Health Financial Systems	RI VERVI EW HOS	SPI TAL	In Lie	eu of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 41				
payments made since the beginning of the cost reporting	g period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT (CERTI FI CATI ON	Provider CCN: 15-005		Worksheet S
AND SETTLEMENT SUMMARY			From 01/01/2017 To 12/31/2017	
				5/30/2018 6:53 am
PART I - COST REPORT STATUS Provider 1. [X] Electronically filed cost report			Date: 5/30/20	D18 Time: 6:53 am
use only 2. [] Manually submitted cost report			Date. 5750720	
3.[0]If this is an amended report ent 4.[F]Medicare Utilization. Enter "F"	er the number for full or "L	of times the provide " for low.	er resubmitted this o	cost report
Contractor 5. [1] Cost Report Status 6. Date Rece			10. NPR Date:	
use only (1) As Submitted 7. Contractor (2) Settled without Audit 8. [N]Ini	or No. tial Report fo	or this Provider CCN	11.Contractor's Vend	lor Code: 4
(3) Settled with Audit 9. [N] Fin	al Report for	this Provider CCN		mes reopened = $0-9$.
(4) Reopened				
(5) Amended				
PART II - CERTIFICATION				
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION (
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER F PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR IN				
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RE		KI OKBAOK OK WERE ON		
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR AD	MINISTRATOR OF	PROVI DER(S)		
I HEREBY CERTIFY that I have read the above ce	rtification st	atement and that I h	ave examined the acc	companyi ng
electronically filed or manually submitted cos				
Expenses prepared by RIVERVIEW HOSPITAL (15-00 ending 12/31/2017 and to the best of my knowled				
complete and prepared from the books and record				
except as noted. I further certify that I am	familiar with	the laws and regulat	ions regarding the p	provision of
health care services, and that the services ide laws and regulations.	entified in th	is cost report were	provided in compliar	nce with such
5				
[]I have read and agree with the above cert signature on this certification statement				
signature on this continued on statement	(Si gned)	, , , , , , , , , , , , , , , , , , ,	one of my original s	si glia cai o.
	(Si glied)		ninistrator of Provid	der(s)
		Title		
		nue		
		Date		
Cost Contar Description		Title XVIII		

			11.010				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	23, 607	-26, 484	0	218, 431	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-16, 173	0		38, 104	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	9, 088	0		0	7.00
200.0	D Total	0	16, 522	-26, 484	0	256, 535	200. 00
			a				

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	ler CCN: 1		Period: From 01/01/		Workshe Part I	et S-2	
						To 12/31/	2017	Date/Ti		
	1.00	2.00		3.00			4.00	5/29/20	<u>)18 8:5</u>	0 pm
	Hospital and Hospital Health Care Co			0.00			1.00			
00	Street: 395 WESTFIELD ROAD	P0 Box:								1.
00	City: NOBLESVILLE	State: IN		e: 46060-		: y: HAMI LTON		nt Curat	om (D	2.
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		nt Syst 0, or		
			Number	Number	Type		V V			1
		1.00	2.00	3.00	4.00	5.00	6.00	-	-	
	Hospital and Hospital-Based Componer		1	1	T			1		
00	Hospital	RI VERVI EW HOSPI TAL	150059	26900	1	07/07/1966	N	P	0	3.
)0)0	Subprovider - IPF Subprovider - IRF	RI VERVI EW HOSPI TAL REHAB	15T059	26900	5	01/01/1994	N	Р	0	4. 5.
00	Subprovider - (Other)						1			6.
00	Swing Beds - SNF						1			7.
00	Swing Beds - NF		155440	2/000		10/0/ /1000				8.
0 00	Hospi tal-Based SNF Hospi tal-Based NF	RIVERVIEW HOSPITAL SNF	155669	26900		10/26/1999	N	P	N	9.
00	Hospi tal -Based OLTC						1			111.
00	Hospital-Based HHA						1			12.
00	Separately Certified ASC						1			13.
00	Hospi tal -Based Hospi ce									14.
00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									15.
00	Hospital-Based (CMHC) I						1			17.
00	Renal Dialysis						1			18.
00	Other						Ĺ	<u> </u>		19.
						From: 1.00				-
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20.
00	Type of Control (see instructions)					9				21.
	Inpatient PPS Information									
00	Does this facility qualify and is it share hospital adjustment, in accorc					Y		N	i .	22.
	for yes or "N" for no. Is this facil					e				
	amendment hospital?) In column 2, er				(_) (-				
01	Did this hospital receive interim ur					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)	opor tring period becarri	ig on or c							
02	Is this a newly merged hospital that					N		N	l	22.
	determined at cost report settlement				2	S				
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for					n				
	or after October 1.		110 0031 1		periou o					
	Did this hospital receive a geograph			oportring						
03				o rural a				N	I	22.
03	of the OMB standards for delineating	statistical areas adop	ted by CMS	o rural a: S in FY20	15? Enter			Ν	I	22.
03	of the OMB standards for delineating in column 1, "Y" for yes or "N" for	statistical areas adop no for the portion of th	ted by CMS he cost re	o rural a S in FY20 eporting p	15? Enter period			N	I	22.
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00	of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 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 Nedicaid 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 CH	statistical areas adop no for the portion of th 2, "Y" for yes or "N" for r after October 1. (see t more than 499 beds (a: "Y" for yes or "N" for r dicaid days on lines 24 f census days, or 3 if o is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state	ted by CMS he cost re or no for instructi s counted ho. and/or 25 date of di d differer r "Y" for ate In-S aid Medi lays elig unp da 0 2.	o rural a: porting the portions) Doe: in accord below? below? scharge. t from ti yes or "I tate 0 caid 5 ible Me aid pai ys 00	15? Enter beriod on of this s this dance with n column Is the me method V" for no ut-of dicaid I d days of 3.00	e h Out-of State Hedicaid el gible unpaid 4.00	ledicai IMO day	N id O ys Mec c c	ther di cai d days 5. 00	23.
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00	of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 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 Nedicaid 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 CH	statistical areas adop no for the portion of th 2, "Y" for yes or "N" for r after October 1. (see t more than 499 beds (a: "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if of is cost reporting period iod? In column 2, enter In-State umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state umn 2,	ted by CMS he cost re for no for instructi s counted ho. and/or 25 date of di d differer r "Y" for te In-S aid Medi ays elig unp da 0 2. 285	o rural as porting the portions) Does in accord b below? is scharge. the from the yes or "I tate 0 caid 5 ible Me aid pai ys 00 1,228	15? Enter beriod on of this dance with n column Is the me method <u>wi for no</u> ut-of dicaid 1 d days 0 <u>3.00</u>	e h Out-of State Hedicaid eligible unpaid 4.00 0	ledicai IMO day	N ys Mec c 938	ther di cai d days 5. 00	22. 23. 23. 22.
00	of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but not 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 the used in the prior cost reporting per Medicaid eligible unpaid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in col method and eligible unpaid days in f this provider is an IRF, enter the Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	statistical areas adop no for the portion of th 2, "Y" for yes or "N" for r after October 1. (see t more than 499 beds (at "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if of is cost reporting period iod? In column 2, enter 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 umn 4, Medicaid	ted by CMS he cost re for no for instructi s counted ho. and/or 25 date of di d differer r "Y" for te In-S aid Medi ays elig unp da 0 2. 285	o rural as porting the portions) Does in accord b below? is scharge. the from the yes or "I tate 0 caid 5 ible Me aid pai ys 00 1,228	15? Enter beriod on of this dance with n column Is the me method <u>wi for no</u> ut-of dicaid 1 d days 0 <u>3.00</u>	e h Out-of State Hedicaid eligible unpaid 4.00 0	ledicai IMO day	N ys Mec c 938	ther di cai d days 5. 00	23.

	ancial Systems RIVI ND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		HOSPITAL Provider CC	N. 15-0059 P	In eriod:	Lieu	u of For Workshe		
IUSI I IAL A	NO HOST THE HEALTH CARE COM LEA TRENTITICATION DA			F	rom 01/01/2		Part I		
					o 12/31/2		Date/Ti 5/29/20	18 8:5	
					Urban/Rura 1.00	IS	Date of 2.0		
	r your standard geographic classification (not wa			ginning of the	1100	1	2.0		26.0
cost 27.00 Ente	reporting period. Enter "1" for urban or "2" for r your standard geographic classification (not wa	rural. ade) sta	atus at the end	d of the cost		1			27.0
repo	orting period. Enter in column 1, "1" for urban or	"2" f	or rural. If ap	opl i cabl e,					
	er the effective date of the geographic reclassifing is a sole community hospital (SCH), enter the			CH status in		0			35.0
	ct in the cost reporting period.				D · · ·				
					Begi nni ng 1. 00	<u>]:</u>	Endi 2. C		-
	r applicable beginning and ending dates of SCH st		Subscript line	36 for number				-	36.0
	periods in excess of one and enter subsequent date his is a Medicare dependent hospital (MDH), enter		umber of period	ds MDH status		0			37.0
	n effect in the cost reporting period. his hospital a former MDH that is eligible for th		trancitional n	wmont in	N				37.0
	prdance with FY 2016 OPPS final rule? Enter "Y" for				IN IN				37.0
	ructions) ine 37 is 1, enter the beginning and ending dates		Historius Ifli	no 37 is					38.0
	ter than 1, subscript this line for the number of								30.0
ente	r subsequent dates.				Y/N		Y/	M	
					1.00		2.0		
	; this facility qualify for the inpatient hospital itals in accordance with 42 CFR §412.101(b)(2)(i)				N		N		39.0
for	yes or "N" for no. Does the facility meet the mil	eage r	equirements in	accordance					
	1 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column ructions)	12"Y"	for yes or "N'	for no. (see					
40.00 Is t	his hospital subject to the HAC program reduction				N		N		40.0
	for no in column 1, for discharges prior to Octob n column 2, for discharges on or after October 1.			es or "N" for					
						V	XVIII	XIX	
Pros	pective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00 Does	this facility qualify and receive Capital paymer	nt for (di sproporti onat	te share in acc	cordance	Ν	Y	Ν	45.0
	1 42 CFR Section §412.320? (see instructions) his facility eligible for additional payment exce	eption ·	for extraordina	ary circumstand	ces	Ν	N	N	46.0
	uant to 42 CFR §412.348(f)? If yes, complete Wks1	. L, P	t. III and Wkst	t. L-1, Pt. I	through				
Pt. 47.00 Is t	his a new hospital under 42 CFR §412.300(b) PPS o	api talʻ	? Enter "Y for	yes or "N" fo	or no.	Ν	N	N	47.0
	he facility electing full federal capital payment	:? Ento	er "Y" for yes	or "N" for no.		Ν	N	N	48. C
	hing Hospitals his a hospital involved in training residents in	approv	ed GME programs	s? Enter "Y" 1	for yes	N	1		56.0
	N" for no. ine 56 is yes, is this the first cost reporting p	oriod (during which re	sidents in an	proved				57.0
GME	programs trained at this facility? Enter "Y" for	yes o	r "N" for no ir	n column 1. If	column 1				57.0
	Y" did residents start training in the first monty yes or "N" for no in column 2. If column 2 is "N								
"N",	complete Wkst. D, Parts III & IV and D-2, Pt. II	, if a	oplicable.						
	ine 56 is yes, did this facility elect cost reimb ned in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' services a	as	Ν			58. C
	costs claimed on line 100 of Worksheet A? If yes	•				N		<u> </u>	59.0
				NAHE 413.85 Y/N	Worksheet Line #		Pass-Th Qualifi		
							Cri teri c	on Code	
				1.00	2.00		3.0	00	1
	you claiming nursing and allied health education	. ,		Y					60.0
	programs that meet the criteria under $$413.85?$ (ine 60 is yes, complete columns 2 and 3 for each				23	3. 00	1		60.0
inst	ructions)	Y/N	IME	Direct GME	IME		Di rect	GME	
	your hospital receive FTE slots under ACA	1.00	2.00	3.00	4.00	0.00	5. C		61.0
sect	ion 5503? Enter "Y" for yes or "N" for no in					5.00		0.00	1 01.0
	mn 1. (see instructions) er the average number of unweighted primary care				-				61.0
FTEs	from the hospital's 3 most recent cost reports								51.0
	ng and submitted before March 23, 2010. (see ructions)								
51.02 Ente	er the current year total unweighted primary care								61.0
	count (excluding OB/GYN, general surgery FTEs, primary care FTEs added under section 5503 of								
ACA)	. (see instructions)								
	r the base line FTE count for primary care 'or general surgery residents, which is used for								61.0
dete	rmining compliance with the 75% test. (see								
i nst	ructions)	1							L

Health Financial Systems RIVE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		IOSPI TAL Provi der C	CN: 15-0059	Peri od:	u of Form CMS-2 Worksheet S-2	
NOSTTAL AND NOSTTAL HEALTH GARL COMPLEX TELNTITICATION DA			civ. 13-0039	From 01/01/2017 To 12/31/2017	Part I	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 						61.04
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name			Direct GME FTE Count	
(1.10 Of the FTFe in Line (1.05 - modify each new		1.00	2.00	3.00	4.00	(1 10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
51.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction of S2.01 Enter the number of FTE residents that rotated from a second s	tions)					62. 00 62. 01
during in this cost reporting period of HRSA THC prog	ram. (s	ee instructio			0.00	02.01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se			ost reporting	period? Enter	N	63.00
"Y" for yes or "N" for no in column 1. If yes, comple			<u>67. (see inst</u>	ructions)		
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi dei Si te	r Hospital	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	· .		inis base yea	a is your cost r	eporting	
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter ir of (column 1 divided by (column 1 + column 2)). (see	y train -primar all non l non-pr i column instruc	ned residents ry care provider rimary care a 3 the ratio ctions)	0.	00 0. 00		
Program Name		ogram Code	Unweighted FTEs Nonproviden Site	FTES in	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2.00	3.00	4.00	5.00	1

	EX IDENTIFICATION DA	AIA Provider	Fr	eriod: com 01/01/2017	Worksheet S-2 Part I	
			To	12/31/2017	Date/Time Pre 5/29/2018 8:5	pared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	4))	
	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in						
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unweighted	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			FTEs Nonprovider	Hospital	(col. 1 + col. 2))	
			Si te			
			1.00	2.00	3.00	
Section 5504 of the ACA Current N beginning on or after July 1, 201		n Nonprovider Settir	ngsEffective fo	or cost reporti	ing periods	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column :					
	<u>column 2)). (see in:</u> Program Name	structions) Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	Program Name	Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	Program Name	Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital 4.00 0.00	(col. 3 + col. 4)) 5.00 0.000000	
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	Program Name	Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00 0.000000	
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) Inpatient Psychiatric Facility PF 00	Program Name 1.00 25 25 25 25 25 25 25 25 25 25	Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	67. (
 O0 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) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) 	Program Name 1.00 2S ychiatric Facility (the facility have al efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii) ate which program y	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
 O0 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, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psychiatric Synthesis Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFC column 3: If column 2 is Y, indic 	Program Name 1.00 1.00 2S /chiatric Facility (the facility have an efore November 15, 21 umn 2: Did this fac 2 412.424 (d)(1)(iii) cate which program you y PPS habilitation Facility	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col. 3 + col. 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	_

Health Financial Systems RIVERVIEW HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPI TAL Provi der CO	1	In Lie Period: From 01/01/2017 To 12/31/2017		2 epared:
				1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)86.00Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		2		N	85.00 86.00
87.00 Is this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under section		N	87.00
			V	XI X	
			1.00	2.00	
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificat			N	92.00
93.00 Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	Ν	Ν	93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	Ν	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for n	o in the	N	N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"	0. 00 Y	0. 00 Y	97.00 98.00		
 column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the ref. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title VIX 			Y	Y	98. 01
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of 			Y	Y	98. 02
 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crime reimbursed 101% of inpatient services cost? Enter "Y" for years 			Ν	N	98.03
<pre>for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in</pre>			N	N	98.04
<pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in o there is the XVI.</pre>			Y	Y	98.05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.</pre>			Y	Y	98.06
Rural Providers				1	_
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment	N N		105.00 106.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in column			N		107.00
yes, the GME elimination is not made on Wkst. B, Pt. I, col- reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the p	rogram is cost			
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dule? See 42	N		108.00
	Physi cal	Occupati onal		Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3.00 N	4.00 N	109.00
				1.00	-
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	'Y" for yes or	"N" for no. I	f yes,	1.00 N	110.00

Health Financial Systems RIVERVIEW HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:		lr Period: From 01/01/ To 12/31/	2017	u of For Workshe Part I Date/Ti 5/29/20	et S-2 me Pre	epared:
				5729720	010 0.3	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Comm Health Integration Project (FCHIP) demonstration for this cost reporting per "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, ent- integration prong of the FCHIP demo in which this CAH is participating in co Enter all that apply: "A" for Ambulance services; "B" for additional beds; a for tele-health services.	riod? Enter er the lumn 2.	1.00 N		2. (00	111.00
			1.00	2.00	3.00	
 Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in consisting yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term of psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1. 11(00 this facility classified on a professorial caster? Enter "Y" for yes or "N" for no in constant of the psychiatric for the psychiatric state. 	"E", enter care (inclu definition	in column udes	N		0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" no.		"N" for	N Y			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	the policy	is	2			118.00
	Premi ums	Losse	5	Insur	ance	
	1.00	2.00		3. (00	-
118.01 List amounts of malpractice premiums and paid losses:	895, 07	12	0		(0118.01
		1.00		2.0	00	_
 118.02 Are malpractice premiums and paid losses reported in a cost center other than Administrative and General? If yes, submit supporting schedule listing cost 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 Harmless provis \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) 	centers ion in ACA or yes or Outpatient	N		Ν		118. 02 119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable devices cl patients? Enter "Y" for yes or "N" for no.	charged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903(w) Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter i the Worksheet A line number where these taxes are included.		N				122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" fo	orno.lf	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification in column 1 and termination date, if applicable, in column 2.	ation date					126. 00
 127.00 If this is a Medicare certified heart transplant center, enter the certifica in column 1 and termination date, if applicable, in column 2. 	ntion date					127.00
128.00 If this is a Medicare certified liver transplant center, enter the certifica in column 1 and termination date, if applicable, in column 2.	ntion date					128.00
129.00 If this is a Medicare certified lung transplant center, enter the certificat column 1 and termination date, if applicable, in column 2.	ion date ir	ו				129. 00
130.00 If this is a Medicare certified pancreas transplant center, enter the certificate in column 1 and termination date, if applicable, in column 2.						130.00
131.00 f this is a Medicare certified intestinal transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.						131.00
132.00 f this is a Medicare certified islet transplant center, enter the certifica in column 1 and termination date, if applicable, in column 2.						132.00
133.00 If this is a Medicare certified other transplant center, enter the certifica in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OPO number in .						133.00 134.00
and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pu		Y				140.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home of are claimed, enter in column 2 the home office chain number. (see instruction	fice costs					

