 0	0	8
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	(	0 0	0	8
0	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	(	0 0	0	Ģ
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	(	0 0	0	Ģ
	Disproportionate Share Adjustme		1					
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0448	0. 0448	0. 0448	0. 0448		10
00	Disproportionate share adjustment (see instructions)	34.00	147, 510	0	(	0 147, 510	147, 510	11
01	Uncompensated care payments Additional payment for high per	36.00 centage of ESF	527, 325 RD benefi ci ary	0 di scharges	527, 325	5 0	527, 325	11
00	Total ESRD additional payment	46.00	0	0	(	0 0	0	12
00	(see instructions) Subtotal (see instructions)	47.00	14, 090, 961	0	527, 325	5 13, 563, 636		
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0		0 0	0	14
00	Total payment for inpatient operating costs (see instructions)	49.00	14, 090, 961	0	527, 325	5 13, 563, 636	14, 090, 961	15
00	Payment for inpatient program capital	50.00	1, 155, 386	0	(	1, 155, 386	1, 155, 386	16
00	Special add-on payments for new technologies	54.00	1, 588	0	(	1, 588	1, 588	
01 02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	о	0	(	o o	0	17   17
. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)		0	0	(	0	0	18

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2016 Fo 12/31/2016		pared:
				Title	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	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	527, 32	5 14, 720, 610	15, 247, 935	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, 058, 723	0		0 1, 058, 723	1, 058, 723	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2.00	57, 173	0		57, 173	57, 173	21.00
21.01	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	21.01
	outlier payments							
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		o o	0	23.00
24.00	Al lowable disproportionate share percentage (see instructions)	10.00	0. 0373	0. 0373	0. 037	3 0. 0373		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	39, 490	0		39, 490	39, 490	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 155, 386	0		1, 155, 386	1, 155, 386	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.00000	0. 000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E,	70. 96				D	0	28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

	Financial Systems	RI VERVI EW		NI 45 0050		u of Form CMS-2	2552-10
HOSPIT	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5	Provider CC	IN: 15-0059	Period: From 01/01/2016 To 12/31/2016		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0		0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13, 170, 532		13, 170, 532		1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	245, 594		0 245, 594	245, 594	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0 0.00000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000		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 care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
10.00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0448	0.044	0.0448		10.00
	(see instructions)						
11.00	Disproportionate share adjustment (see instructions)	34.00	147, 510		0 147, 510		
11.01	Uncompensated care payments	36.00	527, 325	402, 78	124, 537	527, 325	11.01
12.00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46.00	di scharges 0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	14, 090, 961	402, 78	13, 688, 173	14, 090, 961	13, 00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0	,	0 0	0	
15.00	instructions) Total payment for inpatient operating costs	49.00	14, 090, 961	402, 78	13, 688, 173	14, 090, 961	15.00
16.00	(see instructions) Payment for inpatient program capital	50.00	1, 155, 386		0 1, 155, 386	1, 155, 386	16.00
17.00	Special add-on payments for new technologies	54.00	1, 133, 388		0 1, 133, 388		
17.01	Net organ acquisition cost		., 500		., 500	., 200	17.01
17.02	Credits received from manufacturers for	68.00	0		0 0	0	17.02
	replaced devices for applicable MS-DRGs						
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00

	Financial Systems	RI VERVI EW			In Lie	u of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2016 To 12/31/2016		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1, 058, 723		0 1, 058, 723	1, 058, 723	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	57, 173		0 57, 173	57, 173	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.00	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0373	0. 03	73 0. 0373		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	39, 490		0 39, 490	39, 490	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 155, 386		0 1, 155, 386	1, 155, 386	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0	1	0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0	1	0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	27, 290	1	0 27, 290	27, 290	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70, 94	l o		0 0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	<u> </u>	
32.00	HAC Reduction Program adjustment (see	70.99	1.00	4, 0			32.00
100.00	instructions) Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