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			PITAL Provider CC	CN: 15-0				Worksheet S- Part I	epared:
1.00		2.00					3.00		
If this facility is part of a chain the home office and enter the home office					the n	name an	d address	of the	
home office and enter the home of 41.00 Name:	Contractor name an				ntracto	or's Nu	umber:		141.00
42.00 Street:	PO Box:					0. 0			142.00
43.00 Ci ty:	State:			Zij	o Code	:			143.00
									_
44.00 Are provider based physicians' cos	to included in Worksho	ot 12						1.00 Y	144.00
144. OOJATE PLOVI del based physicians cos		etAr						T	144.00
							1.00	2.00	1
 45.00 If costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility inception period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d) 	for yes or "N" for no clude Medicare utilizat for no in column 2. yy changed from the pre- n column 1. (See CMS Pu	o in co ion fo eviousl	lumn 1. If c r this cost y filed cost	column report t repor	i ng t?		Y		145. 00
								1.00	
147.00 Was there a change in the statisti								N	147.00
148.00 Was there a change in the order of					N" £	nc		N N	148.00
149.00Was there a change to the simplifi	ed cost finding method	1? Ente	Part A		n for rt B		Title V	Title XIX	149.00
			1.00		. 00		3.00	4.00	-
Does this facility contain a prov	der that qualifies for	r an ex				ition o			
or charges? Enter "Y" for yes or '	N" for no for each con	nponent		and Pa		(See 4			-
55. 00 Hospi tal			N		N		N	N	155.0
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	1	N N		N N	N N	156.0
58. 00 SUBPROVI DER			i v				N		158.00
59. 00 SNF			Ν		Ν		Ν	N	159.00
60.00 HOME HEALTH AGENCY			Ν	1	Ν		Ν	N	160. 00
61.00 CMHC					N		N	N	161.00
								1.00	-
Multicampus									
65.00 Is this hospital part of a Multica	mpus hospital that has	s one o	r more campu	uses in	di ffe	rent C	BSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name		County	Stat	- 7i	p Code	CBSA	FTE/Campus	
	0		1.00	2.0		3.00	4.00	5.00	-
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									0 166. 00
								1.00	-
Health Information Technology (HI						nt Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a mea	ani ngfu	l user (line			, ente	r the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is r				- qual i	fy for	a har	dshi p		168. 0
exception under §413.70(a)(6)(ii)	PEnter "Y" for yes or	"N" fo	r no. (see i	nstruc	ti ons)		·		
69.00 If this provider is a meaningful u		and is	not a CAH ((line 1	05 is	"N"),	enter the	0.2	25169. 0
transition factor. (see instruction	///s/					Be	egi nni ng	Endi ng	
							1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	eginning date and endi	ng dat	e for the re	eportin	g	07	/01/2016	09/30/2016	170.00
							1.00	2.00	-
71.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans u "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I,	line 2, col	. 6? E	nter	n	N		0 171. 00

IOSPI ⁻	Financial Systems RIVERVIEW TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0059	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pro 5/29/2018 8:	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente	er all dates in t	he	
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N		1 1.0
. 00	reporting period? If yes, enter the date of the change in c					1.0
	Treportring period: Tr yes, enter the date of the enange th e	01 unit 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P	rogram? If	N			2.0
	yes, enter in column 2 the date of termination and in colum	in 3, "V" for				
~ ~	voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o	g management	N			3.
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
~~	Financial Data and Reports		N N	•	07/01/2010	4.0
. 00	Column 1: Were the financial statements prepared by a Cert		Y	A	07/01/2018	4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	ilable in				
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues diffe	rent from	N			5.
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
				1.00	2.00	-
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If yor is th	o providor la	s N		6.0
. 00	the legal operator of the program?	TT yes, is tr	le provider is	5 N		0.
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	structions		Y		7.0
. 00	Were nursing school and/or allied health programs approved		l during the	Ŷ		8.0
	cost reporting period? If yes, see instructions.		5			
. 00	Are costs claimed for Interns and Residents in an approved		al education	Ν		9. (
	program in the current cost report? If yes, see instruction					
0.00	Was an approved Intern and Resident GME program initiated o	r renewed in t	the current	Ν		10. (
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& Pin an Ann	roved	Ν		11. (
1.00	Teaching Program on Worksheet A? If yes, see instructions.		noveu	IN IN		
					Y/N	
					1.00	
	Bad Debts					_
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.
3.00	If line 12 is yes, did the provider's bad debt collection p	olicy change d	luring this co	ost reporting	Ν	13.0
1 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	vas saa in	structions	Ν	14.
4.00	Bed Complement	into warveu: Ti	yes, see m.		IN	- 14.1
5.00	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	tructions.	N	15.0
			t A	Par		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	_
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	N		N		16. (
5.00	If either column 1 or 3 is yes, enter the paid-through	IN		IN		10.
	date of the PS&R Report used in columns 2 and 4. (see					
	instructions)					
7.00	Was the cost report prepared using the PS&R Report for	Y	03/29/2018	Y	03/28/2018	17.
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
0 00	in columns 2 and 4. (see instructions)					
<u>u nn</u>	J	N		N		18.
0.00	Report data for additional claims that have been billed					
0.00						
8.00	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.	Ν		Ν		10
9. 00		Ν		Ν		19.

0SD11	Financial Systems RIVERVIEW AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		CN: 15-0059	Period:	eu of Form CMS- Worksheet S-2	
USFTI	AL AND HOSTIAL HEALTH CARE REIMBORSEMENT QUESTIONNAIRE	FIOVICEI C	CN. 15-0059	From 01/01/2017 To 12/31/2017	' Part II	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: bescribe 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.	N		Ν		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS F	IUSPITALS)			-
2.00	Have assets been relifed for Medicare purposes? If yes, se					22.00
3.00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ing the cost		23.00
4.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into durina	this cost re	eporting period?		24.00
	If yes, see instructions	0				
5.00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period	? IT yes, see		25.00
6.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see		26.00
7.00	instructions. Has the provider's capitalization policy changed during th	a cost roportir	a poriod2 lf	^c voc cubmit		27.00
7.00	copy.	e cost reportin		yes, subili t		27.0
0.00	Interest Expense		·		1	
8.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	ntered into dur	ring the cost	reporting		28.0
9.00	Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)		29.0
0. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		deht? If yes	500		30.0
0.00	instructions.	arrey wren new	debt: IT yes	5, 300		30.0
1.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	s, see		31.0
	Purchased Services					
2.00	Have changes or new agreements occurred in patient care se		ed through co	ontractual		32. 0
3.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competi	tive bidding? If		33.0
	no, see instructions.		.g	g		
	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	providor b	sod physicians?		34.0
4.00	If yes, see instructions.	rrangement with		iseu physicians?		34.0
5.00	If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based		35.0
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs Were home office costs claimed on the cost report?				T	24 0
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	?		36.0
	If yes, see instructions.	. ,				
7.00			Trom that of	-		38.0
7.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes enter in column 2 the fiscal year en		office			
7.00 8.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth	d of the home o		5,		39.0
7.00 8.00 9.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.	d of the home c er chain compor	nents? If yes	5,		
7.00 8.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth	d of the home c er chain compor	nents? If yes	5,		39.00 40.00
7.00 8.00 9.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the	d of the home c er chain compor home office?	nents? If yes If yes, see			
7.00 8.00 9.00 0.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions.	d of the home c er chain compor home office?	nents? If yes		. 00	
7.00 8.00 9.00 0.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	d of the home c er chain compor home office?	nents? If yes If yes, see		. 00	40.00
7.00 8.00 9.00 0.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	d of the home of chain comport home office?	nents? If yes If yes, see	2	. 00	
7.00 8.00 9.00 0.00 1.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	d of the home of chain comport home office?	nents? If yes If yes, see	2	. 00	40.00
7.00 8.00 9.00 0.00 1.00 2.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	d of the home of er chain comport home office?	nents? If yes If yes, see	2		40.0

Heal th	Financial Systems RIVERVIEW	HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0059	Period: From 01/01/2017	Worksheet S-2 Part II			
			To 12/31/2017		pared: 0 pm		
		3.00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	DI RECTOR			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		Peri od:	Worksheet S-3	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/29/2018 8:50	
				I		I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	90	32, 85	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		90	32, 85	0.00		7.00
	beds) (see instructions)		, .	02,00	0.00		
8.00	INTENSIVE CARE UNIT	31.00	15	5, 47	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		105	38, 32	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER – IPF						16.00
17.00	SUBPROVIDER – IRF	41.00	24	8, 76	0	0	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9, 12	25	0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30. 00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	00.00				0	26.00
26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER	89.00	154			0	26.25
27.00	Total (sum of lines 14-26) Observation Bed Days		154			0	27.00
29.00	Ambul ance Trips					0	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see fisting to the second s						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		U U		~		32.00
52.01	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0059		eriod: com 01/01/2017 o 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/29/2018 8:5	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time B	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, 149	282	12, 75	54			1.00
2.00	HMO and other (see instructions)	2, 261	2, 105					2.00
3.00	HMO I PF Subprovi der	0	_,					3.00
4.00	HMO IRF Subprovider	357	161					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, 149	282	12, 75	54			7.00
8.00	INTENSIVE CARE UNIT	929	0	2, 29	93			8.00
9.00	CORONARY CARE UNI T							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY		0		0			13.00
14.00	Total (see instructions)	6, 078	282	15, 04	47	0.00	1, 056. 08	
15.00	CAH visits	0	o		0			15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF	3, 599	49	5,64	43	0.00	23. 21	17.00
18.00	SUBPROVIDER							18.00
19.00	SKILLED NURSING FACILITY	3, 146	o	4, 02	22	0.00	0.00	19.00
20.00	NURSING FACILITY		-					20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24.10	HOSPICE (non-distinct part)	0	0	3	37			24.10
25.00	СМНС – СМНС							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)					0.00	1, 079. 29	27.00
28.00	Observation Bed Days		0	1, 74	44			28.00
29.00	Ambul ance Trips	0						29.00
30. 00	Employee discount days (see instruction)				0			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	64	13	31			32.00
32.01	Total ancillary labor & delivery room	-			0			32.01
	outpatient days (see instructions)				-			
33.00	LTCH non-covered days	0						33.00
33 01	LTCH site neutral days and discharges	0						33.01

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0059	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/29/2018 8:50	pared
		Full Time		Di s	charges		[
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	component	Workers	ii tie v			Patients	
		11.00	12.00	13.00	14.00	15.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	1, 4	64 70	3, 803	1. (
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			_			
00	HMO and other (see instructions)			5	08 651		2.
00	HMO I PF Subprovider				0		3.
00 00	HMO IRF Subprovider				14		4. 5.
00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5. 6.
00	Total Adults and Peds. (exclude observation						7.
00	beds) (see instructions)						/.
00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNIT						9.
. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGICAL INTENSIVE CARE UNIT						11.
2. 00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY						13.
1.00	Total (see instructions)	0.00	C	1,4	64 70	3, 803	14.
5.00	CAH visits						15.
. 00	SUBPROVIDER - IPF						16.
. 00	SUBPROVIDER - IRF	0.00	C	2	95 4	458	
. 00	SUBPROVIDER						18
. 00	SKILLED NURSING FACILITY	0.00					19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23
. 10	HOSPICE HOSPICE (non-distinct part)						24
. 00	CMHC - CMHC						24
. 00	RURAL HEALTH CLINIC						26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 00	Total (sum of lines 14-26)	0,00					27
. 00	Observation Bed Days	0100					28
. 00	Ambul ance Trips						29
. 00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31.
. 00	Labor & delivery days (see instructions)						32.
. 01	Total ancillary labor & delivery room						32.
	outpatient days (see instructions)						
8.00	LTCH non-covered days				0		33.
3. 01	LTCH site neutral days and discharges				0		33.

SPI T	AL WAGE INDEX INFORMATION		RI VERVI EW	Provider C		Period: From 01/01/2017 To 12/31/2017		pared:
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
00	Total salaries (see instructions)	200.00	70, 349, 309	-207, 117	70, 142, 193	2 2, 244, 921. 00	31. 24	1.0
00	Non-physician anesthetist Part		C	o		0.00	0. 00	2.0
00	A Non-physician anesthetist Part		(0		0. 00	0.00	3.0
	В			-				
00	Physician-Part A - Administrative		(0		0.00	0.00	4.0
01	Physicians - Part A - Teaching		0	-		0.00		
00	Physician and Non Physician-Part B		(0		0.00	0.00	5.0
00	Non-physician-Part B for		C	0		0.00	0.00	6.0
	hospital-based RHC and FQHC services							
00	Interns & residents (in an approved program)	21.00	C	0		0.00	0. 00	7.0
01	Contracted interns and		C	o		0.00	0. 00	7.0
	residents (in an approved programs)							
00	Home office and/or related		C	0		0.00	0. 00	8.0
00	organization personnel SNF	44.00	C			0. 00	0.00	9.0
. 00	Excluded area salaries (see		27, 360, 860	268, 408	27, 629, 26			
	instructions) OTHER WAGES & RELATED COSTS							-
. 00	Contract Labor: Direct Patient		238, 532	2 0	238, 53	2 7, 738. 00	30. 83	11. C
. 00	Care Contract Labor: Top Level		C	o		0.00	0.00	12.0
	management and other management and administrative services							
. 00	Contract Labor: Physician-Part		345, 517	0	345, 51	7 2, 664. 00	129. 70	13.0
. 00	A - Administrative Home office and/or related		ſ	0		0. 00	0.00	14.0
	orgainzation salaries and							
. 01	wage-related costs Home office salaries		C	o		0.00	0.00	14.0
. 02	Related organization salaries		0	0		0.00		14.0
. 00	Home office: Physician Part A - Administrative		Ĺ			0.00	0.00	15.0
. 00	Home office and Contract		C	0		0.00	0.00	16. (
	Physicians Part A - Teaching WAGE-RELATED COSTS							
. 00	Wage-related costs (core) (see instructions)		11, 401, 179	0	11, 401, 17	9		17. (
. 00	Wage-related costs (other)		C	0		c		18.0
. 00	(see instructions) Excluded areas		4, 784, 315	5 O	4, 784, 31	5		19.0
. 00	Non-physician anesthetist Part		() () () () () () () () () () () () () (0	(D D		20.
. 00	A Non-physician anesthetist Part		(0		b		21. (
	B Physician Part A -		(D		22. (
	Administrative					-		
. 01 . 00	Physician Part A - Teaching Physician Part B		(22. (23. (
. 00	Wage-related costs (RHC/FQHC)		C	-		0		24.0
. 00	Interns & residents (in an approved program)		(0				25.0
. 50	Home office wage-related		C	0		D		25.5
. 51	(core) Related organization		(o		b		25.5
. 52	wage-related (core) Home office: Physician Part A - Administrative -		C	0		D		25. 5
	wage-related (core)							
. 53	Home office & Contract Physicians Part A - Teaching -		(0				25.5
	wage-related (core)							
. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	S 4.00	443, 484	327, 045	770, 52	9 21, 566. 00	35. 73	26. (
	Administrative & General	5.00	8, 372, 803					

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	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet S-3 Part II Date/Time Pre 5/29/2018 8:5	pared:
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col.$		col. 5)	
				A-6)	3)	col. 4		
	r	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		2, 378, 734	0	2, 378, 734	4 7, 585.00		
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 676, 444	0	1, 676, 444	4 63, 642. 00	26.34	30.00
31.00	Laundry & Linen Service	8.00	49, 198	0	49, 198	3, 295. 00	14. 93	31.00
32.00	Housekeepi ng	9.00	815, 155	0	815, 155	5 59, 300. 00	13. 75	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10.00	1, 053, 583	-785, 094	268, 489	22, 919. 00	11. 71	34.00
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00
36.00	Cafeteria	11.00	0	708, 801	708, 801	43, 750. 00	16. 20	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	517, 258	0	517, 258	3 10, 378. 00	49.84	38.00
39.00	Central Services and Supply	14.00	439, 621	194, 452	634, 073	3 37, 029. 00	17. 12	39.00
40.00	Pharmacy	15.00	2, 534, 640	-192, 115	2, 342, 525	73, 958.00	31.67	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	825, 130		825, 130			
42.00	Soci al Servi ce	17.00	640, 288	0	640, 288	18, 068. 00	35.44	42.00
43.00	Other General Service	18.00	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 01/01/2017 To 12/31/2017		
		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				-		
1.00	Net salaries (see		72, 728, 043	-207, 117	72, 520, 92	6 2, 252, 506. 00	32.20	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		27, 360, 860	268, 408	27, 629, 26	8 647, 383.00	42.68	2.00
3.00	Subtotal salaries (line 1		45, 367, 183	-475, 525	44, 891, 65	8 1, 605, 123. 00	27.97	3.00
5.00	minus line 2)		45, 507, 105	-475, 525	44, 071, 03	1,005,125.00	21.71	5.00
4.00	Subtotal other wages & related		584, 049	0	584, 04	9 10, 402. 00	56. 15	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs (see inst.)		11, 401, 179	0	11, 401, 17	9 0.00	25.40	5.00
6.00	Total (sum of lines 3 thru 5)		57, 352, 411	-475, 525	56, 876, 88	6 1, 615, 525. 00	35, 21	6,00
7.00	Total overhead cost (see		19, 746, 338					7.00
	instructions)							