	Financial Systems RIVERVIEW HC			eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2016	Worksheet E Part B	
			To 12/31/2016	Date/Time Pre	
		Title XVIII	Hospi tal	5/24/2017 3: 5 PPS	4 pili
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			9, 045	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct	ctions)		13, 913, 748	
3.00 4.00	PPS payments Outlier payment (see instructions)			12, 317, 211 71, 814	
5.00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	1
8.00 9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		67, 587	
10.00	Organ acqui si ti ons			0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			9, 045	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12.00	Reasonable charges Ancillary service charges			22, 940	12 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)	-		22, 940	14.00
45 00	Customary charges				1 4 5 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13		on a chargebasis		10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
	Total customary charges (see instructions)			22, 940	
19.00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds li	ne 11) (see	13, 895	19.00
20.00	Excess of reasonable cost over customary charges (complete or	nlyifline 11 exceeds li	ne 18) (see	0	20.00
	instructions)	5			
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH se	ee instructions)			21.00
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			12, 456, 612	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	
26.00 27.00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			2, 503, 831 9, 961, 826	
27.00	instructions)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I			0	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	)		0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			9, 961, 826 2, 557	
32.00	Subtotal (line 30 minus line 31)			9, 959, 269	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)		· · ·	
	Composite rate ESRD (from Wkst. 1-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			145, 868 94, 814	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		98, 852	
37.00	Subtotal (see instructions)	<i>,</i>		10, 054, 083	
38.00	MSP-LCC reconciliation amount from PS&R			-153	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	nc)		0	
39. 50 39. 98	Partial or full credits received from manufacturers for repla		ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			10, 054, 236	
40.01	Sequestration adjustment (see instructions)			201, 085 9, 836, 539	
41.00 42.00	Interim payments Tentative settlement (for contractors use only)			9, 836, 539	
43.00	Bal ance due provider/program (see instructions)			16, 612	
44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	
	\$115.2				
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-0059	Period: From 01/01/2016 To 12/31/2016		pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		13, 249, 8		9, 686, 820 0	1. 2. 3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01 02 03 04 05	ADJUSTMENTS TO PROVIDER	12/31/2016 06/20/2016	43, 3 69, 7		149, 719 0 0 0 0	3. 3. 3. 3. 3.
	Provider to Program	1 1		-1	-	
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0	0 0 0 0	3. 3. 3. 3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		113, 0	-	149, 719	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		13, 362, 8	72	9, 836, 539	4.
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
D1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program	1				-
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		37,60	00	16, 612	6
)2	SETTLEMENT TO PROGRAM		40,400,5	0	0	6
00	Total Medicare program liability (see instructions)		13, 400, 4		9, 853, 151	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1.00	2.00	

IALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component (	CN: 15-0059 CCN: 15-T059	Period: From 01/01/2016 To 12/31/2016		epared
		Title	XVIII	Subprovider - IRF	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	-
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		6, 265, 7 [,]	0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	
04				0	0	
)5				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53				0	0	
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0 0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6, 265, 7	99	0	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	
)2				0	0	
)3	Drovidor to Drogram			0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0	
52				0	0	
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		2, 1	26	0	
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		6, 267, 9		0	7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	

	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0059 CCN: 15-5669	Period: From 01/01/2016 To 12/31/2016				
		Title	XVIII	Skilled Facil	5			+ piii
		Inpatien	t Part A			t B		
		mm/dd/yyyy	Amount		/уууу	Amount		
		1.00	2.00		00	4.00		
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 550, 2	0			0	1. ( 2. (
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							3. (
01	ADJUSTMENTS TO PROVIDER			0			0	3. (
. 02				0			0	3. (
. 03				0			0	3.
. 04				0			0	3.
05	Provider to Program			0			0	3.
50	ADJUSTMENTS TO PROGRAM			0			0	3.
51				0			0	3.
52				0			Ő	3.
53				0			0	3.
54				0			0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0			0	3.
	3. 50-3. 98)							
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 550, 2	24			0	4.
	TO BE COMPLETED BY CONTRACTOR							
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							5.
	Program to Provider							
01	TENTATI VE TO PROVI DER			0			0	5.
02				0			0	5.
03				0			0	5.
	Provider to Program			-1				_
50 51	TENTATI VE TO PROGRAM			0			0 0	5. 5.
51 52				0			0	э. 5.
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0			0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on							6
	the cost report. (1)							
01	SETTLEMENT TO PROVIDER		7,0	89			0	6
02	SETTLEMENT TO PROGRAM			0			0	6.
00	Total Medicare program liability (see instructions)		1, 557, 3				0	7.
				Contr	actor ber	NPR Date (Mo/Day/Yr		
	-	(	)	1.		2.00	/	