Heal th	Financial Systems	RIVERVIEW HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
HOSPIT	AL WAGE RELATED COSTS		Provider CCN:	15-0059	Period: From 01/01/2017 To 12/31/2017		pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETI REMENT COST						
1.00	401K Employer Contributions					1, 172, 256	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contributi	on				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see ins	structions)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instru	uctions)				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Orga	jani 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 Fe	ees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					9, 167, 380	8.00
8.01	Health Insurance (Self Funded without a Third P	Party Administra	ator)			0	8. 01
8.02	Health Insurance (Self Funded with a Third Part	ty Administrator	-)			0	8. 02
8.03	Health Insurance (Purchased)					0	8.03
9.00	Prescription Drug Plan					84, 386	9.00
10.00	Dental, Hearing and Vision Plan					191, 157	10.00
11.00	Life Insurance (If employee is owner or benefic	ci ary)				33, 281	11.00
12.00	Accident Insurance (If employee is owner or ben					0	12.00
13.00	Disability Insurance (If employee is owner or b					0	13.00
14.00	Long-Term Care Insurance (If employee is owner	or beneficiary)	1			243, 981	
15.00	'Workers' Compensation Insurance					29, 578	15.00
16.00	Retirement Health Care Cost (Only current year,	not the extra	ordi nary accrua	l require	d by FASB 106.	0	16.00
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only					5, 171, 769	
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					19, 646	
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER					-	
21.00	Executive Deferred Compensation (Other Than Ret instructions))	tirement Cost Re	eported on line	s 1 throu	gh 4 above. (see	0	
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					72, 060	
24.00	Total Wage Related cost (Sum of lines 1 -23)					16, 185, 494	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0059	Peri od:	Worksheet S-3	
			From 01/01/2017	Part V	
			To 12/31/2017	Date/Time Pre 5/29/2018 8:50	
	Cost Center Description		Contract Labor		5 pm
	Cost Center Description		1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identifi	cati on:			
1.00	Total facility's contract labor and benefit co	st	238, 532	16, 185, 494	1.00
2.00	Hospi tal		238, 532	16, 185, 494	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

Item Bit Mark Item		Financial Systems RIVERVIEW				eu of Form CMS-2	
No. The Pick Pick Pick as a heap table. Busine Sime names of care or was there no Medicare util i action? In row yas in column 1 and do not complete the rest of this worksheet. No. No. <th>PRUSPI</th> <th>CTIVE PAYMENT FOR SNE STATISTICAL DATA</th> <th>Provi der C</th> <th></th> <th>Period: From 01/01/2017 To 12/31/2017</th> <th>Date/Time Pre</th> <th>pared:</th>	PRUSPI	CTIVE PAYMENT FOR SNE STATISTICAL DATA	Provi der C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
10 If this facility contains a hosp tail-based SH:, were all pattents onlaw 1 and so not							
mass therm no Modicare util Lot time? "Y" for yes in column 1 and du not z.u z.u z.u	1.00	If this facility contains a hospital-based SNF, were all p	atients under r	managed care	1.00	2.00	1.00
200 Does, this hospit all have an agreement under either section 1983 for section 1983 for section 2983 for year of the agreement of a section 1983 for agreement and the section 1983 for agreement and the agreement of agreement and the agreement of the ag		or was there no Medicare utilization? Enter "Y" for yes in					
date: (modd//yoyd) in col umn 2 forup Swir nave swi ng med swi rotal (sum of coll (sum of coll (sum of coll (sum of coll (sumo	2.00	Does this hospital have an agreement under either section					2.00
1.00 2.00 3.00 4.00 3.00 4.00 80.0 0 0.00 3.00 3.00 4.00 80.0 0 0 0.00 6.00 7.00 80.0 80.0 0 0.00 80.0 0 0.00 80.0 8.00 80.0 80.0 80.0 0.00 80.0 0.00 0.00 80.0 0.00		date (mm/dd/yyyy) in column 2.	Group	SNF Days	Swing Bed SNF	Total (sum of	
3.00 RUX 0 0 0 3.00 5.00 RVX 0 0 0 4.00 5.00 RVX 0 0 0 5.00 7.00 RVX 0 0 0 6.00 8.00 RVX 0 0 0 0 6.00 8.00 RVX 0 0 0 0 0 9.00 RVX 0 0 0 0 0 10.00 RUX 0 0 0 0 0 11.00 RUX 0 0 1 10 0 1 10 11.00 RUX 0 0 1 10 1 <			1.00	2.00			
5.00 PXX 0 0 0 5.00 7.00 PKK 0 0 0 0 10.00 PKK 0 0 0 0 11.00 PKK 0 0 0 0 12.00 PKK 0 0 0 0 12.00 PKK 0 0 0 0 12.00 PKK 0 0 0 0 13.00 PKK 0 0 0 0 14.00 PKK 0 0 0 0 15.00 PKK 23 0 23 0 15.00 PKK 23 0 23 0 15.00 PKK 33 0 33 1 16.00 PKK 33 0 33 0 17.00 PKK 33 0 0 0 17.00 PKK 33 0 33 0 17.00 PKK 33 0 0 0 17.00 PKK 33 0 0 0 17.00 PKK 3 0 34 0 17.00 <	3.00		RUX		0 0	0	3.00
6.00 RVL 0 0 0 0 0 8.00 RVL 0 0 0 0 0 8.00 RVL 0 0 0 0 0 0 11.00 RVL 0 <td< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td><td>1</td></td<>					-		1
8.00 RHL 0 0 0 0 0 0 10 00 RMM 0 0 0 0 0 11 00 RLM 0 0 0 0 0 0 11 00 RLM 0<	6.00						6.00
9,00 RMX 0 0 0 0 0 0 1100 RLX 0 0 0 0 0 0 1100 RLX 0 0 0 0 0 0 0 1300 RLX 0 <td< td=""><td>7.00</td><td></td><td></td><td></td><td>-</td><td></td><td>7.00</td></td<>	7.00				-		7.00
10.00 944. 0 0 0 10 12.00 940. 92.7 0 0.27 12.00 12.00 940. 92.7 0 0.27 12.00 13.00 940. 92.8 0 12.60 15.00 940. 92.8 0 22.60 15.00 940. 92.8 0 22.60 17.00 940. 43.8 0 43.8 18.00 17.00 940. 94.8 0 43.8 19.00 19.00 940. 94.8 0 43.8 10.0 10.1 19.00 940. 94.8 0 0 0 22.00 10.00 94.00 94.00 0 0 0 22.00 24.00 92.00 84.8 0 0 0 25.00 25.00 84.9 0 0 0 25.00 26.00 84.9 0 0 0 0 25.00 27.00 82.0 0 0 0 0 0 0 27.00 82.0 0 0 0 0 0 0 0 0 0					-		
12.00 RUE 9.7 0 9.29 12.00 14.00 RUA 1.153 0 1.151 13.00 14.00 RUA 3.47 0 3.44 14.00 15.00 RVC 2.268 0 2.26 15.00 16.00 RVG 2.263 0 2.26 15.00 16.00 RVG 2.26 0 2.26 15.00 18.00 RVG 4.4 0 0 2.10 19.00 RVR 2.28 0 2.12 15.00 22.00 RVR 2.31 0 0 2.20 22.00 RVR 0 0 0 2.20 22.00 RVA 0 0 0 2.30 23.00 RLA 0 0 0 2.30 24.00 ES3 0 0 0 2.30 25.00 RLA 0 0 2.30 26.00 ES3 0 0 3.00 35.00 HC1 3 0 3.30 36.00 HC2 0 0 3.40 37.00 HC2 0 0 3.40	10.00						10.00
13.00 RUB 1,150 <t< td=""><td>11.00</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	11.00						
H4 00 RUA BAT 0 FAT 14, 00 15, 00 RVG 266 0 236 16, 00 16, 00 RVG 246 0 236 16, 00 18, 00 RVA 43 0 445 16, 00 216 16, 00 216 16, 00 216 16, 00 216 16, 00 216 16, 00 216 20, 00 216 216 216 216 216 216 216 216 216 216 216 216 216 216							1
16 00 RVB 236 0 248 16, 00 18 00 RVA 43 0 443 17, 00 18 00 RVA 43 0 443 18, 00 33 19, 00 20, 00 RVA 21 0 22, 00 21, 00 27, 10 28, 00 28, 00 28, 00 28, 00 28, 00 28, 00 28, 00 28, 00 28, 00 28, 00 33, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 <	14.00		RUA	34	7 0	347	14.00
17. 00 RVA 443 0 45 17. 00 19. 00 RHC 45 0 45 17. 00 19. 00 RHB 33 0 33 19. 00 21. 00 RMA 21 0 0. 21 0. 02 22. 00 RMC 7 0 0. 21 0. 02 22. 00 22. 00 RMA 0 0 0. 02 23. 00 0 0. 02 24. 00 0. 02 24. 00 0. 02 24. 00 0. 02 25. 00 0. 02 0. 02 25. 00 0. 02 0. 02 0. 02 26. 00 25. 00 0. 02	15.00						
18.00 PHC HHS 35 0 33 19.00 20.00 PHHB 33 0 37.00 21.00 21.00 RMA 21 0 7.7 27.00 22.00 RMB 0 0 0 23.00 22.00 RMB 0 0 24.00 23.00 24.00 RLA 0 0 24.00 25.00 25.00 20.00 25.00 25.00 20.00 27.00 25.00 20.00 27.00 25.00 20.00	16.00						
20.00 HHA 21 0 12 0 21 0 21 0 21 0 21.00 NMB 0 0 21.00 21.00 21.00 21.00 22.00 NMB 0 0 22.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 24.00 0 24.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 27.00 25.00 27.00 25.00 20.00 27.00 28.00 27.00 20.00 20.00 27.00 20.00 <	18.00						
21.00 RMC 7 0 7 2.00 23.00 RMA 0 0 22.00 23.00 RMA 0 0 22.00 23.00 RMA 0 0 22.00 24.00 RLB 0 0 24.00 25.00 RLA 0 0 24.00 25.00 ES3 0 0 25.00 27.00 ES51 0 0 0 28.00 29.00 HE1 0 0 0 30.00 30.00 HD1 4 0 0 33.00 31.00 HD2 0 0 0 33.400 35.00 HB2 0 0 0 33.400 36.00 LE2 0 0 0 34.00 37.00 LE2 0 0 0 34.00 38.00 LE2 0 0 0 34.00 39.00 LE2 0 0 0 0 34.00 44							
22 00 RNA 0 0 0 23 00 25 00 RLA 0 0 0 24 00 26 00 RLA 0 0 0 25 00 27 00 ES2 0 0 0 27 00 28 00 ES1 0 0 0 28 00 29 00 ES1 0 0 0 30 0 31 00 HE1 0 0 0 31 00 32 00 H01 4 0 44 32 0 33 00 HE2 0 0 0 33 0 34 00 H21 3 0 33 40 0 33 40 35 00 HB2 0 0 0 36 00 34 00 41 00 LE2 0 0 0 37 00 34 00 0 34 00 42 00 LE2 0 0 0 34 00 0 34 00 0 34 00 0 34 00 0 34 00 0 34 00 0 0 0 0	21.00						21.00
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58.00 SSC 0 0 58.00 59.00 SSB 0 0 59.00 60.00 SSA 0 0 60.00 61.00 IB2 0 0 61.00 62.00 IB1 0 0 62.00 63.00 IA1 0 0 63.00 64.00 BB1 0 0 63.00 65.00 BB1 0 0 64.00 66.00 BB1 0 0 64.00 67.00 BA2 0 0 67.00	56.00 57.00				-		
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	66.00 67.00						
68.00 BA1 0 0 68.00	67.00 68.00						67.00

Heal th Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552 PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA Provider CCN: 15-0059 Period: From 01/01/2017 To 12/31/2017 Worksheet S-7 Date/Time Prepare 5/29/2018 8:50 pm Group SNF Days Swing Bed SNF Days Total (sum of col. 2 + 3) 1.00 2.00 3.00 4.00	ared: pm 69.00
Group SNF Days Swing Bed SNF Total (sum of col. 2 + 3) 1.00 2.00 3.00 4.00	69.00
1.00 2.00 3.00 4.00	
69.00 PE2 0 0 0 69.	
70.00 PE1 3 0 3 70.	70.00
71.00 PD2 0 0 71.	71.00
72.00 PD1 0 0 72.	72.00
	73.00
	74.00
	75.00
	76.00
	77.00
	78.00
199.00 AAA 0 0 0 119.	
200. 00 TOTAL 3, 146 0 3, 146 200.	
CBSA at CBSA on/after	00.00
Beginning of October 1 of	
Cost Reporting the Cost	
Period Reporting	
Period (if	
aplicable)	
1.00 2.00	
SNF_SERVICES	
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, 26900 26900 201.	01.00
in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	
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. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related	
expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in	
column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I,	
line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated	
with direct patient care and related expenses for each category. (see instructions)	
	02.00
	03.00
	04.00
	05.00
	06.00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3) 2,328,876 207.	07.00

Heal th	Financial Systems RIVERVIEW HOSPI	TAL		In Lie	eu of Form CMS-	2552-10
HOSPI 1	 10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state instructions for each line) Private grants, donations, or endowment income restricted to funding chari Government grants, appropriations or transfers for support of hospital operation. 		: 15-0059	Period: From 01/01/2017	Worksheet S-1	0
				To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00		ded by line	e 202 columr	18)	0. 312632	1.00
2.00					6, 525, 689	
3.00					Y	3.00
4.00			from Medica	ii d?	_	4.00
5.00 6.00		om Medicaid			0	
8.00 7.00					28, 802, 466 9, 004, 573	
8.00		ine 7 minus	sum of lir	ues 2 and 5 [.] if	2, 478, 884	
0.00					2, 170, 001	0.00
		⁻ each line)				
9.00					0	
					0	
			- 11 0	£ then	0	
12.00		ine ii minu	IS IT në 9; I	r < zero then	0	12.00
		uctions for	each line)		<u> </u>	
13.00					0	13.00
14.00	Charges for patients covered under state or local indigent care	program (No	t included	in lines 6 or	0	14.00
					_	
15.00				- 15 minus line	0	
16.00		gent care p	brogram (IIr	ie 15 minus line	0	16.00
		o and state/	'local indic	ent care program	ns (see	
				1 3		
					0	
					0	
19. 00		Indigent ca	are programs	s (sum of lines	2, 478, 884	19.00
			Uni nsured	Insured	Total (col. 1	
		_	patients	patients	+ col . 2)	
	Uncompanyated Cara (cap instructions for each line)		1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	Lity	4, 816, 54	2, 375, 349	7, 191, 894	20.00
20.00	(see instructions)	They	4, 010, 3-	2, 373, 347	, , , , , , , , , , , , , , , , , , , ,	20.00
21.00	Cost of patients approved for charity care and uninsured discour	nts (see	1, 505, 80	2, 375, 349	3, 881, 155	21.00
	instructions)					
22.00	Payments received from patients for amounts previously written of	off as		0 0	0	22.00
23.00	charity care Cost of charity care (line 21 minus line 22)		1, 505, 80	2, 375, 349	3, 881, 155	23.00
23.00			1, 505, 80	2, 375, 349	3,001,133	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient		nd a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p				_	
25.00	If line 24 is yes, enter the charges for patient days beyond the	e indigent c	are program	's length of	0	25.00
26 00	stay limit Total bad debt expense for the entire hospital complex (see inst	tructions)			8, 632, 058	26.00
	Medicare reimbursable bad debts for the entire hospital complex (see first		uctions)		127, 861	
	Medicare allowable bad debts for the entire hospital complex (se				196, 710	
	Non-Medicare bad debt expense (see instructions)		- /		8, 435, 348	
	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see in	nstructions)		2, 706, 009	
30.00					6, 587, 164	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			9, 066, 048	31.00

		= EXPENSES	Provider CC		eriod: rom 01/01/2017	Worksheet A	
					o 12/31/2017	Date/Time Prep 5/29/2018 8:50	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Recl assi fi ed Tri al Bal ance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		14, 301, 232	14, 301, 232	-250, 950	14, 050, 282	 1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	443, 484	8, 015, 585	8, 459, 069		8, 786, 114	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	8, 372, 803	21, 543, 777	29, 916, 580		28, 800, 845	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 676, 444	4, 611, 989	6, 288, 433		6, 288, 259	7.00
9.00	00900 HOUSEKEEPING	49, 198 815, 155	321, 332 672, 399	370, 530 1, 487, 554		370, 530 1, 487, 554	9.00
10.00	01000 DI ETARY	1, 053, 583	1, 689, 172	2, 742, 755		698, 676	
		0	0	0	1, 845, 196	1, 845, 196	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	517, 258 439, 621	124, 802 4, 310, 010	642, 060 4, 749, 631		639, 090 14, 320, 982	
	01500 PHARMACY	2, 534, 640	18, 281, 021	20, 815, 661	-231, 575	20, 584, 086	
	01600 MEDI CAL RECORDS & LI BRARY	825, 130	730, 821	1, 555, 951	0	1, 555, 951	16.00
	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	640, 288 0	140, 307 0	780, 595 0		780, 595 203, 117	
-0.00	INPATIENT ROUTINE SERVICE COST CENTERS		0	0	203, 117	200, 117	20.00
	03000 ADULTS & PEDIATRICS	6, 947, 794	1, 070, 667	8, 018, 461	283, 513	8, 301, 974	30.00
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	1, 697, 372 1, 281, 389	311, 878 1, 040, 553	2, 009, 250 2, 321, 942		1, 877, 373 2, 269, 761	31.00 41.00
	04300 NURSERY	1, 201, 309	1, 040, 555	2, 321, 942	-52, 181	2, 209, 701	41.00
	04400 SKILLED NURSING FACILITY	0	2, 135, 242	2, 135, 242	-33, 321	2, 101, 921	44.00
	ANCI LLARY SERVI CE COST CENTERS	1 142 127	14 402 405	15, 545, 532	7 624 040	7, 921, 472	50.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 142, 127 0	14, 403, 405 0	15, 545, 552	-7, 624, 060 0	7,921,472	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 499, 226	825, 380	2, 324, 606	6, 979	2, 331, 585	
	05500 RADI OLOGY-THERAPEUTI C	383, 620	613, 232	996, 852		1, 048, 665	
57.00 57.01	05700 CT SCAN 03630 ULTRA SOUND	243, 736	102, 327	346, 063 0	-51, 899 0	294, 164 0	57.00 57.01
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	209, 279	64, 705	273, 984	-5, 185	268, 799	
59.00	05900 CARDI AC CATHETERI ZATI ON	764, 279	1, 472, 527	2, 236, 806		1, 662, 218	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2, 328, 857	3, 140, 069	5, 468, 926	21, 721	5, 490, 647 0	60.00 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	514, 016	514, 016	Ŭ	514, 016	63.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	989, 351 3, 982, 703	192, 705 2, 194, 218	1, 182, 056	316, 937 -4, 528	1, 498, 993	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	3, 982, 703	2, 194, 218	6, 176, 921 0	-4, 528	6, 172, 393 0	67.00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	851, 130	156, 364	1, 007, 494	143, 935	1, 151, 429	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 142, 634	1, 142, 634	0	0 1, 142, 634	71.00
	07300 DRUGS CHARGED TO PATIENTS	Ő	0	0	0		73.00
	07400 RENAL DI ALYSI S	0	362, 136	362, 136	-1, 701	360, 435	
	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	775, 099	0 1, 090, 893	0 1, 865, 992	- 104, 390	0 1, 761, 602	76.00 76.01
	03070 WOMEN'S CENTER	378, 745	132, 340	511, 085		461, 536	
	03330 ENDOSCOPY	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS	786, 934	426, 673	1, 213, 607	-87, 400	1, 126, 207	90.00
90. 01	09001 OUTPATI ENT	501, 199	562, 788	1, 063, 987		990, 132	90.00
	09100 EMERGENCY	2, 139, 394	1, 130, 838	3, 270, 232	-114, 057	3, 156, 175	
	09101 SHORT STAY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	91.01 92.00
	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVI CES	54, 922	40, 448	95, 370	0	95, 370	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	44, 324, 760	107, 868, 485	152, 193, 245	217, 533	152, 410, 778	110 00
116.00	NONREIMBURSABLE COST CENTERS	44, 324, 700	107, 808, 485	152, 195, 245	217, 555	152, 410, 776	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	213, 215	186, 554	399, 769		399, 769	
	19200 PHYSICIANS' PRIVATE OFFICES	22, 898, 528	12, 774, 323	35, 672, 851		35, 258, 786	
	19201 FOUNDATI ON 19202 CLI NI CS	162, 788 969, 392	11, 656 225, 769	174, 444 1, 195, 161	-604	174, 444 1, 194, 557	
192.03	19206 HOME HEALTH PARTNERSHIP	0	150	150	0	150	192. 03
	19207 WESTFIELD SCHOOLS	992, 201	118, 785	1, 110, 986		1, 109, 511	
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE	788, 425	442, 123 239, 276	1, 230, 548 239, 276		1, 230, 548 239, 276	
	19205 RI VERVI EW MEDI CAL ARTS	0	173, 105	239, 270 173, 105		173, 105	
192.08					0		193.00
193.00	19300 NONPALD WORKERS	U	0	0	U 0		
193. 00 194. 00	19300 NONPALD WORKERS 07950 WORKMED 07951 MEALS ON WHEELS	0	0	0	0 198, 611		194.00

CLASSI FI CA	TION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CCN: 1	15-0059	Period:	Worksheet A	
					From 01/01/2017 To 12/31/2017	Date/Time Prep	
	Cost Center Description	Adjustments	Net Expenses			5/29/2018 8:50	0 pm
			For Allocation				
		6.00	7.00				
	L SERVICE COST CENTERS	1 407	14 040 705				1
1 1	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	-1, 497 -106, 232	14, 048, 785 8, 679, 882				1. 4.
	ADMINISTRATIVE & GENERAL	-9, 793, 055	19,007,790				5
	OPERATION OF PLANT	-15, 144	6, 273, 115				7.
	LAUNDRY & LINEN SERVICE	0	370, 530				8.
	HOUSEKEEPING	0	1, 487, 554				9
	DI ETARY	0	698, 676				10
00 01100	CAFETERI A	-716, 907	1, 128, 289				11
00 01300	NURSING ADMINISTRATION	0	639, 090				13
00 01400	CENTRAL SERVICES & SUPPLY	0	14, 320, 982				14
	PHARMACY	-5, 589, 619	14, 994, 467				15
	MEDICAL RECORDS & LIBRARY	-1, 643	1, 554, 308				16
1 1	SOCIAL SERVICE	0	780, 595				17
	PARAMED ED PRGM PHARMACY	0	203, 117				23
	ENT ROUTINE SERVICE COST CENTERS		7 70/ 017				20
1 1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	-575, 057	7, 726, 917				30
	SUBPROVIDER - IRF	0	1, 877, 373 2, 269, 761				31 41
	NURSERY	0	2, 209, 701				41
	SKILLED NURSING FACILITY	-125, 211	1, 976, 710				44
	ARY SERVICE COST CENTERS	120,211	1, 770, 710				
	OPERATI NG ROOM	-2, 796, 411	5, 125, 061				50.
	DELIVERY ROOM & LABOR ROOM	0	0				52
00 05400	RADI OLOGY-DI AGNOSTI C	-3, 500	2, 328, 085				54
00 05500	RADI OLOGY-THERAPEUTI C	0	1, 048, 665				55
	CT SCAN	0	294, 164				57
	ULTRA SOUND	0	0				57
	MAGNETIC RESONANCE IMAGING (MRI)	0	268, 799				58
	CARDI AC CATHETERI ZATI ON	-760, 833	901, 385				59
	LABORATORY	-112, 938	5, 377, 709				60
	BLOOD LABORATORY	0	514.01				60
	BLOOD STORING, PROCESSING & TRANS.	0	514, 016				63
	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	-310,000	1, 188, 993				64 65
	PHYSI CAL THERAPY	-310,000	6, 172, 393				66
	OCCUPATI ONAL THERAPY	0	0, 172, 375				67
	SPEECH PATHOLOGY	0	0				68
	ELECTROCARDI OLOGY	0	1, 151, 429				69
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71
	IMPL. DEV. CHARGED TO PATIENT	0	1, 142, 634				72
00 07300	DRUGS CHARGED TO PATIENTS	0	o				73
	RENAL DIALYSIS	0	360, 435				74.
	OTHER ANCI LLARY	0	0				76
	CARDI AC REHAB	0	1, 761, 602				76
	WOMEN'S CENTER	0	461, 536				76
		0	0				76
	I ENT SERVICE COST CENTERS	~	1 104 007				000
00 09000	OUTPATI ENT	0 -50	1, 126, 207 990, 082				90. 90.
00 09100		-50	3, 156, 175				90
	SHORT STAY	0	3, 150, 175				91
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92
	REIMBURSABLE COST CENTERS	1					
00 09500	AMBULANCE SERVICES	-1, 690	93, 680				95
SPECI A	L PURPOSE COST CENTERS	· · · · ·					
	SUBTOTALS (SUM OF LINES 1 through 117)	-20, 909, 787	131, 500, 991				118
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	399, 769				190
	PHYSI CLANS' PRI VATE OFFI CES	0	35, 258, 786				192
	FOUNDATION	0	174, 444				192
2.0219202		0	1, 194, 557				192
	HOME HEALTH PARTNERSHIP	0	1 100 511				192
	WESTFIELD SCHOOLS	0	1, 109, 511				192 192
	PRACTICE MANAGEMENT MOB - NOBLESVILLE SQUARE	0	1, 230, 548 239, 276				192
	RIVERVIEW MEDICAL ARTS	0	173, 105				192
	NONPAID WORKERS	0	0				192
4.0007950		0					193
	MEALS ON WHEELS	0	198, 611				194
	TOTAL (SUM OF LINES 118 through 199)	-20, 909, 787	171, 479, 748				200

SS	IFICATIONS			Provider CCN: 15-00		Worksheet A-6
					From 01/01/2017 To 12/31/2017	Date/Time Prepared:
						5/29/2018 8:50 pm
+	Cost Center	Increases Line #	Salary	Other		
+	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS	0.00	1.00	5.00		
	CAFETERIA	11.00	708, 801	1, 136, 395		1.00
-		†	708, 801	1, 136, 395		
	B - MEALS ON WHEELS					
1	MEALS ON WHEELS	194.01	76, 293	<u>122, 3</u> 18		1.00
	0		76, 293	122, 318		
	C - INSURANCE RECLASS					
4	ADMI NI STRATI VE & GENERAL	5.00	<u>0</u>	<u>250, 9</u> 50		1.0
0	0		0	250, 950		
	D - MED SUPPLY RECLASS		-1			
6	CENTRAL SERVICES & SUPPLY	14.00	0	9, 376, 899		1.0
		0.00	0	0		2.0
		0.00	0	0		3.0
		0.00	0	0		4.00
		0.00	0	0		5.0
		0.00	0	0		6.0
		0.00	0	0		7.0
		0.00 0.00	0	0 0		8.0
		0.00	0	0		10.0
		0.00	0	0		11.0
		0.00	0	0		12.0
		0.00				
		0.00	0	0 0		13. C 14. C
		0.00	0	0		14. 0
		0.00	0	0		16.0
		0.00	0	0		17.0
		0.00	0	0		18.0
		0.00	0	0		19.0
		0.00	0	0		20.0
		0.00	0	0		20.0
		0.00	0	0		21.0
		0.00	0	0		23.0
		0.00	0	0		24.0
		0.00	0	0		25.0
		0.00	0	Ö		26.0
		0.00	0	Ö		27.0
t				9, 376, 899		
Ī	E - RSMA RECLASS	•	· ·	· · ·		
- [EMPLOYEE BENEFITS DEPARTMENT	4.00	327, 045	0		1.0
- 0	CENTRAL SERVICES & SUPPLY	14.00	194, 452	0		2.0
0	OPERATING_ROOM	50.00	<u>3, 357, 7</u> 71	0		3.0
6	0		3, 879, 268	ō		
L	F - PHYSICIAN PROFESSIONAL FE					
	ADULTS & PEDIATRICS	30.00	0	575, 000		1.0
	OPERATING ROOM	50.00	0	61, 750		2.0
	RADI OLOGY-DI AGNOSTI C	54.00	0	13, 300		3. C
	RADI OLOGY-THERAPEUTI C	55.00	0	52, 800		4. C
	LABORATORY	60.00	0	60, 418		5.0
	RESPI RATORY THERAPY	65.00	0	350, 000		6.0
	ELECTROCARDI OLOGY	69.00	0	146, 250		7.0
	OUTPATI ENT	90.01	0	37, 167		8.0
	EMERGENCY	91.00	0	20, 000		9.0
	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	50,000		10. C
E C			0	1, 366, 685		
	H - PARAMED ED PHARMACY RESID		102 115	11.000		1.0
ŀ	PARAMED_ED_PRGM_PHARMACY	<u>23.</u> 00	<u>192, 115</u>	- 11,002		1.0
H	U I - COMMUNITY RELATIONS RECLA	\$\$	192, 115	11, 002		
H	ADMINISTRATIVE & GENERAL	5.00	0	207, 117		1.0
/			Y			1.0
t	()	1		207, 117		

	Financial Systems IFICATIONS		RIVERVIEW		CCN: 15-0059	Peri od:	u of Form CMS-2552 Worksheet A-6
						From 01/01/2017 To 12/31/2017	Date/Time Prepare 5/29/2018 8:50 pr
		Decreases					<u> 372972018 8.30 pi</u>
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	. <u>.</u>	
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS	10.00	700 001	1 124 205		0	1
0	<u>DI ETARY</u>	<u> </u>	<u>708, 801</u> 708, 801	<u>1, 136, 3</u> 95 1, 136, 395		o	1
H	B - MEALS ON WHEELS		706, 601	1, 130, 393			
	DI ETARY	10.00	76, 293	122, 318	1	0	1
Ĭ			76, 293	122, 318		1	
	C – INSURANCE RECLASS		10,270	122,010			
	NEW CAP REL COSTS-BLDG &	1.00	0	250, 950	1	2	1
	FIXT						
	0		o	250, 950			
	D - MED SUPPLY RECLASS				1		
	OPERATION OF PLANT	7.00	0	174		0	1
	DI ETARY	10.00	0	272		0	2
	NURSING ADMINISTRATION	13.00	0	2, 970		0	3
		15.00	0	28, 458		0	4
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00	U	291, 487		0	5
	SUBPROVIDER – IRF	31.00 41.00	0	131, 877 52, 181		ol	6
	SUBPROVIDER - TRF SKILLED NURSING FACILITY	41.00	0	33, 321		0	8
	OPERATING ROOM	50.00	0	7, 164, 313		0	9
	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 321		0	10
	RADI OLOGY-THERAPEUTI C	55.00	0	987		0	11
	CT SCAN	57.00	0	51, 899		0	12
00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5, 185		0	13
00	CARDIAC CATHETERIZATION	59.00	0	574, 588		o	14
00	LABORATORY	60.00	0	38, 697		o	15
00	RESPI RATORY THERAPY	65.00	0	33, 063		o	16
	PHYSICAL THERAPY	66.00	0	4, 528		o	17
	ELECTROCARDI OLOGY	69.00	0	2, 315		0	18
	RENAL DI ALYSI S	74.00	0	1, 701		0	19
	CARDIAC REHAB	76.01	0	104, 390		0	20
	WOMEN'S CENTER	76.02	0	49, 549		0	21
	CLINIC OUTPATIENT	90.00 90.01	0	87,400		ol	22
	EMERGENCY	90.01	0	111, 022 134, 057		0	23
	PHYSICIANS' PRIVATE OFFICES	192.00	0	464, 065		0	24
	CLINICS	192.00	0	404, 003		0	26
	WESTFIELD SCHOOLS	192.04	0	1, 475		0	27
	0			9, 376, 899			
h	E - RSMA RECLASS		-	, ., .,			
	OPERATING ROOM	50.00	3, 879, 268	0		0	1
0		0.00	0	0		0	2
0				0		o	3
			3, 879, 268	0			
0	F - PHYSICIAN PROFESSIONAL FE ADMINISTRATIVE & GENERAL	. <u>ES</u> 5. 00		1, 366, 685		0	1
0	ADIVITIVI STRATIVE & GENERAL	0.00	0	1, 300, 083 م		o	2
0		0.00	0	0		0	3
0		0.00	0	0		Ő	4
0		0.00	0	0		õ	5
0		0.00	0	0		o	6
o		0.00	o	0		0	7
0		0.00	o	0		0	8
0		0.00	o	0		0	9
00		0.00	0	0		0	10
Į.	0		0	1, 366, 685			
	H – PARAMED ED PHARMACY RESID					1	
0	PHARMACY		19 <u>2, 1</u> 15	1 <u>1, 0</u> 02		0	1
l	0		192, 115	11, 002			
	I - COMMUNITY RELATIONS RECLA						
0	ADMI NI STRATI VE & GENERAL		207, 117	0	<u>├── ── </u>	Q	1
	U		207, 117	0	1		

Health Financial Systems	RI VERVI EW I	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		То	od: 01/01/2017 12/31/2017		pared:
			Acqui si ti ons				
	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 CAPI	TAL ASSET BALANCES						
1.00 Land	15, 917, 384	44,000		0	44, 000	0	1.00
2.00 Land Improvements	2, 872, 696	19, 416		0	19, 416	0	2.00
3.00 Buildings and Fixtures	101, 500, 313	1, 000, 795		0	1, 000, 795	0	3.00
4.00 Building Improvements	0	0		0	0	0	4.00
5.00 Fixed Equipment	40, 032, 252	968, 511		0	968, 511	0	5.00
6.00 Movable Equipment	94, 934, 810	37, 737, 964		0	37, 737, 964	103, 482	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	255, 257, 455	39, 770, 686		0	39, 770, 686	103, 482	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	255, 257, 455	39, 770, 686		0	39, 770, 686	103, 482	10.00
	Endi ng Bal ance	Fully					
	_	Depreci ated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPI	TAL ASSET BALANCES						
1.00 Land	15, 961, 384	0					1.00
2.00 Land Improvements	2, 892, 112	0					2.00
3.00 Buildings and Fixtures	102, 501, 108	0					3.00
4.00 Building Improvements	0	0					4.00
5.00 Fixed Equipment	41, 000, 763	0					5.00
6.00 Movable Equipment	132, 569, 292	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	294, 924, 659	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	294, 924, 659	0					10.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0059	Period: From 01/01/2017	Worksheet A-7 Part II	
					To 12/31/2017		pared:
			SL	IMMARY OF CAF	PITAL	372772010 0.3	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		9.00	10.00	11.00	instructions) 12.00	instructions) 13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	14, 301, 232	0		0 0	0	1.00
3.00	Total (sum of lines 1-2)	14, 301, 232	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	•	Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	14, 301, 232				1.00
3.00	Total (sum of lines 1-2)	0	14, 301, 232				3.00