Heal th	Financial Systems RIVERVIEW HC	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0059	Peri od:	Worksheet E-1	
			From 01/01/2016 To 12/31/2016		narod:
			10 12/31/2010	5/24/2017 3:54	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	1			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14	3, 928	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		6, 379	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 356	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		15, 656	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			366, 444, 874	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		6, 720, 270	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of a	certified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			363, 179	
9.00	Sequestration adjustment amount (see instructions)			7, 264	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		355, 915	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			352, 438	
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)	3, 477	32.00

	Financial Systems RIVERVIEW H			u of Form CMS-2	
CALCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2016	Worksheet E-3 Part III	
		Component CCN: 15-T059	To 12/31/2016	Date/Time Pre	
		Title XVIII	Subprovider -	5/24/2017 3: 5 PPS	4 pm
			IRF	1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
	Net Federal PPS Payment (see instructions)			6, 353, 741	1.0
	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0143	2.0
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			129, 616	3. (
1.00	Outlier Payments			75, 513	4.0
5.00	Unweighted intern and resident FTE count in the most recent	cost reporting period en	ding on or prior	0.00	5.0
	to November 15, 2004 (see instructions)				
5.01	Cap increases for the unweighted intern and resident FTE cou			0.00	5.0
	program or hospital closure, that would not be counted with	out a temporary cap adjust	ment under 42		
( 00	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
6.00	New Teaching program adjustment. (see instructions)	the new preason arouth n	onled of a "new	0.00	6.0
7.00	Current year's unweighted FTE count of I&R excluding FTEs in teaching program" (see instructions)	i the new program growth p	errod of a new	0.00	7.0
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth r	eriod of a "new	0.00	8.0
5.00	teaching program" (see instructions)			0.00	0.0
9.00	Intern and resident count for IRF PPS medical education adju	ustment (see instructions)		0.00	9. (
	Average Daily Census (see instructions)			16. 295082	
	Teaching Adjustment Factor (see instructions)			0.000000	
	Teaching Adjustment (see instructions)			0	12.
	Total PPS Payment (see instructions)			6, 558, 870	13.
4.00	Nursing and Allied Health Managed Care payments (see instruc	ction)		0	14.
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.
6.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	16.
7.00	Subtotal (see instructions)			6, 558, 870	17.
8.00	Primary payer payments			0	18.
9.00	Subtotal (line 17 less line 18).			6, 558, 870	19.
	Deducti bl es			119, 644	
	Subtotal (line 19 minus line 20)			6, 439, 226	
	Coinsurance			52, 808	
	Subtotal (line 21 minus line 22)			6, 386, 418	
	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		3, 180	
	Adjusted reimbursable bad debts (see instructions)			2, 067	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	26.
	Subtotal (sum of lines 23 and 25)			6, 388, 485	27.
	Direct graduate medical education payments (from Wkst. E-4,	TThe 49)		0	28.
	Other pass through costs (see instructions)			7, 357	
	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30. 31.
	Pioneer ACO demonstration payment adjustment (see instruction	anc)		0	31.
	Recovery of Accel erated Depreciation			0	
2.00	Total amount payable to the provider (see instructions)			6, 395, 842	
	Sequestration adjustment (see instructions)			127, 917	
	Interim payments			6, 265, 799	
1	Tentative settlement (for contractor use only)			0,200,777	34.0
	Balance due provider/program (line 32 minus lines 32.01, 33,	and 34)		2, 126	
	Protested amounts (nonallowable cost report items) in accord	<i>,</i>	chapter 1.	128, 085	
	§115. 2		P	, 200	
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			75, 513	
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51. (
	The rate used to calculate the Time Value of Money				52.0
· 2 00	Time Value of Money (see instructions)			0	53.