Provider CCN: 15-0059 Period: From 01/01/201 Worksheet A-7 Part 111 Worksheet A-7 Part 111 Cost Center Description Gross Assets Capitalized Leases Gross Assets Ratio (see instructions) Insurance PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 102, 501, 108 0 102, 501, 108 1.00000 0 1.00 3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 0.00000 0 3.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Taxes Other Capital-Relate Cost Center Description Taxes Other Capital-Relate Cost Center Description 1.00 1.00 0 0.00 0 3.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Taxes Other Capital-Relate Cost Center Description Taxes Other Capital-Relate Cost S set Depreciation 1.00 Lease 1.00 0 0 0 0 0 14, 301, 232 0 1.00 1.00 11.00 12.00 13.00 14.00 15.00 14, 048, 785 1.00	Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL Gross Assets Capitalized for Ratio (col. 1 - col. 2) Gross Assets for Ratio (col. 1 - col. 2) Ratio (see instructions) Insurance PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 102, 501, 108 0 102, 501, 108 1.000000 0 1.00 3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 1.000000 <	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		From 01/01/2017	Part III Date/Time Pre	pared:
Cost Center Description Gross Assets Leases Capitalized Leases Gross Assets for Ratio (col. 1 - col. 2) Ratio (see instructions) Insurance PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 Cost Center Description Taxes Other Capital-Relate Total (sum of cols.5 Depreciation Lease New CAP REL COSTS-BLDG & FIXT 0 0 0.00 7.00 8.00 9.00 10.00 0 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 14, 301, 232 0 3.00 3.00 Total (sum of lines 1-2) 0 0 0							0 pm
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLOG & FLXT 102, 501, 108 0 102, 501, 108 1.000000 0 1.00 3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL 3.00 0 0 0 102, 501, 108 0 0 0 3.00 0 Cost Center Description Taxes Other capital -Relate d Costs through 7) Total (sum of Depreciation Lease 1.00 1.00 NEW CAP REL COSTS-BLOG & FLXT 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 1.00 SUMMARY		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 1.00 1.00 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 d costs Depreciation Lease 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 1.00 1.00 3.00 Total (sum of lines 1-2) 0 0 14, 301, 232 0 3.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 14, 301, 232 0 3.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 3.00 Total (sum of lines	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 1.00 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL Cost Center Description Taxes Other Total (sum of cols. 5 Capital - Relate d Costs through 7) 6.00 7.00 8.00 9.00 10.00 Summary of CAPITAL Costs Through 7) 0 0 1.00 10.			Leases	for Ratio	instructions)		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 102,501,108 0 102,501,108 1.00000 0 1.00 3.00 Total (sum of lines 1-2) 102,501,108 0 102,501,108 1.00000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL 3.00 0 0 1.02,501,108 0 102,501,108 0 1.00 1.00 Taxes Other Total (sum of cols.5 through 7) Lease 1.00 0 0 7.00 8.00 9.00 10.00 1.00 1.00 Insurance (see instructions) SUMMARY OF CAPITAL 0 0 1.00 1.00 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14,301,232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 0 14,301,232 0				(col. 1 - col			
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Description Description<				2)			
1.00 NEW CAP REL COSTS-BLDG & FIXT 102, 501, 108 0 102, 501, 108 1.000000 0 1.00 3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 3.00 Total (sum of lines 1-2) 11.00 12.00 <		1.00	2.00	3.00	4.00	5.00	
3.00 Total (sum of lines 1-2) 102, 501, 108 0 102, 501, 108 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL<	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 14, 301, 232 0 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 14, 301, 232 0 1.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols. 9 Total (2) (sum of cols. 9 1.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.048,785 1.00 New CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 14,048,785	1.00 NEW CAP REL COSTS-BLDG & FIXT	102, 501, 108	0	102, 501, 10	8 1.000000	0	1.00
Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 14.00 15.00 100 NEW CAP REL COSTS-BLDG & FIXT -1, 497 -250, 950 0 0 14, 048, 785 1.00	3.00 Total (sum of lines 1-2)	102, 501, 108	0	102, 501, 10	8 1.000000	0	3.00
Capital-Relate d Costs cols.5 through 7) d PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital-Relate instructions) Total (2) (sum of cols.9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT -1, 497 -250, 950 0 0 14, 048, 785 1.00		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Capital-Relate cols.5 d Costs through 7) 6.00 7.00 8.00 9.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
I.OO PART III - RECONCILIATION OF CAPITAL COSTS CENTERS I.OO 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 0 14, 301, 232 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 0 0 0 3.00 16.00 3.00	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
6.00 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 14,301,232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14,301,232 0 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 0 0 0 3.00 Interest Insurance (see instructions) Taxes (see instructions) 0			Capi tal -Rel ate	cols. 5			
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Instructions) 11.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS I.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS I.00 NEW CAP REL COSTS-BLDG & FIXT I.00 III - RECONCILIATION OF CAPITAL COSTS CENTERS I.00 I New CAP REL COSTS-BLDG & FIXT			d Costs	through 7)			
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 14, 301, 232 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 0 14, 301, 232 0 3.00 SUMMARY OF CAPI TAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 -1, 497 -250, 950 0 0 14, 048, 785 1.00		6.00	7.00	8.00	9.00	10.00	
3.00 Total (sum of lines 1-2) 0 0 0 14, 301, 232 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT -1, 497 -250, 950 0 0 14, 048, 785 1.00	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS		_			
SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see of cols. 9 of cols. 11.00 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 1.00	1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 14, 301, 232	0	1.00
Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS NEW CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 14,048,785 1.00	3.00 Total (sum of lines 1-2)	0	0		0 14, 301, 232	0	3.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 NEW CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 14,048,785 1.00			SL	JMMARY OF CAPI	TAL		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 NEW CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 14,048,785 1.00							
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS -1,497 -250,950 0 0 14,048,785 1.00	Cost Center Description	Interest					
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 NEW CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 14,048,785 1.00			instructions)	instructions)			
II.00 12.00 13.00 14.00 15.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 14,048,785 1.00						through 14)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT -1,497 -250,950 0 0 14,048,785 1.00							
1. 00 NEW CAP REL COSTS-BLDG & FIXT -1, 497 -250, 950 0 0 14, 048, 785 1. 00			12.00	13.00	14.00	15.00	
					1		
3 00 Total (sum of lines 1.2) .1 497 .250 950 0 0 14 048 785 3 00							
	3.00 Total (sum of lines 1-2)	-1, 497	-250, 950		0 0	14, 048, 785	3.00

	Financial Systems MENTS TO EXPENSES			Fr	In Lie eriod: fom 01/01/2017	Worksheet A-8	
				Expense CLassification on		Date/Time Prep 5/29/2018 8:50	
				To/From Which the Amount is t			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00	2.00	3.00 DNEW CAP REL COSTS-BLDG &	4.00	5.00 0	1.
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		(0*** Cost Center Deleted ***	2.00	0	2.
. 00	Investment income - other (chapter 2)		(D	0.00	0	3.
ł. 00	Trade, quantity, and time		(D	0.00	0	4.
5.00	discounts (chapter 8) Refunds and rebates of		(ס	0.00	0	5.
5.00	expenses (chapter 8) Rental of provider space by		(D	0.00	0	6.
7.00	suppliers (chapter 8) Telephone services (pay		(0.00	0	7.
	stations excluded) (chapter 21)		,		0.00	0	
8. 00	Television and radio service (chapter 21)		(0.00	0	8.
9. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	(-3, 557, 290		0.00	0	
	adjustment Sale of scrap, waste, etc.	A-0-2	-3, 337, 270		0.00		10.
	(chapter 23)				0.00		
2.00	Related organization transactions (chapter 10)	A-8-1	-457, 691			0	
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	(-538,053	D 3CAFETERI A	0.00 11.00	0	
5.00	Rental of quarters to employee and others		(D	0.00	0	15
6. 00	Sale of medical and surgical supplies to other than		(D	0.00	0	16
7.00	patients Sale of drugs to other than		(0.00	0	17.
	patients Sale of medical records and		(0.00	0	18.
	abstracts Nursing and allied health		, (0.00		19.
9.00	education (tuition, fees, books, etc.)				0.00	0	17.
	Vending machines		(D	0.00	0	
1. 00	Income from imposition of interest, finance or penalty		(0.00	0	21.
22.00	charges (chapter 21) Interest expense on Medicare		(0.00	0	22.
	overpayments and borrowings to repay Medicare overpayments						
3. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	(DRESPI RATORY THERAPY	65.00		23.
4. 00	limitation (chapter 14) Adjustment for physical	A-8-3	(DPHYSICAL THERAPY	66.00		24.
1.00	therapy costs in excess of limitation (chapter 14)		,		00.00		21.
5. 00	Utilization review -		(0*** Cost Center Deleted ***	114.00		25.
. = .	physicians' compensation (chapter 21)						_
6. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		(NEW CAP REL COSTS-BLDG &	1.00	0	26
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		(D*** Cost Center Deleted ***	2.00	0	27.
8.00 9.00	Non-physician Anesthetist		(D*** Cost Center Deleted ***	19. 00 0. 00	0	28 29
	Adjustment for occupational	A-8-3	(OCCUPATI ONAL THERAPY	67.00	0	30.
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		(DADULTS & PEDIATRICS	30.00		30.
81. 00	Adjustment for speech pathology costs in excess of	A-8-3	(SPEECH PATHOLOGY	68.00		31.
22 00	limitation (chapter 14) CAH HIT Adjustment for		,		0.00	0	32.
2.00	Depreciation and Interest		(0.00	0	32

	Financial Systems		RI VERVI EW I			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0059	Period: From 01/01/2017	Worksheet A-8	
					To 12/31/2017	Date/Time Pre	pared:
						5/29/2018 8:5	0 pm
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER REV MEDICAL REPORT	В	-1, 643	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	OTHER REV RADIOLOGY FILM	В		RADI OLOGY-DI AGNOSTI C	54.00		
33. 02	OTHER REVENUES-OTHER	В	0,	ADMI NI STRATI VE & GENERAL	5.00	0	33. 02
	REV-FI TNESS	_					
33.03	OTHER REVENUES ->PURCHASE	В	-34, 955,	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33. 04	DISCOUNTS OTHER REV ->VHA DIVIDENDS:	В	0	ADMI NI STRATI VE & GENERAL	5.00	0	33.04
33.04	OTHER REV ->VHA DIVIDENDS.	D	0.	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	NON-OP EXPENSE INVESTMENT FEES	В	212 813	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06	EMPLOYEE HEALTH/INF CONT -	В		EMPLOYEE BENEFITS DEPARTMEN			
	OTHER REV	_	-			-	
33.07	RADI OLOGY-OTHER REVENUE-CDS	В	-2, 950	RADI OLOGY-DI AGNOSTI C	54.00	0	33.07
	FOR LEGA						
33.08	AMBULANCE ->OTHER REVENUE	В		AMBULANCE SERVICES	95.00		
33.09	LABORATORY -> OTHER REVENUE	В		LABORATORY	60.00		
34.00	EMPLOYEE WELLNESS- OTHER	В	-14, 214	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	34.00
	REVENUE	_			5.00		
36.00	PR/MARKETING- OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		
38.00	MISCELLANEOUS INTEREST INCOME	B B		ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-BLDG &	5.00		
39.00	INTEREST INCOME - BOND FUNDS	В		FIXT	1.00	11	39.00
40.00	RENTAL INCOME - TCU	В		SKILLED NURSING FACILITY	44.00	0	40.00
41.00	COMMUNITY RELATIONS	Ā		ADMI NI STRATI VE & GENERAL	5.00		
42.00	COMMUNITY RELATIONS BENEFITS	А		EMPLOYEE BENEFITS DEPARTMEN			42.00
44.00	CRNA	А	-675, 000	OPERATING ROOM	50.00	0	44.00
45.00	MATERNITY CENTER ->OTHER	В	-57	ADULTS & PEDIATRICS	30.00	0	45.00
	REVENUE						
45.01	I HA LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
45.02	LAB-NURSING HOME- OTHER	В	-104	LABORATORY	60.00	0	45.02
45 00		•	7 047 400		F 00		45 00
45.03 45.06	HAF EXPENSE ENGINEERING - ENERGY REBATES	A B		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00		
45.06	WOUND CARE-OTHER REVENUE	В		OUTPATIENT	90.01	0	
45.07	EDUCATION OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		
45.08	SHO/UNCLAIMED REFUNDS	В		ADMINI STRATI VE & GENERAL	5.00		
45.11	OP PHARMACY REVENUE	В	-5, 589, 619		15.00		
45.12	DI ETARY-SALES PR DEDUCT	В		CAFETERIA	11.00		
45.13	RADI OLOGY-OTHER REVENUE-SI LVER			RADI OLOGY-DI AGNOSTI C	54.00		
	RECOV						
45.14	WELLNESS SERVICES -	В	-68, 997	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	45.14
	EXTERNAL->-OTHER						
45.15	ORG IMPROVEMENT ->OTHER	В	0,	ADMI NI STRATI VE & GENERAL	5.00	0	45.15
45 44	REVENUE		_			-	15 1
45.16 50.00	OTHER REV PREMIER PROGRAM	В		CENTRAL SERVICES & SUPPLY	14.00	0	
	TOTAL (sum of lines 1 thru 49)		-20, 909, 787		1	1	50.00
50.00	(Transfer to Worksheet A,						

(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.

Heal th	Financial Systems	RI VERVI EW	/ HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0059	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
5/29/2018 8:5						
	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	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	OPERATING ROOM	3, 897, 095	4, 354, 786	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	3, 897, 095	4, 354, 786	5.00
	0		0			

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

			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership			
1.00	2.00	3.00	4.00	5.00			
 B INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE							

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

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

i ci indui					
6.00	В	RSMA	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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

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

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

Health Financial Systems RIVERVIEW HO	RI VERVI EW HOSPI TAL			
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0059	Period: From 01/01/2017	Worksheet A-8-1	
OFFICE COSTS			Date/Time Prepared:	

	-		5/29/2018 8:5	50 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-457, 691	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-457, 691			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

IId	SILUI	been posted to worksheet A,	COLINIUS		Ζ,	the amount	arrowabre	SHOULD DE	TH COLUMN 4 OF	this part.	
		Related Organization(s)									
		and/or Home Office									
		Type of Business	1								
		(4								
		6. 00									
		B. INTERRELATIONSHIP TO RELA	TED ORGAN	I ZATI ON	(S) A	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 9.00 10.00 100.00	8.00
9.00	9.00
10.00	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.

Heal th	Financial Syste	ems	RI VERVI EW	HOSPI TAL		In Li	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider (Provider CCN: 15-0059		Worksheet A-8-2	
						From 01/01/2017 To 12/31/2017		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	1, 663, 720	1, 663, 720		239, 400	0	1.00
2.00	59.00	CARDIAC CATHETERIZATION	760, 833	760, 833	. (0 179,000	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	146, 543	146, 543	. (0 0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	575, 000	575,000) (0 179,000	0	4.00
5.00	65.00	RESPI RATORY THERAPY	310, 000	310, 000) (0 179,000	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	691	691	(0 179,000	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	100, 359	100, 359) (0 179,000	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	150	150) (179,000	0	8.00
9.00	0.00		0	c) (0 0		9.00
10.00	0.00		0	c) (o l	0	10.00
200.00			3, 557, 296	3, 557, 296			0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE	Memberships &	Component	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	50.00	OPERATING ROOM	0	C)	0 0	0	1.00
2.00	59.00	CARDIAC CATHETERIZATION	0			0 0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	C) (0 0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	C) (0 0	0	4.00
5.00	65.00	RESPI RATORY THERAPY	0	C) (o l	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	C) (o l	0	6.00
7.00		ADMINISTRATIVE & GENERAL	0	c) (o l	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	0	c) (o l	0	8.00
9.00	0, 00		0	C		0 0	0	9.00
10.00	0.00		0				0	10.00
200.00			0				0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00	50.00	OPERATING ROOM	0	C) (1, 663, 720		1.00
2.00	59.00	CARDI AC CATHETERI ZATI ON	0	C) (760, 833		2.00
3.00		ADMINISTRATIVE & GENERAL	0			146, 543		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	c) (575,000		4.00
5.00	65.00	RESPI RATORY THERAPY	0	C) (310,000		5.00
6.00		ADMI NI STRATI VE & GENERAL	0			691		6.00
7.00		ADMI NI STRATI VE & GENERAL	0	-		100, 359		7.00
8.00		ADMI NI STRATI VE & GENERAL	0			150		8.00
9.00	0.00		0	-				9.00
10.00	0.00		0	-				10.00
200.00	0.00		0			3, 557, 296		200.00
_000.00	I	1			ļ.	5,557,270	1	

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST A	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: Worksheet B From 01/01/2017 Part I		
					0 12/31/2017	Date/Time Pre	pared:
			CAPI TAL			5/29/2018 8:5	0 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FLXT	BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A col. 7)					
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS			1		1	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	14, 048, 785					1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	8, 679, 882 19, 007, 790				21 717 220	4.00 5.00
7.00	00700 OPERATION OF PLANT	6, 273, 115					
8.00	00800 LAUNDRY & LINEN SERVICE	370, 530					
9.00	00900 HOUSEKEEPI NG	1, 487, 554		159, 705			
10.00	01000 DI ETARY	698, 676					
11.00		1, 128, 289		138, 868			
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	639, 090 14, 320, 982		101, 341 124, 228			
	01500 PHARMACY	14, 994, 467	178, 146				
	01600 MEDI CAL RECORDS & LI BRARY	1, 554, 308					
	01700 SOCIAL SERVICE	780, 595					17.00
23.00	02300 PARAMED ED PRGM PHARMACY	203, 117	4, 480	37, 639	245, 236	35, 562	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	7, 726, 917	2, 210, 213	1, 361, 212	11, 298, 342	1, 638, 395	30.00
30.00	03100 I NTENSI VE CARE UNI T	1, 877, 373					31.00
	04100 SUBPROVI DER – I RF	2, 269, 761	387, 712				41.00
43.00	04300 NURSERY	0	0			0	43.00
44.00	04400 SKILLED NURSING FACILITY	1, 976, 710	267, 522	0	2, 244, 232	325, 441	44.00
F0 00	ANCI LLARY SERVICE COST CENTERS	E 10E 0/1	007.000	101 504	(150 /57	000.054	
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	5, 125, 061	907,002	121, 594		892, 354 0	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 328, 085	-	-	-	-	
	05500 RADI OLOGY-THERAPEUTI C	1, 048, 665					
57.00	05700 CT SCAN	294, 164	0	47, 753	341, 917	49, 582	57.00
	03630 ULTRA SOUND	0	0	0	-	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	268, 799		41,002		44, 925	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	901, 385 5, 377, 709					
60.00	06001 BLOOD LABORATORY	0, 3, 7, 7, 707	0	430, 270		0,112	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	514, 016	52, 175	0	566, 191	82, 104	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	1, 188, 993					
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 172, 393	0	780, 291	6, 952, 684 0	1, 008, 223	
	06800 SPEECH PATHOLOGY	0	0	0		-	
	06900 ELECTROCARDI OLOGY	1, 151, 429	309, 608	166, 753	1, 627, 790	236, 049	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	
	07200 I MPL. DEV. CHARGED TO PATIENT	1, 142, 634	0	0	1, 142, 634		
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	360, 435	26, 853		0 387, 288	0 56, 161	
	03020 OTHER ANCI LLARY	0	20, 000	0	0	0	
	03140 CARDI AC REHAB	1, 761, 602	45, 729	151, 857	1, 959, 188		
	03070 WOMEN'S CENTER	461, 536	235, 205	74, 204	770, 945		
76.03		0	0	0	0	0	76.03
90.00	OUTPATIENT SERVICE COST CENTERS	1, 126, 207	0	154, 176	1, 280, 383	185, 671	90.00
	09001 OUTPATI ENT	990, 082	100, 071	98, 195			
	09100 EMERGENCY	3, 156, 175					
	09101 SHORT STAY	0	0	0		0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
05 00	OTHER REIMBURSABLE COST CENTERS	00 (00		10.7(0	101.110	45.445	05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	93, 680	0	10, 760	104, 440	15, 145	95.00
118.00		131, 500, 991	13, 639, 192	8, 477, 639	130, 808, 393	15, 819, 516	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	399, 769	174, 677	41, 773	616, 219	89, 359	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	35, 258, 786		0	35, 493, 702	5, 146, 984	192.00
	19201 FOUNDATI ON	174, 444	0				
		1, 194, 557	0	0	.,,		
	19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS	150 1, 109, 511	0	0	150 1, 109, 511		192.03
	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT	1, 109, 511	0		1, 109, 511		
	19204 MOB - NOBLESVILLE SQUARE	239, 276		194, 392			
	19205 RI VERVI EW MEDI CAL ARTS	173, 105		0			
	19300 NONPAI D WORKERS	0	0	0			193.00
194.00	07950 WORKMED	0	0	0	0	0	194.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2017 To 12/31/2017		pared: 0 pm	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL		
	0	1.00	4.00	4A	5.00		
194.01 07951 MEALS ON WHEELS	198, 611	0	14, 94	7 213, 558	30, 968		
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0 0		201.00	
202.00 TOTAL (sum lines 118 through 201)	171, 479, 748	14, 048, 785	8, 760, 64	4 171, 479, 748	21, 717, 320	202.00	