	Financial Systems RIVERVIEW HOS			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Peri od:	Worksheet E-3	
		Component CCN: 15-5669	From 01/01/2016 To 12/31/2016	Part VI Date/Time Pre	narod
		component con. 13-3007	10 12/31/2010	5/24/2017 3:5	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-	1 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH			1.00	
	SERVICES	ER HEALTH SERVICES FOR I	IILE AVIII PARI A	PPS SINF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			1, 695, 528	1.00
2.00	Routine service other pass through costs			0	2.00
3.00	Ancillary service other pass through costs			7, 233	3.00
4.00	Subtotal (sum of lines 1 through 3)			1, 702, 761	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine co	osts 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			113, 666	
8.00	Allowable bad debts (see instructions)			0	
9.00	Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions)		0	
	Adjusted reimbursable bad debts (see instructions) Utilization review			0	10.00 11.00
		and 11) (case instruction	20)	0 1, 589, 095	
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 1 Inpatient primary payer payments	and II)(see Instructio	115)	1, 589, 095	13.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00
	Pioneer ACO demonstration payment adjustment (see instruction:	-)		0	14.00
14.99	Recovery of Accel erated Depreciation	3)		0	14.99
15.00	Subtotal (see instructions			1, 589, 095	
15.00	Sequestration adjustment (see instructions)			31, 782	
	Interim payments			1, 550, 224	
	Tentative settlement (for contractor use only)			1,000,221	17.00
	Balance due provider/program (line 15 minus lines 15.01, 16, s	and 17)		7,089	
	Protested amounts (nonallowable cost report items) in accorda		2, chapter 1,	0	19.00
	§115. 2		,p	-	

		HOSPITAL		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2016 To 12/31/2016		pared:
		Title XIX	Hospi tal	Cost	4 pili
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	SERVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		708, 464		1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0	_	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		708, 464	0	
5.00 6.00	Inpatient primary payer payments Outpatient primary payer payments		0	0	5.00 6.00
6.00 7.00	Subtotal (line 4 less sum of lines 5 and 6)		708, 464	0	1
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		708, 404	0	7.00
	Reasonable Charges				1
8.00	Routi ne servi ce charges		538, 684		8.00
9.00	Ancillary service charges		1, 170, 500	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 709, 184	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment	for services on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable		on O	0	14.00
	a charge basis had such payment been made in accordance wit	th 42 CFR §413.13(e)			45 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
16.00 17.00	Total customary charges (see instructions)	only if line 14 exceeds	1, 709, 184	0	
17.00	Excess of customary charges over reasonable cost (complete line 4) (see instructions)	only IT The 16 exceeds	1, 000, 720	0	17.00
18.00	Excess of reasonable cost over customary charges (complete	only if line 4 exceeds lin	ne O	0	18.00
	16) (see instructions)	5			
19.00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see in		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or lin		708, 464	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only	be completed for PPS provi			
22.00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24.00 25.00	Program capital payments Capital exception payments (see instructions)		0		24.00 25.00
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	V)	0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)	,,	708, 464	0	1
	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	d 6)	708, 464	0	31.00
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	1
34.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	and 33)	708, 464	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		700 474	0	
38.00	Subtotal (line 36 ± line 37) Direct graduate modical education payments (from Wkst E 4)		708, 464	0	
39.00 40.00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 3		708, 464	0	39.00 40.00
40.00	Interim payments	נינ	558, 711	0	40.00
41.00	Balance due provider/program (line 40 minus line 41)		149, 753	0	
			147,700	-	
43.00	Protested amounts (nonallowable cost report items) in accor	rdance with CMS Pub 15-2	()	0	43.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Peri od:	Worksheet E-3	2552
		Component CCN: 15-T059	From 01/01/2016 To 12/31/2016	Part VII Date/Time Pre	pare
		Title XIX	Subprovider -	5/24/2017 3:5 Cost	
			I RF		
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	SERVICES FOR TITLES V OR X	IX SERVICES		
00	COMPUTATION OF NET COST OF COVERED SERVICES		01.1/0		
00	Inpatient hospital/SNF/NF services Medical and other services		91, 169	0	1
00	Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		91, 169	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		91, 169	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				+
00	Routi ne servi ce charges		90, 644		8
00	Ancillary service charges		100, 499	0	
0. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00			191, 143	0	12
. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment	for sorvices on a charge	0	0	13
5.00	basis	for services on a charge	0	0	
. 00	Amounts that would have been realized from patients liable	for payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with				
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	
. 00	Total customary charges (see instructions)		191, 143	0	
. 00	Excess of customary charges over reasonable cost (complete line 4) (see instructions)	only IT line 16 exceeds	99, 974	0	17
3. 00	Excess of reasonable cost over customary charges (complete	only if line 4 exceeds lin	e 0	0	18
	16) (see instructions)			-	
0. 00	Interns and Residents (see instructions)		0	0	19
). 00	Cost of physicians' services in a teaching hospital (see in		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or lin		91, 169	0	21
2. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only Other than outlier payments	be completed for PPS provi	ders.	0	22
3.00	Outlier payments		0	0	
. 00	Program capital payments		0	Ũ	24
. 00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only	y)	01 1/0	0	
. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		91, 169	0	29
00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	d 6)	91, 169	0	
	Deducti bl es		0	0	32
	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	-
. 00	Utilization review	and 22)	01 1/0	0	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		91, 169	0	
. 00 3. 00	Subtotal (line 36 ± line 37)		91, 169	0	
0.00		)	0	0	39
0. 00	Total amount payable to the provider (sum of lines 38 and		91, 169	0	40
. 00	Interim payments		24, 144	0	
2.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in acco		67, 025	0	
3.00		rdanco with CMS Dub 15 2		0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet G Date/Time Pre 5/24/2017 3:5	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	12, 118, 440		0 0	0	1.00
00	Temporary investments	3, 697, 233		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	26, 522, 676		0 0	0	
00 00	Other receivable Allowances for uncollectible notes and accounts receivable	192, 816			0	
00	Inventory	3, 980, 209		0 0	0	
00	Prepaid expenses	0, 700, 207		0 0	0	
00	Other current assets	17, 760, 145		o 0	0	9.0
0. 00	Due from other funds	0		0 0	0	
1.00	Total current assets (sum of lines 1-10)	64, 271, 519		0 0	0	11.0
2. 00	FI XED ASSETS Land	15, 917, 384		0 0	0	12.0
3.00	Land improvements	2, 872, 696		0 0	0	
	Accumul ated depreciation	-3, 597, 883		0 0	0	
5.00	Buildings	100, 109, 039		0 0	0	15.0
5.00	Accumulated depreciation	-57, 329, 258		0 0	0	
7.00	Leasehold improvements	1, 391, 274		0 0 0 0	0	
3.00 9.00	Accumulated depreciation Fixed equipment	60, 541, 136		0 0	0	
). 00	Accumulated depreciation	-29, 785, 505		0 0	0	
1.00	Automobiles and trucks	0		0 0	0	21.0
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	74, 425, 926		0 0	0	
	Accumulated depreciation Minor equipment depreciable	-50, 035, 769		0 0 0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
3. 00	Accumulated depreciation	0		0 0	0	28.0
	Minor equipment-nondepreciable	0		0 0	0	
0. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	114, 509, 040		0 0	0	30. 0
1.00	Investments	53, 953, 020		0 0	0	31.0
2.00	Deposits on Leases	00,700,020		0 0	0	
3.00	Due from owners/officers	2, 369, 315		0 0	0	33.0
4.00	Other assets	8, 490, 827		0 0	0	
5.00	Total other assets (sum of lines 31-34)	64, 813, 162		0 0 0 0	0	
5.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	243, 593, 721		0 0	0	36.0
7.00	Accounts payable	7, 389, 208		0 0	0	37.0
3.00	Salaries, wages, and fees payable	9, 442, 833		0 0	0	
9.00	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term) Deferred income	6, 180, 361		0 0	0	
2.00	Accelerated payments	0		0 0	0	42.0
3.00	Due to other funds	0		0 0	0	
4.00	Other current liabilities	49, 362, 672		0 0	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	72, 375, 074		0 0	0	45.0
5. 00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46. C
7.00	Notes payable	34, 054, 078		0 0	0	
3.00	Unsecured Loans	01, 004, 070		0 0	0	
9.00	Other long term liabilities	1, 337, 112		0 0	0	
0. 00	Total long term liabilities (sum of lines 46 thru 49)	35, 391, 190		0 0	0	
1.00	Total liabilities (sum of lines 45 and 50)	107, 766, 264		0 0	0	51.0
2. 00	CAPI TAL ACCOUNTS General fund balance	135, 827, 457				52.0
2.00	Specific purpose fund	155, 027, 437		0		53.0
4.00	Donor created - endowment fund balance - restricted			0		54.0
5.00	Donor created - endowment fund balance - unrestricted			0		55.0
5.00	Governing body created - endowment fund balance			0		56.0
7.00	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.0
9.00	Total fund balances (sum of lines 52 thru 58)	135, 827, 457		o o	0	59.0
						1 1 1 1 1