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2017	Worksheet B Part I	
				To		Date/Time Pre 5/29/2018 8:5	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	0.00	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						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	13, 622, 896					5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	75, 764					8.00
9.00	00900 HOUSEKEEPI NG	61, 288		1, 986, 375			9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	534, 460 0		6, 373 59, 485	1, 740, 767 0	1, 510, 395	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	-	0	0	13, 747	
14.00	01400 CENTRAL SERVICES & SUPPLY	193, 966			0	49, 051	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	320, 915 160, 744		53, 112 10, 622	0	97, 971 46, 985	
17.00	01700 SOCIAL SERVICE	85, 553		10, 022	0	23, 934	
23.00	02300 PARAMED ED PRGM PHARMACY	8, 071	0	0	0	1, 880	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 001 520	175 204	707, 451	072 011	200, 225	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 981, 529 736, 861			872, 011 93, 430	299, 225 60, 668	
41.00	04100 SUBPROVI DER – I RF	698, 432			411, 953	63, 959	
43.00	04300 NURSERY	0	-	-	0	0	
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	481, 920	40, 558	127, 468	363, 373	0	44.00
50.00	05000 OPERATI NG ROOM	1, 633, 894	54, 276	206, 073	0	132, 231	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-	-	0	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	517, 224 369, 758			0	67, 553 13, 383	1
57.00	05700 CT SCAN	0			0	10, 066	
57.01	03630 ULTRA SOUND	0	-	0	0	0	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0 149, 913	0 14, 429	2, 124	0	7, 560 24, 359	
60.00	06000 LABORATORY	647, 403		74, 356	0	128, 662	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	93, 989	0	0	0	0	
65.00	06500 RESPI RATORY THERAPY	96, 019	0	6, 373	0	40, 340	
66.00	06600 PHYSI CAL THERAPY	0			0	172, 690	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	-	0	0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 557, 736	0 4, 799	0 42, 489	0	0 31, 416	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	Ö	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	48, 374		0	0	0	
	03020 OTHER ANCI LLARY	0	0	0	0	0	
76.01	03140 CARDI AC REHAB	82, 377			0	31, 935	
76. 02 76. 03	03070 WOMEN' S CENTER 03330 ENDOSCOPY	423, 704	2, 789	42, 489	0	20, 169 0	
70.03	OUTPATIENT SERVICE COST CENTERS	0		0	V	0	70.03
90.00	09000 CLINIC	0			0	36, 942	
90. 01 91. 00	09001 OUTPATI ENT 09100 EMERGENCY	180, 271 744, 880			0	21, 542 81, 564	
91.00	09101 SHORT STAY	000	0	0	0	01, 304	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0		0	2 720	95.00
95.00	SPECIAL PURPOSE COST CENTERS	0	0	0	0	2, 730	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 885, 045	514, 726	1, 897, 148	1, 740, 767	1, 480, 562	118.00
100.00	NONREI MBURSABLE COST CENTERS	214 //7		2.124		17.000	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	314, 667 423, 184		_,	0		190.00 192.00
	19201 FOUNDATI ON	0	0	0	0		192.01
	19202 CLI NI CS	0	199	87, 103	0		192. 02
	19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS	0	0	0	0		192. 03 192. 04
	19207 WESTFIELD SCHOOLS	0	183	0	0		192.04
192.06	19204 MOB - NOBLESVILLE SQUARE	0	0	0	Ō	0	192.06
	19205 RIVERVIEW MEDICAL ARTS 19300 NONPAID WORKERS	0	0	0	0		192.08 193.00
	07950 WORKMED	0	0	0	0		193.00
194.01	07951 MEALS ON WHEELS	0	0	o o	0		194.01
200.00		_	_			~	200.00
201.00 202.00		13, 622, 896	559, 219	0 1, 986, 375	0 1, 740, 767	0 1, 510, 395	
						, ., ., .	

COST ALLOCATION - OPERAL SERVICE CISTS Prevalue Technology Period Technology Perio	Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost: Centrer Description Number of Auxil Not 2000 Prevents/ School 2000 Prevents/ School 2000 Centre Description School 2000 School 2000 <	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	Fr	om 01/01/2017	Part I	nared [.]
APPINI INTRATION SERVICE CS & SUPPLY PECODES & I 15:00 15:00 15:00 16:00 17:00 10:00 00000 ENVINES 15:00 16:00 17:00 10:00 00000 ENVINES ENVINES 10:00 10:00 10:00 10:00 00000 ENVINES ENVINES ENVINES 10:00 10:00 10:00 00:0000 ENVINES ENVINES ENVINES ENVINES 10:00	Cost Center Description	NURSI NG	CENTRAL			5/29/2018 8:5	<u>Opm</u>
Internal Selentics Cost Optimized 13.00 14.00 15.00 16.00 17.00 0 Description Selentics Selection Selection Selection Selection Selection 1.00 Control (Larger) Selection			SERVICES &		RECORDS &		
1.000 00000 Nax CAP REL COSTS-BLOG & FLX1 4.00 0.00000 00000 NATENCY ESPECTS ESPECTS END CAPACING 5.00 0.00000 00000 NATENCY ESPECTS ESPECTS END CAPACING 5.00 0.00000 00000 NATENCY ESPECTS ESPECTS END CAPACING 5.00 0.0000 00000 NATENCY ESPECTS ESPECTS ESPECTS 6.00 0.0000 00000 NATENCY ESPECTS ESPECTS 6.00 0.0000 00000 NATENCY ESPECTS ESPECTS 6.00 0.0000 00000 NATENCY ESPECTS ESPECTS 7.00 1.000 10000 NATENCY ESPECTS ESPECT 7.00 1.000 00000 NATENCY ESPECTS ESPECT 7.00 1.000 00000 NATENCY ESPECTS ESPECT 7.00 1.000 00000 00000 00000 100000 1.000 000000 00000 00000 1000000 1.000000000000000000 000000000000000000000000000000000000		13.00		15.00		17.00	
4.00 OxADD PREI OVF ENERTIES FERENTINT 4.00 5.00							1 00
7.00 00700 DEPENT IN 010 7.00 00700 FAUNDER'S LINES REVICE 8.00 9.00 00700 DEPENT IN 01 8.00 6.00 7.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
B.CO. CORROL MARKING & LINEN SLAVICE B.D. 5.07 B.C. 5.0							
9.00 0000 00000 0000 0000 0000 0000 0000 000							
11.00 01100 CAFETERIA B61,549 110,912,571 110,912,571 110,912,571 12.00 0100 CHINGAL SINTID S & SUPPLY 0 0 18,370,322 2,285,222 11,010,011,010,011,011,011,011,011,011,	9. 00 00900 HOUSEKEEPI NG						
13.00 01300 MURSIN IS AULIAN STRATION 861.549 16,912,271 15.00 01500 PHARMACY 0 16,912,271 15.00 01500 PHARMACY 0 10,912,271 15.00 01500 PHARMACY 0 0 0 10,000 15.00 01500 PHARMACY 0 0 0 10,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 10,000,000 1,000,000 10,000,000,000,000 10,000,000,000,000,000,000,000,000,000,							
15:00 01:500 PHARMACY 0 0 18:370.322 2.285.32 11:00 10:00 01:700 SCIII AL SERVICE 0	13.00 01300 NURSING ADMINISTRATION	861, 549					
16.00 0 HEOL CAL RECORDS A LIBRARY 0 0 0 2.285, 324 1, 201, 37 23.00 0 CARD JARAMU DI PROL PLANMACY 0 0 0 0, 1, 201, 23 0 0 0, 1, 201, 23 0 0, 1, 201, 23 0 0 0, 1, 201, 23 0 0 0, 1, 201, 23 0 0 0 0, 1, 201, 23 0 0 0 0, 1, 201, 23 0		0		10 270 222			
17.00 01700 SOCIAL SERVICE 0 0 0 17.01 23 17.00 23 17.00 23 17.00 23 17.00 23 17.00 23 17.00 23 17.00 23 17.00 23 17.00<		0	0		2, 285, 326		
INPARTIENT RULT EXERVICE COST CENTERS	17.00 01700 SOCIAL SERVICE	0	0	-	0		17.00
90.00 3000 CADULTS A FEDIATRICS 510.071 0 540.946 963.825 30.00 11.00 3100 (THENSIVE CARE INIT 103.417 0 0 106.533 10.00 41.00 04100 (SUBPROVIDER - I RF 109.024 0 0 0.0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>23.00</td>		0	0	0	0	0	23.00
11.00 04100 SUBPROVIDER - I FE 109,026 0 0 0 106,523 41.00 43.00 04400 SKILLED NURSING FACILITY 0 0 0 0 23.00 44.00 SKILLED NURSING FACILITY 0 0 0 0 12,221 74,892 44.00 50.00 DISDOL QUEY-INTIK ROM 00 0 0 667,697 0 50.00 51.00 DISDOL QUEY-INTIK ROM 00 0 0 67.00 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 57.00 50.00 60.00 0 0 0 0 0 0 0 0 0 0 50.00		510, 071	0	0	549, 945	963, 825	30.00
43.00 04300 NURSERV 0 <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td>			-	-			
44 400 0 44400 SKILLED NURSI NG FACILITY 0 0 12,221 74,892 44,00 MOLLLARY SERVIC COST CENTERS 0 0 0 0 667,692 0500 0500 0 50.00 0 0 0 0 0 50.00 50.00 50.00 0 0 0 0 0 0 50.00 <t< td=""><td></td><td></td><td>-</td><td></td><td>0</td><td>-</td><td></td></t<>			-		0	-	
50.00 65000 0FORD DELVERY ROOM 0 </td <td>44.00 04400 SKILLED NURSING FACILITY</td> <td></td> <td>0</td> <td>-</td> <td>12, 221</td> <td></td> <td></td>	44.00 04400 SKILLED NURSING FACILITY		0	-	12, 221		
52.00 05200 PELLVERY ROUM & LABOR ROOM 0 0 0 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 5.00 0 0 0 0 0 0 0 5.00 0			0	0	967 602	0	50.00
55.00 05500 ADD LOGY-THERAPEUTIC 0 0 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 57.01 55.00 55.00 55.00 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 57.01 55.00 56.01 56.00		-		-			
57.00 05700 CT SCAN 0 0 0 0 57.00 0 57.00		0	0	0			
17. 01 03430 UTRA SOUND 0 0 0 0 57. 01 59. 00 05000 CARDIA C, CATHETERIZATI ON 0 0 0 0 59. 00 59. 00 05000 CARDIA C, CATHETERIZATI ON 0		0	0	0	54, 994	-	
99 00 00 0		0	0	0	0		
60 00 0000 LABORATORY 0 0 54.994 0		0	0	0	0		
0.0001 0.0001 LABORATORY 0		0	0	0	0 54 994	-	
64.00 lot 00 0		0	0	0	0		
65:00 00 00 0 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
66.00 Code Operation Code Operation </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
68:00 ORGON SPEECH PATHOLOGY O O O 68:00 O 68:00 O 68:00 O 68:00 O 68:00 O 0<		0	0	0	439, 956	-	
69:00 00 00 00 36,663 00 69:00 01:00 07100 07100 07100 071.00 071.00 0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
17.1 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 16,912,571 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 73.00		0	0	0	36, 663		
73.00 OP 07300 DRUGS CHARGED TO PATIENTS 0 18, 370, 322 0 0 73.00 74.00 O7400 RENAL DI ALYSIS 0 </td <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>0</td> <td>16, 912, 571</td> <td>0</td> <td>0</td> <td></td> <td>71.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16, 912, 571	0	0		71.00
74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 0 0 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 76.01 76.03 03330 ENDSCOPY 0 0 0 0 0 76.03 00.00 09001 CLINIC 0 <td< td=""><td></td><td>0</td><td>0</td><td>19 270 222</td><td>0</td><td></td><td></td></td<>		0	0	19 270 222	0		
76.00 03020 OTHER ANCILLARY 0 0 0 0 76.00 76.01 03140 CARDI AC REHAB 0		0	0	18, 370, 322	0	_	
76. 02 03070 WWEN'S CENTER 0 0 0 0 76. 02 76. 03 0330 ENDOSCOPY 0 <td>76.00 03020 OTHER ANCI LLARY</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>76.00</td>	76.00 03020 OTHER ANCI LLARY	0	0	0	0		76.00
76. 03 03302 ENDOSCOPY 0 0 0 0 0 0 76. 03 OUTPATI ENT SERVICE COST CENTERS 0		0	0	0	0		
90.00 09000 CLINIC 0		0	0	0	0		
90.01 09001 OUTPATIENT 0							
91.00 09100 EMERGENCY 139,035 0 0 122,210 0 91.00 91.01 09101 SHORT STAY 0 0 0 0 0 91.01 92.00 095200 005SERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 91.01 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 95.00 NORREI MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 861,549 16,912,571 18,370,322 2,273,105 1,201,293 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 192.01 192.01 192.02 192.02 192.01 192.02 192.02 192.02 192.02 192.02 192.03 192.04 192.07 192.02 192.02 192.02 192.03 192.04 192.05 192.05		0	Ű	-	0		
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 0THER REIMBURSABLE COST CENTERS 95.00 0	91. 00 09100 EMERGENCY	139, 035	0	0	122, 210		91.00
OTHER REI MBURSABLE COST CENTERS 0		0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 861,549 16,912,571 18,370,322 2,273,105 1,201,293 118.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 FOUNDATI ON 0 0 0 192.02 192.02 192.01 192.02 192.03 192.04 192.04 192.04 192.04 192.04 192.04 192.04 192.04 192.05 192.05 192.04 192.05 192.05 192.04 192.05 192.05 192.05 192.06 192.06 192.04 192.06							92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 861,549 16,912,571 18,370,322 2,273,105 1,201,293 118.00 NORREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.01 FOUNDATI ON 0 0 0 0 192.02 192.02 19202 CLI NI CS 0 0 0 192.02 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0 192.03 192.04 19207 WESTFI ELD SCHOOLS 0 0 0 0 192.04 192.05 19203 PRACTI CE MANAGEMENT 0 0 0 192.04 192.06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 192.06 192.06 19204 NOB - NOBLESVI LLE SQUARE 0 0 0		0	0	0	0	0	95.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.01 19201 FOUNDATI ON 0 0 0 0 192.01 192.02 CLI NI CS 0 0 0 0 192.02 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0 192.02 192.04 19207 WESTFI ELD SCHOOLS 0 0 0 192.03 192.05 19203 PRACTI CE MANAGEMENT 0 0 0 192.04 192.05 19203 PRACTI CE MANAGEMENT 0 0 0 192.05 192.06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 192.08 192.05 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 192.08 192.08 192.08		861 549	16 912 571	18 370 322	2 273 105	1 201 293	118 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 192.01 19201 FOUNDATION 0 0 0 0 192.01 192.02 19202 CLINICS 0 0 0 192.02 192.02 192.03 19206 HOME HEALTH PATNERSHI P 0 0 0 192.03 192.04 19207 WESTFI ELD SCHOOLS 0 0 0 192.03 192.05 19203 PRACTI CE MANAGEMENT 0 0 0 192.05 192.06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07950 WALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adjus		001, 347	10, 712, 371	10, 370, 322	2, 273, 103	1,201,275	110.00
192.01 FOUNDATION 0 0 0 192.01 192.02 CLINICS 0 0 0 192.02 192.03 19206 HOME HEALTH PATNERSHIP 0 0 0 0 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 0 0 192.03 192.05 19208 PRACTICE MANAGEMENT 0 0 0 0 192.04 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 192.08 19205 NONPAID WORKERS 0 0 0 0 192.08 193.00 19300 NONPAID WORKERS 0 0 0 193.00 194.01 07950 WORMED 0 0 0 194.00 194.01 07950 WEAKES 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 0 0 201.00		-	-	0	0		
192.02 CLINICS 0 0 12,221 0 192.02 192.03 19206 HOME HEALTH PARTNERSHIP 0 0 0 0 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 0 0 192.04 192.05 19203 PRACTICE MANAGEMENT 0 0 0 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
192.04 19207 WESTFIELD SCHOOLS 0 0 0 192.04 192.05 19203 PRACTICE MANAGEMENT 0 0 0 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDICAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 193.00 194.01 07950 WORKMED 0 0 0 0 194.00 194.01 07950 MEALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 0 0 0 201.00	192. 02 19202 CLI NI CS	0	0	0	12, 221	0	192. 02
192.05 19203 PRACTICE MANAGEMENT 0 0 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19200 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07950 WORKMED 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		0	0	0	0		
192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 193.00 194.01 07950 WORKMED 0 0 0 0 194.00 194.01 07950 WORKARS 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 194.00 200.00 Cross Foot Adjustments 0 0 0 194.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		0	0	0	0		•
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	192.06 19204 MOB - NOBLESVILLE SQUARE	0	Ō	0	ō	0	192.06
194.00 07950 WORKMED 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		0	0	0	0		
194.01 07951 MEALS ON WHEELS 0 0 0 194.01 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0		0	0	0	0		
201.00 Negative Cost Centers 0 </td <td>194.0107951 MEALS ON WHEELS</td> <td>0</td> <td>Ō</td> <td>0</td> <td>Ō</td> <td></td> <td>194.01</td>	194.0107951 MEALS ON WHEELS	0	Ō	0	Ō		194.01
202.00 TOTAL (sum lines 118 through 201) 861, 549 16, 912, 571 18, 370, 322 2, 285, 326 1, 201, 293 202.00			0	0	0	0	200.00
		861, 549	16, 912, 571	18, 370, 322	2, 285, 326	1, 201, 293	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	RI VERVI EW H	Provider C		eri od:	u of Form CMS-25 Worksheet B	<u>102-10</u>
				Fr To	com 01/01/2017 0 12/31/2017	Part I Date/Time Prepa 5/29/2018 8:50	ared:
	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown	Total	372972018 8. 50	pm
		23.00	24.00	Adjustments 25.00	26.00		
- F	GENERAL SERVICE COST CENTERS	23.00	24.00	25.00	20.00		_
4.00 5.00 7.00 8.00 9.00 10.00 11.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION						1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00
15. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						14.00 15.00 16.00 17.00
	02300 PARAMED ED PRGM PHARMACY	290, 749					23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	0	20, 996, 080 4, 352, 200		20, 996, 080 4, 352, 200		30. 00 31. 00
43.00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	4, 897, 719 0	0	4, 897, 719 0		41.00 43.00
	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	3, 670, 105	0	3, 670, 105	· · · · · · · · · · · · · · · · · · ·	44.00
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	9, 940, 177 0	0	9, 940, 177 0		50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 988, 388	0	3, 988, 388		54.00
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	1, 981, 471 401, 565	0	1, 981, 471 401, 565		55.00 57.00
57.01	03630 ULTRA SOUND	0	0	0	0		57.01
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	364, 410 1, 487, 536	1	364, 410 1, 487, 536		58.00 59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	0	7, 996, 890	0	7, 996, 890		60. 00 60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	742, 284	0	742, 284		63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 1, 787, 117	0	0 1, 787, 117		64.00 65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	8, 578, 268	0	8, 578, 268 0		66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0		68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	2, 536, 942 16, 912, 571	0	2, 536, 942 16, 912, 571		69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 308, 330	0	1, 308, 330		72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	290, 749 0	18, 661, 071 491, 823	0	18, 661, 071 491, 823		73.00 74.00
	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	0	0 2, 400, 508	0	0 2, 400, 508		76. 00 76. 01
76. 02	03070 WOMEN'S CENTER	0	1, 371, 892		1, 371, 892	· · ·	76. 02
	03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	0	0	0	0		76. 03
90.00	09000 CLI NI C	0	1, 503, 753		1, 503, 753		90.00
	09001 OUTPATI ENT 09100 EMERGENCY	0	1, 592, 550 5, 910, 999	1	1, 592, 550 5, 910, 999		90. 01 91. 00
92.00	09101 SHORT STAY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	0 0	0		91. 01 92. 00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	122, 315	0	122, 315		95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	290, 749	123, 996, 964	0	123, 996, 964	1	118.00
	NONREI MBURSABLE COST CENTERS	270,747					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 039, 749 41, 107, 981	0	1, 039, 749 41, 107, 981		190.00 192.00
192.01	19201 FOUNDATI ON	0	242, 473		242, 473	1	192.01 192.02
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP	0	1, 467, 305 172	0	1, 467, 305 172	1	192. 03
	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT	0	1, 270, 403 1, 409, 175		1, 270, 403 1, 409, 175		192.04 192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	496, 555	0	496, 555	1	192.06
	19205 RIVERVIEW MEDICAL ARTS 19300 NONPAID WORKERS	0	198, 207 0	0	198, 207 0		192.08 193.00
194.00	07950 WORKMED	0	0	0	0	1	194.00
194.01 200.00	07951 MEALS ON WHEELS Cross Foot Adjustments	0	250, 764	0	250, 764 0		194.01 200.00