Heal th	Financial Systems	RIVERVIEW F	IOSPI TAL			In Lie	u of Form CN	/S-2	552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0059		eriod: com 01/01/2016 o 12/31/2016		Prep	
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fu	und	
		1.00	2.00	2.00		4.00	F 00		
1.00	Fund balances at beginning of period	1.00	133, 954, 764	3.00		4.00	5.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1, 872, 693						2.00
3.00	Total (sum of line 1 and line 2)		135, 827, 457			0			3.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0			0 0	4.00 5.00
6.00		0			0			0	5.00 6.00
7.00		0			0			o	7.00
8.00		0			0			0	8.00
9.00		0			0			0	9.00
10.00	Total additions (sum of line 4-9)		0			0			10.00
11.00	Subtotal (line 3 plus line 10)		135, 827, 457		~	0			11.00
12.00 13.00	Deductions (debit adjustments) (specify)	0			0 0			0 0	12.00 13.00
14.00		0			0			0	14.00
15.00		0			0			0	15.00
16.00		0			0			0	16.00
17.00		0			0			0	17.00
18.00 19.00	Total deductions (sum of lines 12-17)		125 027 457			0			18. 00 19. 00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		135, 827, 457			0			19.00
		Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00					
1.00	Fund balances at beginning of period	0			0				1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				_				2.00
3.00	Total (sum of line 1 and line 2)	0			0				3.00
4.00 5.00	Additions (credit adjustments) (specify)		0						4.00 5.00
6.00			0						6.00
7.00			0						7.00
8.00			0						8.00
9.00			0		_				9.00
10.00	Total additions (sum of line 4-9)	0			0				10. 00 11. 00
11.00 12.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		U				12.00
13.00	beddetrons (debrt ddjustments) (speerry)		0						13.00
14.00			0						14.00
15.00			0						15.00
16.00			0						16.00
17.00	Tatal deductions (our of lines 12 17)		0						17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0				18. 00 19. 00
17.00	sheet (line 11 minus line 18)				Ű				17.00
				•					

	Financial Systems RIVERVIEW H				n Lie	eu of Form CMS-	
STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0059	Period: From 01/01, To 12/31,			pared:
	Cost Center Description		I npati ent	Outpati	ent	Total	
			1.00	2.00		3.00	
	PART I - PATIENT REVENUES			2100		0.00	
	General Inpatient Routine Services						1
	Hospi tal		25, 835, 5	08		25, 835, 508	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF		6, 300, 6	55		6, 300, 655	
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY		2, 272, 1	04		2, 272, 104	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)		34, 408, 2	67		34, 408, 267	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT		5, 321, 4	68		5, 321, 468	11.00
12.00	CORONARY CARE UNI T						12.00
	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum o	flines	5, 321, 4	68		5, 321, 468	16.00
	11-15)						
	Total inpatient routine care services (sum of lines 10 and 1	6)	39, 729, 7			39, 729, 735	
	Ancillary services		95, 899, 9				
	Outpatient services		4, 157, 1	07 32, 27	7, 233		
	RURAL HEALTH CLINIC			0	0	-	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
	HOME HEALTH AGENCY			-	_		22.00
	AMBULANCE SERVICES			0	0	0	
24.00							24.00
	AMBULATORY SURGICAL CENTER (D. P.)						25.00
	HOSPICE					40.00/ 554	26.00
	PHYSICIANS' PRIVATE OFFICES			0 48,03			
	CLINICS PRO FEE				2, 133		
	DI ABETI C EDUCAI TON		00 /		9, 740 4 201		
	Total patient revenues (sum of lines 17-27)(transfer column	2 to Wkst	88, 4 139, 875, 3		4,381		
20.00	G-3, line 1)	J LU WKSL.	137,075,3	202, 13	0, 043	422,000,100	20.00
	PART II - OPERATING EXPENSES					1	
	Operating expenses (per Wkst. A, column 3, line 200)			185, 27	5 665		29.00
	ADD (SPECIFY)			0	-, 500		30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		185, 27	5, 665		43.00
	to Wkst. G-3, line 4)		1			1	1