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 01/01/2017 To 12/31/2017		
Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cos & 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 through 201)	290, 749	171, 479, 748		0 171, 479, 748		202.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2017	Worksheet B Part II	
				Ţ		Date/Time Pre 5/29/2018 8:5	
			CAPI TAL			572972018 8.5	0 pili
		Discontinu	RELATED COSTS	Cultated			
	Cost Center Description	Directly Assigned New	NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS	ADMI NI STRATI VE & GENERAL	
		Capi tal	1171		DEPARTMENT		
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	80, 762	80, 762	80, 762		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	1, 109, 688	1, 109, 688			5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE		5, 296, 037 42, 058	5, 296, 037 42, 058	3, 028 89	89, 327 3, 170	7.00 8.00
9.00	00900 HOUSEKEEPI NG	0	34, 022	34, 022	1, 472	12, 623	
10.00	01000 DI ETARY	0	296, 688	296, 688	485	7, 868	
11.00		0	0	0	1, 280 934	9, 514	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	107, 674	107, 674	934 1. 145	5, 559 109, 263	
15.00	01500 PHARMACY	0	178, 146	178, 146	4, 231	117, 362	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	89, 232	89, 232	1, 490		
17.00 23.00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	0	47, 492 4, 480	47, 492 4, 480		7, 159	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	4,400	4, 480	547	1,041	23.00
30.00	03000 ADULTS & PEDIATRICS	0	2, 210, 213	2, 210, 213	12, 548	84, 828	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	409, 044	409, 044	3, 065	19, 663	
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY		387, 712	387, 712 0	2, 314 0	21,837	41.00 43.00
	04400 SKILLED NURSING FACILITY	0	267, 522	267, 522	0	16, 850	
	ANCI LLARY SERVI CE COST CENTERS	1				I	
50.00	05000 OPERATING ROOM	0	907, 002	907, 002	1, 121	46, 202	50.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C		0 287, 120	0 287, 120	0 2, 708	0 21, 840	52.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	205, 259	205, 259	693	9,979	
57.00	05700 CT SCAN	0	0	0	440	2, 567	
57.01 58.00	03630 ULTRA SOUND 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0 378	0	57.01 58.00
58.00	05900 CARDI AC CATHETERI ZATI ON	0	83, 219	83, 219		2, 326 8, 517	59.00
60.00	06000 LABORATORY	0	359, 384	359, 384	4, 206	46, 500	
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	52, 175	52, 175 0	0	4, 251 0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	0	53, 302	53, 302	1, 787		
66.00	06600 PHYSI CAL THERAPY	0	0	0	7, 193		
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0 309, 608	0 309, 608	0 1, 537	0 12, 221	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 2, 908	
	07400 RENAL DIALYSIS 03020 OTHER ANCILLARY		26, 853 0	26, 853 0	0	2,908	74.00 76.00
	03140 CARDI AC REHAB	0	45, 729	45, 729	1, 400		
	03070 WOMEN'S CENTER	0	235, 205	235, 205			
76.03	03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	0	0	0	0	0	76.03
90.00	09000 CLINIC	0	0	0	1, 421	9, 613	90.00
	09001 OUTPATI ENT	0	100, 071	100, 071	905		
	09100 EMERGENCY	0	413, 495	413, 495			
	09101 SHORT STAY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	91.01 92.00
/2:00	OTHER REIMBURSABLE COST CENTERS		1			I	12100
95.00	09500 AMBULANCE SERVICES	0	0	0	99	784	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	13, 639, 192	13, 639, 192	78, 153	819, 055	110 00
110.00	NONREIMBURSABLE COST CENTERS	0	13, 039, 192	13, 039, 192	/0, 153	019,055	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	174, 677	174, 677	385		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	234, 916	234, 916	0		
	19201 FOUNDATI ON 19202 CLI NI CS	0	0	0	294 0		192. 01 192. 02
	19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192.02
192.04	19207 WESTFIELD SCHOOLS	0	0	0	0	8, 330	192. 04
	19203 PRACTICE MANAGEMENT	0	0	0	0		192.05
	19204 MOB - NOBLESVILLE SQUARE 19205 RIVERVIEW MEDICAL ARTS		0		1, 792 0		192.06 192.08
	19300 NONPAI D WORKERS	0	0	0	0		193.00
	07950 WORKMED	0	0	0	0		194.00
194.01	07951 MEALS ON WHEELS	0	0	0	138	1,603	194.01

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0059	Period: From 01/01/2017 To 12/31/2017		
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
	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 through 201)	C	14, 048, 785	14, 048, 78	80, 762	1, 124, 441	202.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	Fi	eriod: rom 01/01/2017	Worksheet B Part II	
				Т	b 12/31/2017	Date/Time Pre 5/29/2018 8:5	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	5, 388, 392					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	29, 968					8.00
9.00	00900 HOUSEKEEPING	24, 242		72, 359	F1/ /70		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	211, 400		232 2, 167	516, 673	12, 961	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	2,107	0	12, 901	
14.00	01400 CENTRAL SERVICES & SUPPLY	76, 721	566	-	0	421	•
15.00	01500 PHARMACY	126, 935	0	.,	0	841	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	63, 581	0	387	0	403	
17.00 23.00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	33, 840 3, 192		0	0	205 16	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	J, 172	0	0	V	10	23.00
30.00	03000 ADULTS & PEDIATRICS	1, 574, 851	23, 596	25, 770	258, 819	2, 567	30.00
31.00	03100 I NTENSI VE CARE UNI T	291, 458			27, 731	521	31.00
41.00	04100 SUBPROVIDER - IRF	276, 258			122, 271	549	•
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0 190, 618	-	0 4, 643	0 107, 852	0	
44.00	ANCI LLARY SERVICE COST CENTERS	170,010	5,400	4, 043	107,032	0	1 44. 00
50.00	05000 OPERATING ROOM	646, 269			0	1, 135	
52.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0 204, 583	-	-	0	0	52.00
54.00 55.00	05500 RADI OLOGY-DI AGNOSTI C	204, 583			0	580 115	•
57.00	05700 CT SCAN	0			0	86	
57.01	03630 ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	77	0	65	•
59.00	05900 CARDI AC CATHETERI ZATI ON	59, 297			0	209	•
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	256, 073		2, 709	0	1, 104 0	60.00 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	37, 176	-	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00		37, 979		_	0	346	•
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	635		0	1, 482 0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	-	0	0	•
69.00	06900 ELECTROCARDI OLOGY	220, 606	646	1, 548	0	270	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	•
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DI ALYSI S	19, 134		0	0	0	•
	03020 OTHER ANCI LLARY	0	0	0	0	0	
	03140 CARDI AC REHAB	32, 583			0	274	
76.02	03070 WOMEN'S CENTER	167, 592 0			0	173	
76.03	03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.03
90.00	09000 CLINIC	0	102	0	0	317	90.00
90.01	09001 OUTPATI ENT	71, 304			0	185	
91.00 91.01	09100 EMERGENCY 09101 SHORT STAY	294, 629	10, 162	6, 578	0	700 0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		1		1		
95.00	09500 AMBULANCE SERVICES	0	0	0	0	23	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	5, 096, 543	69, 294	69, 109	516, 673	12 705	118.00
110.00	NONREI MBURSABLE COST CENTERS	0,070,010	07,271	07,107	010,070	12, 700	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	124, 463		77	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	167, 386	5, 939	0	0		192.00
	19201 FOUNDATI ON 19202 CLI NI CS	0	27	3, 173	0		192. 01 192. 02
	19202 CEINICS	0	0		0		192.02
192.04	19207 WESTFIELD SCHOOLS	0	0	0	Ö	0	192.04
	19203 PRACTI CE MANAGEMENT	0	25	0	0		192.05
	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192.06 192.08
	19205 RIVERVIEW MEDICAL ARTS 19300 NONPAID WORKERS				0		192.08
	07950 WORKMED	0	0	0	0		194.00
194.01	07951 MEALS ON WHEELS	0	0	0	0		194.01
200.00		_				-	200.00
201.00 202.00		0 5, 388, 392	0 75, 285	0 72, 359	0 516, 673		201.00 202.00
202.00		0,000,072	, , , , 200	, 2, 007	310, 010	12, 701	

ALLOCATION OF CAPTAL ENLINE COSTS Provider Other 15 005 Period Provider Description Image: Control Description MINISTRAT Control Description MINISTRAT Description		ancial Systems	RI VERVI EW				u of Form CMS-2	2552-10
Operation Ausdrove Provide cost Second a secon	ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider CC	Fr	om 01/01/2017		
Participant Participant Participant Participant Participant Participant 1 Decision Encoder Contracts 15:00 16:00 10:00							5/29/2018 8:5	
Support LUBBARY LUBBARY		Cost Center Description			PHARMACY		SOCIAL SERVICE	
Definition Definition Description 10 000000000000000000000000000000000000				SUPPLY	15.00	LI BRARY	17.00	
100 SDIOD RATE CAP: RELCGS IS PRAVTING 1.00 00 CONCORD ADDRESS IN CONSTRUCT 4.00 100 SDIOD RATE VIET REALTS IN COL 5.00 100 CONCORD ADDRESS IN CONSTRUCT 6.011 100 CONCORD ADDRESS IN CONSTRUCT 0 296.87 1100 CONCORD ADDRESS IN CONSTRUCT 0 296.87 1100 CONCORD ADDRESS IN CONSTRUCT 0 296.87 1100 CONCORD ADDRESS IN CONSTRUCT 0 0 0 1100 CONCORD ADDRESS IN CONSTRUCT 0 0 0 270.00 1100 CONCORD ADDRESS IN CONSTRUCT 0 0 0 0 270.00 1100 CONCORD ADDRESS INC AND TO THE ADDRESS INCORD ADDR	GENE	RAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
0 000000 ADMINISTRATIVE & GENERAL. 5.00 0 0000000 LARGEY & LINES SENIO C 5.00 0 0000000 LARGEY & LINES SENIO C 5.00 0.000000 LARGEY & LINES SENIO C 1.00 1.00 011000 CAP ELBAN 1.00 1.00 011000 CAP ELBAN 0.00 1.00 01000 PARAMAN 0.00 0.00 1.00 01000 PARAMAN 0.00 0.00 0.00 1.00 01000 PARAMAN 0.00 0.00 0.00 0.00 1.00 01000 PARAMAN 0.00 0.00 0.00 0.00 0.00 1.00 01000 PARAMAN 0.00	1.00 0010	NEW CAP REL COSTS-BLDG & FIXT						
2.00 CORED QUELATING OF PLANI 2.00 0.00 CORED QUELATING OF PLANI 2.00 0.00 CORED QUELATING OF PLANI 2.00 0.00 CORED QUELATING 2.00 0.00 CORETENA 3.00 0.00 CORETENA SUPPLY 0 0.00 CORETENA SUPPLY 0 0 0.00 CORETENA SUPPLY 0 0 0 10.00 CORE CORETAL SERVICES SUPPLY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
9,00 00000 HOUSENEETING (0000 FERRY 0000 FERRY FERRY 000 FERRY								
10.00 01000 DETARY 10.00 10000 DETARY 10.00 1000000000000000000000000000000000000								
11.00 01100 CAFETERIA 11.00								
14.00 01400 CENTRAL SERVICES & SUPPLY 0 205.67 429,450 16.00 150.00 15.00 01500 MECORDS & LIBRARY 0 0 0 16.00 199.00 17.00 15.00 1	11.00 0110	O CAFETERI A						11.00
15. 00 01500 PHAMACY 0 0 429, 450 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00				205 867				
17.00 01700 SCLAL SERVICE 0 0 0 23.00 10.00 000000 000000 0 23.00 000000 0 23.00 000000 0 23.00 000000 0 0 23.00 000000 0 0 23.00 000000 0<			0	275,007	429, 450			
23:00 DOD D </td <td></td> <td></td> <td>0</td> <td>0</td> <td>-</td> <td></td> <td>00.050</td> <td></td>			0	0	-		00.050	
INPARTIENT FOUTINE SERVICE COST CENTERS			0	0	-	-		•
31.00 03100 INTERSIVE CARE UNIT 1794 0 0 9, 469 4, 193 31.00 43.00 04300 MARSERY 0	I NPA	TI ENT ROUTI NE SERVI CE COST CENTERS	1	1	1			
11.00 04100 SUBPROVIDER - 1 PF B37 0 0 7,668 41.00 04.00 05.00 06.00 0					-			
44.00 04400_SKILLED NURSI NG FACLITY 0 0 902 5.02 44.00 MOLLARY SERVIC COST CENTERS 0 <t< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td>•</td></t<>				0	0			•
MCD LLARY SERVICE COST CENTERS MCD LLARY SER				-	0	0		•
50. 00 65000 00000 0 <			0	<u> </u>	0	902	5, 602	44.00
54. 00 66400 RADI LOCY-LIA AGNOSTI C 0 0 4.05 5.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 66.00	50.00 0500	O OPERATING ROOM			-			•
55. 00 05500 RAD LOGY. THERAPEUTI C 0 0 4, 058 0 55. 00 57. 00 03330 ULTRA SOUND 0 0 0 0 57. 01 58. 00 05600 CARDIA C. CATHETER JATI ON 0 0 0 0 58. 00 59. 00 05600 CARDIA C. CATHETER JATI ON 0 <td></td> <td></td> <td>0</td> <td>-</td> <td>0</td> <td></td> <td>-</td> <td>•</td>			0	-	0		-	•
57. 01 03430 UTRA SOUND 0 0 0 0 57. 01 58.00 05600 CARDIAC CATHETER JATION 0 0 0 0 58.00 59.00 05600 CARDIAC CATHETER JATION 0 0 0 0 0 68.00 60.00 06001 LABORATORY 0 0 0 0 63.00 63.00 63.00 63.00 63.00 0 0 64.00 65.00 0 0 0 0 64.00 65.00 0 0 0 0 0 66.00 65.00 0 0 0 0 0 0 66.00 65.00 0			0	0	0			
B8 00 OSB00 MARCHIC RESONANCE I MGLING (ML) 0			0	0	0	0	-	
99 00 05900 CARDUA C. CATHETERIZATION 0 0 0 0 0 0 99 00 0			0	0	0	0		
60 001 0 0001 0 0 <			0	0	0	0		
63.00 0 0 0 0 0 63.00 61.000 63.00 63.00 64.00 64.00 66.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 67.00 67.00 66.00 67.00 66.00 68.00 68.00 68.00 68.00 68.00 67.00			0	0	0			
65.00 0 0 0 0 0 0 0 0 0 0 0 65.00 0			0	0	0	0		
66.00 Decord PHYSICAL THERAPY 0 0 32, 467 0 66.00 67.00 06700 0000 0 0 0 0 67.00 0			0	0	0	0		
67:00 OCUPATIONAL THERAPY 0 0 0 0 0 67:00 0<			0	0	0	0 32 467	0	
69:00 00 0 2,766 0 69:00 69:00 69:00 69:00 69:00 0 71:00			0	0	0	0		
171.00 VPIO MEDICAL SUPPLIES CHARGED TO PATIENTS 0 295,867 0 0 71.00 72.00 07300 IMPL DEV. CHARGED TO PATIENTS 0 0 429,450 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 429,450 0 0 74.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74.00 76.01 03140 CABDIAC REHAB 0			0	0	0	Ű		
12.00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 <td< td=""><td></td><td></td><td>0</td><td>0 295, 867</td><td>0</td><td></td><td></td><td></td></td<>			0	0 295, 867	0			
74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0	72.00 0720	OIMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
76. 00 03202 0THER ANCILLARY 0 0 0 0 76. 00 76. 01 03140 CARDIAC REHAB 0 0 0 0 0 0 76. 01 76. 02 03370 ENDOSCOPY 0			0	0	429, 450	0		•
76. 02 03070 WOMEN'S CENTER 0 0 0 0 76. 02 76. 03 03330 ENDOSCOPY 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>•</td>			0	0	0	0		•
76. 03 03302 ENDOSCOPY 0			0	0	0	0		•
OUTPATIENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>•</td></t<>			0	0	0	0		•
90.01 09001 0UTPATIENT 0	OUTP	ATIENT SERVICE COST CENTERS	,	-1		-		
91.00 09100 EMERGENCY 1,067 0 0 9,019 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 07HER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 95.00 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 0 95.00 NONREI MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6.611 295,867 429,450 167,744 89,852 118.00 192.00 19200 PHYSICI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 19200 PHYSICI ANS' PRI VATE OFFICES 0 0 0 0 192.01 192.02 19202 CLINICS 0 0 0 0 192.02 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0			0	0	0	0		
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 0THER REIMBURSABLE COST CENTERS 95.00 0 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 95.00 SUBTOTALS (SUM OF LINES 1 through 117) 6.611 295.867 429.450 167.744 89.852 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192.00 192.00 19200 GIVST, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192.00 0 0 192.00 19200 19200 19200 19200 19200 19200 19200 19200 0 0 0 192.00 192.02 19			1,067	0	0	9, 019		
OTHER REI MBURSABLE COST CENTERS 95.00 OP500[AMBULANCE_SERVICES 0			0	0	0	0	0	
95.00 OP500 AMBULANCE SERVICES O <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>								92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 611 295, 867 429, 450 167, 744 89, 852 118.00 NONREI MBURSABLE COST CENTERS	95.00 0950	O AMBULANCE SERVI CES	0	0	0	0	0	95.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 19201 FOUNDATI ON 0 0 0 0 192.01 192.02 19202 CLI NI CS 0 0 0 0 192.02 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0 0 192.03 192.04 19207 WESTFI ELD SCHOOLS 0 0 0 192.04 192.05 19203 PRACTI CE MANAGEMENT 0 0 0 192.05 192.06 19204 MOB - NOBLESVI LLE SOUARE 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 193.00			6 611	205 967	420 450	167 744	00 052	110 00
192.00 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 192.01 FOUNDATION 0 0 0 0 192.01 192.02 CLINICS 0 0 0 0 192.02 192.03 19206 HOME HEALTH PARTNERSHIP 0 0 0 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 0 0 192.03 192.05 19203 PRACTICE MANAGEMENT 0 0 0 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDICAL ARTS 0 0 0 0 192.08 192.09 07950 WORKMED 0 0 0 192.08 192.08 192.09 192.08			0,011	295, 807	429, 450	107, 744	89,852	118.00
192.01 FOUNDATION 0 0 0 192.01 192.02 CLINICS 0 0 0 902 192.02 192.03 19206 HOME HEALTH PARTNERSHIP 0 0 0 0 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 0 0 192.03 192.05 19208 PRACTICE MANAGEMENT 0 0 0 0 192.04 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07950 WORKMED 0 0 0 0 194.00 194.01 07950 WORKMED 0 0 0 194.00 194.00 200.00 Kost Centers 0			0	0	0			•
192.02 CLINICS 0 0 902 192.02 192.03 19206 HOME HEALTH PARTNERSHIP 0 0 0 0 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 0 0 192.04 192.05 19203 PRACTICE MANAGEMENT 0 0 0 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 194.00 194.00 194.00 194.00 194.00 0 194.01 0 194.01 0 194.01 0 0 0 0 194.01 0 194.01 0 0 0 194.01 0 194.01 0 194.01 0 0 0 194.01 0 194.01 0 194.01 0 0 0 194.01 200.00 200.0			0	0	0	0		
192.04 19207 WESTFI ELD SCHOOLS 0 0 0 192.04 192.05 19203 PRACTI CE MANAGEMENT 0 0 0 0 192.05 192.06 19204 MOB - NOBLESVI LLE SOUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.01 200.00 Cross Foot Adj ustments - - 200.00 201.00 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00			0	0	0	902		
192.05 19203 PRACTI CE MANAGEMENT 0 0 0 192.05 192.06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00			0	0	0	0		
192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 192.06 192.08 19205 RI VERVI EW MEDICAL ARTS 0 0 0 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.00 200.00 Cross Foot Adjustments 0 0 0 0 201.00			0	0	0	0		
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 WORKMED 0 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	192.06 1920	04 MOB - NOBLESVILLE SQUARE	0	Ö	Ö	Ö	0	192.06
194.00 07950 WORKMED 0 0 0 194.00 194.01 07951 MEALS ON WHEELS 0 0 0 0 194.01 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00			0	0	0	0		
200.00 Cross Foot Adjustments 200.00			0	0	0	0	0	194.00
201.00 Negative Cost Centers 0 </td <td>194.010795</td> <td>1 MEALS ON WHEELS</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>•</td>	194.010795	1 MEALS ON WHEELS	0	0	0	0	0	•
			0	0	Ο	0	0	
		5	6, 611	295, 867	429, 450	168, 646		