Heal th	Financial Systems	RI VERVI EW HOSPI T	AL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Pro	ovider CCN: 15-0059	Peri od: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prep 5/24/2017 3:54	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, P	Part L column 2 Line 29	)		422, 006, 168	1.00
2.00	Less contractual allowances and discounts		)		250, 399, 284	2.00
3.00	Net patient revenues (line 1 minus line 2				171, 606, 884	3.00
4.00	Less total operating expenses (from Wkst.				185, 275, 665	4.00
4.00 5.00	Net income from service to patients (line				-13, 668, 781	5.00
5.00	OTHER I NCOME				13,000,701	5.00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				2, 066, 677	7.00
8.00	Revenues from telephone and other miscell	aneous communication ser	vi 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
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgical		patients		0	16.00
17.00	Revenue from sale of drugs to other than				0	17.00
18.00	Revenue from sale of medical records and				0	18.00
19.00	Tuition (fees, sale of textbooks, uniform				0	19.00
20.00	Revenue from gifts, flowers, coffee shops	, and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	NON-OPERATING REVENUE AND EXPENSE				952, 724	
	OTHER OPERATING REVENUE				12, 522, 073	
25.00	Total other income (sum of lines 6-24)				15, 541, 474	25.00
26.00	Total (line 5 plus line 25)				1, 872, 693	
	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 and				0	28.00
29.00	Net income (or loss) for the period (line	26 minus line 28)			1, 872, 693	29.00

alth Financial Systems	RIVERVIEW HOS	Provi der CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet L	2002
			From 01/01/2016 To 12/31/2016	Parts I-III Date/Time Pre 5/24/2017 3:5	
		Title XVIII	Hospi tal	PPS	4 pili
			noopritui	110	
				1.00	
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT					
00 Capital DRG other than outlier				1, 058, 723	
01 Model 4 BPCI Capital DRG other tha	n outlier			0	1.
00 Capital DRG outlier payments				57, 173	
01 Model 4 BPCI Capital DRG outlier p				0	
00 Total inpatient days divided by nu		porting period (see inst	ructions)	42.80	
00 Number of interns & residents (see	,			0.00	
00 Indirect medical education percent				0.00	5.
00 Indirect medical education adjustm 1.01) (see instructions)				0	6.
00 Percentage of SSI recipient patien 30) (see instructions)	5	5	, part A line	2.87	7.
00 Percentage of Medicaid patient day	s to total days (see instru	ctions)		15.19	
00 Sum of lines 7 and 8				18.06	
0.00 Allowable disproportionate share p	5 .	)		3.73	
00 Disproportionate share adjustment				39, 490	
2.00 Total prospective capital payments	(see instructions)			1, 155, 386	12.
				1.00	
PART II - PAYMENT UNDER REASONABLE	COST			1.00	
00 Program inpatient routine capital				0	1 1.
00 Program inpatient ancillary capita				0	2.
00 Total inpatient program capital co	. ,			0	3.
00 Capital cost payment factor (see i				0	4.
00 Total inpatient program capital co	<i>,</i>			0	
	· · · · ·			1.00	
PART III - COMPUTATION OF EXCEPTIO	N PAYMENTS			1.00	
00 Program inpatient capital costs (s	ee instructions)			0	1.
00 Program inpatient capital costs for	r extraordinary circumstanc	es (see instructions)		0	2.
00 Net program inpatient capital cost	s (line 1 minus line 2)			0	3.
00 Applicable exception percentage (s	ee instructions)			0.00	4
00 Capital cost for comparison to pay				0	5.
00 Percentage adjustment for extraord	5			0.00	
00 Adjustment to capital minimum paym		circumstances (line 2 x	line 6)	0	7.
00 Capital minimum payment level (lin				0	
00 Current year capital payments (fro				0	
0.00 Current year comparison of capital	1 5	1 1 5 1	,	0	10.
1.00 Carryover of accumulated capital m Worksheet L, Part III, line 14)	1 5		, ,	0	11.
2.00 Net comparison of capital minimum				0	
8.00 Current year exception payment (if				0	
1.00 Carryover of accumulated capital m		apital payment for the f	ollowing period	0	14.
(if line 12 is negative, enter the				_	
	nd canital navment (see ins	tructions)		0	l 15.
5.00 Current year allowable operating a				-	
<ul> <li>b. 00 Current year allowable operating a</li> <li>b. 00 Current year operating and capital</li> <li>c. 00 Current year exception offset amou</li> </ul>	costs (see instructions)			0	