	Financial Systems TION OF CAPITAL RELATED COSTS	RI VERVI EW H		CN: 15-0059 Pe	In Lieu riod:	ı of Form CMS-2552- Worksheet B
				Fro To	om 01/01/2017 12/31/2017	Part II Date/Time Prepared
	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	5/29/2018 8:50 pm
		23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	<u>ј</u>		I		1.0
4.00 5.00 7.00 8.00 9.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY					4. () 5. () 7. () 8. () 9. () 10. ()
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					11. (13. (14. (
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE					15. (15. (16. (17. (
	02300 PARAMED ED PRGM PHARMACY	9, 876				23. (
	INPATIENT ROUTINE SERVICE COST CENTERS		4 000 ===		4 000 7	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT		4, 309, 777 776, 315	1	4, 309, 777 776, 315	30. (
	04100 SUBPROVI DER – I RF		830, 504		830, 504	41. (
	04300 NURSERY		0	0	0	43. (
	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS		599, 449	0	599, 449	44. (
	05000 OPERATING ROOM		1, 680, 574	0	1, 680, 574	50.0
	05200 DELIVERY ROOM & LABOR ROOM		C	0	0	52. (
	05400 RADI OLOGY-DI AGNOSTI C		522, 929		522, 929	54.0
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN		367, 586 3, 093		367, 586 3, 093	55.0
	03630 ULTRA SOUND		3,075	0	5, 075	57.0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		2, 846	0	2, 846	58.0
	05900 CARDI AC CATHETERI ZATI ON		154, 564		154, 564	59.0
	06000 LABORATORY 06001 BLOOD LABORATORY		674, 034	0	674, 034	60. (60. (
	06300 BLOOD STORING, PROCESSING & TRANS.		93, 602	0	93, 602	63.0
	06400 I NTRAVENOUS THERAPY		C	0	0	64.0
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		104, 428 93, 978		104, 428 93, 978	65. (66. (
	06700 OCCUPATI ONAL THERAPY		93, 978 C	0	43, 478 0	67.0
	06800 SPEECH PATHOLOGY		0	0	0	68. (
	06900 ELECTROCARDI OLOGY		549, 142		549, 142	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		295, 867		295, 867	71.0
	07200 TMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS		8, 579 429, 450		8, 579 429, 450	72.0
	07400 RENAL DI ALYSI S		48, 895		48, 895	74. (
	03020 OTHER ANCI LLARY		0	0	0	76.0
	03140 CARDI AC REHAB 03070 WOMEN' S CENTER		96, 300 411, 366		96, 300 411, 366	76.0
	03330 ENDOSCOPY		411, 300 0		0	76.0
	OUTPATIENT SERVICE COST CENTERS				1	
	09000 CLINIC 09001 OUTPATIENT		11, 453		11, 453 183, 974	90. (90. (
	09100 EMERGENCY		183, 974 769, 462		769, 462	90.0
	09101 SHORT STAY		0	0	0	91. (
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0		92. (
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		906	0	906	95.0
	SPECIAL PURPOSE COST CENTERS	<u> </u>	900		900	95.0
	NONREI MBURSABLE COST CENTERS	0	13, 019, 073		13, 019, 073	118. (
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		304, 378 674, 753		304, 378 674, 753	190. (192. (
192.01	19201 FOUNDATI ON		1, 896	0	1, 896	192. (
	19202 CLINICS		13, 071	0	13, 071	192. (
	19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS		1 8, 330	0	1 8, 330	192. (192. (
	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT		8, 330 9, 264		8, 330 9, 264	192. (
192.06	19204 MOB - NOBLESVILLE SQUARE		5, 048		5, 048	192. (
	19205 RI VERVI EW MEDI CAL ARTS		1, 300	0	1, 300	192. (
	19300 NONPALD WORKERS 07950 WORKMED		0	0	0	193. (194. (
	07950 WORKMED 07951 MEALS ON WHEELS		1, 795	0	1, 795	194. (
171.011	Cross Foot Adjustments	9, 876	9, 876		9, 876	200. (

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2017	Worksheet B Part	
				To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
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 through 201)	9, 876	14, 048, 785		0 14, 048, 785		202.00

Low Relation is instruction in terms Construction in terms Tom Ultransistic instruction Construction in terms Display in terms Display instruction Display instructin Display instruction <th< th=""><th></th><th>Financial Systems LLOCATION - STATISTICAL BASIS</th><th>RI VERVI EW</th><th></th><th>CN: 15-0059 F</th><th>In Lie eriod:</th><th>u of Form CMS-: Worksheet B-1</th><th></th></th<>		Financial Systems LLOCATION - STATISTICAL BASIS	RI VERVI EW		CN: 15-0059 F	In Lie eriod:	u of Form CMS-: Worksheet B-1	
Desit Denter Beschiption Desit Pattern Desite plane Desite Pattern DesitePattern Desite Pattern Desite Pattern DesitePattern Desi	0001 A				F	rom 01/01/2017		
Bits Bits <th< td=""><td></td><td></td><td></td><td></td><td> '</td><td>0 12/31/2017</td><td></td><td></td></th<>					'	0 12/31/2017		
FEED CORRESS CORRESS CORRESS CORRESS CORRESS 100 SAMANTES 5.0.0 7.00 7.00 100 SAMANTES 5.0.0 7.00 100 SUMMINESTATTES ENDERABLES 1.00 5.0.0 7.00 1.00 SUMMINESTATTES ENDERABLESTS DELARINENT 2.9.79 4.00 1.02 0.00000 LUNDESTEETEN TESTATES 4.00 1.02 1.02 0.00000 LUNDESTEETEN 1.177 50 1.61 1.62 1.177 50 1.62 1.177 50 1.02 1.		Cost Center Description	RELATED COSTS NEW BLDG &		Reconciliatior			
ID CONTINUES 1 0.0 4 0.0 7.00 100 CONTO				(GROSS				
CEREBAL SERVICE COST CENTERS 1:00 000100 DRIVIONE LEDRENT IS LEPANIPARIT 2,700 45,76,686 -21,777,320 140,702,428 4,00 0:00000 DRIVIONE EDRENT IS LEPANIPARIT 2,700 8,76,686 -21,777,320 11,897,607 20,100 70,00 70,00 11,897,607 11,897,607 11,897,607 11,897,607 11,897,607 11,897,607 11,897,607 11,897,607 11,807,607			1.00		5Δ	5.00	7.00	
4.00 DARDD [DPLICYCE BERNET IS DEPARIMENT 2, 774 44, 715, 318 7, 717, 30 142, 762, 743 5, 50 7.00 DORDO OF RATIO OF PLANT 113, 278 1, 676, 444 61, 461, 267 7, 717, 30 142, 762, 743 71, 717, 50 142, 762, 743 71, 717, 50 1, 676, 644 71, 717, 50 1, 676, 644 71, 717, 50 1, 676, 644 1, 677, 644 1, 677, 644 1, 677, 644 1, 677, 644 1, 677, 644 1, 677, 644 1, 677, 656 1, 717, 50 0 1, 707, 644 1, 607, 664 1, 717, 50 0 1, 607, 607 1, 600 1, 600, 640 1, 620, 640 1, 728, 610 1, 600, 640 1, 600, 640 1, 600, 640 1, 620, 640 1, 728, 134 1, 207, 134 <td></td> <td>GENERAL SERVICE COST CENTERS</td> <td>1.00</td> <td>4.00</td> <td></td> <td>3.00</td> <td>7.00</td> <td></td>		GENERAL SERVICE COST CENTERS	1.00	4.00		3.00	7.00	
5.00 00000 AVMINISTATIVE & CENERAL 38. 900 8. 165. 664 -21. 717. 320 147. 07. 20. 428 2.61. 620 0.00 000000 LANRAY A LIREN SERVICE 1. 458 44, 194 0 1.807. 502. 428 7.00 0.00 000000 LANRAY A LIREN SERVICE 1. 458 44, 194 0 1.627. 715 10. 70 0.00 011000 CAFTERIA 0.01 0.00 010000 1.00. 717. 818 0 1.00. 71 011. 00 11. 00. 716. 70 011. 00 0.00 01000 CAFTERIA 0.00 0.51. 65. 864 7.00. 437 011. 00 11. 00. 716. 70 011. 00 0.00 01000 CAFTERIA A LIREN SERVICE 1.00. 112. 00. 33. 53. 71 1.41. 10. 11. 00. 31. 52. 884 3.725 1.63. 65. 661 3.12. 00 12. 00. 33. 53. 71 1.41. 10. 11. 10. 12. 00. 31. 52. 884 3.725 1.00. 11. 208. 31. 53. 661 3.13. 10. 01. 10. 01. 10. 01. 12. 08. 31. 53. 661 3.13. 10. 01. 10. 01. 10. 01. 10. 01. 12. 08. 31. 53. 661 3.14. 16. 10. 11. 10.								
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14.00 01400 (CENTRAL SERVICES & SUPPLY 37.225 6.34,073 014.552,084 37.25 14.00 15.00 01500 (MEDICAL RECORDS & LIBRARY 3.687 825,133 0 18.65,199 3.087 14.00 23 00 0600 (MEDICAL RECORDS & LIBRARY 3.687 16.00 19.85,199 3.087 16.00 23 00 0500 (LLB SENUC COST CENTERS 16.43 16.00 110,2115 0 225,223 110 23.00 0.00 03000 (INTES NE PROVIDER - IRF 14.151 1.697,372 0 2.618,966 14.151 31.00 11.00 0100 (INTESNE THE INSTICK COST CENTERS 76.463 0			0				-	
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99.00 05900 CARDIAL CATHETERIZATION 2,879 764,279 0 1,134,342 2,879 89,00 00.00 06000 LABORATORY 12,433 2,328,857 0 6,193,363 12,433 60.00 04.00 DAGON LABORATORY 0<			0	-	-	-	-	
60.00 0c000 LABORATORY 12, 433 2, 328, 857 0 6, 193, 363 12, 433 00.00 60.01 BLODD LABORATORY 0			2 879				-	
63:00 06300 BLODD STORING, PROCESSING & TRANS. 1,805 0 0 566,191 1,805 63.00 64:00 064000 INTRAVENDUS THERAPY 1,844 989,351 0 1,436,129 1,844 65.00 66:00 066000 PHYSICAL THERAPY 0 3,982,703 0 6,952,684 66.00 67:00 06700 0CUPATIONAL THERAPY 0 0 0 0 67.00 08:00 068000 SPECH PATHOLOGY 0 0 0 0 67.00 67.00 09:00 0000 ELECTRCARCARDIOLOGY 0 0 0 0 0 67.00 67.00 0000 COUPATIONAL THERAPY 0 0 0 1,627,790 10,711 69.00 69.00 69.00 71.00 71.00 71.0 71.0 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 74.00 74.00 74.00 76.02 76.01 76.02 75.099 1,95.91.88 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
64.00 0 <td></td> <td></td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td></td> <td></td>			0	C		0		
65.00 06500 PESPIRATORY THERAPY 1, 844 690, 371 0 1, 436, 129 1, 844 65.00 66.00 06000 PHYSICLA THERAPY 0 3, 982, 703 0 6, 952, 684 0 66.00 67.00 06700 OCUPATIONAL THERAPY 0 0 0 0 67.00 66.00 66.00 67.00 66.00 67.00 66.00 67.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 67.00 68.00 67.00			1,805	0		566, 191		
66.00 06600 PHYSICAL THERAPY 0 3, 982, 703 0 6, 952, 684 0 6, 67.00 67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 68.00 68.00 06800 SPEECH PATHOLOGY 10, 711 851, 130 0 1, 627, 790 10, 711 69.00 71.00 70.00 MPL DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 72.00 0 0 0 0 72.00 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 76.00 0 <td< td=""><td></td><td></td><td>1,844</td><td>989.351</td><td>-</td><td>1, 436, 129</td><td></td><td></td></td<>			1,844	989.351	-	1, 436, 129		
68.00 06800 SPECH PATHOLOGY 0			0					
69.00 06/900 ELECTROCARDIOLOGY 10,711 851,130 0 1,627,790 10,711 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73.00 0 0 0 0 0 0 0 73.00 0 0 0 0 0 0 0 0 0 0 0 73.00 0 0 0 0 0 73.00 0 0 0 0 73.00 0 0 0 0 0 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 76.02 75.099 0 1,959,188 1,81.73 76.02 76.02 76.02 76.02 76.02 76.02 76.02 76.02 76.02 76.02 76.02 76.02 76.02 <td< td=""><td></td><td></td><td>0</td><td>C</td><td></td><td>-</td><td>-</td><td></td></td<>			0	C		-	-	
71.00 OTOO MEDICAL SUPPLIES CHARGED TO PATIENTS O O O O 71.00 72.00 07300 DRUGS CHARGED TO PATIENT O O 0 1,142,634 O 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS O O 0 0 73.00 74.00 07400 RENAL DIALYSIS 929 O 0 387,288 929 74.00 76.00 03202 OTHER ANCILLARY O O O 0 0 76.00 76.01 03140 CARDIAC REHAB 1,582 775.099 0 1,959,188 1,582 76.01 76.02 03070 WORN'S CENTER 8,137 378,745 O 70.0 0 0 0 70.09 0 0 76.02 0.00 09001 UUTPATIENT SERVICE COST CENTERS 0 0 786,934 0 1,280,383 0 90.00 90.00 90.00 09000 ILINC 0 786,934 0 3,988,820 14.305 91.01 91.01 91.01 9010 <td></td> <td></td> <td>10 711</td> <td>0 951 120</td> <td></td> <td></td> <td></td> <td></td>			10 711	0 951 120				
72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 1, 142, 634 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 929 0 387,288 92.9 74.00 76.00 03020 OTHER ANCILLARY 0 0 0 0 76.00 76.01 03140 CARDI AC REHAB 1,582 775,099 0 1,959,188 1,582 76.01 76.02 03070 WOMEN'S CENTER 8,137 378,745 0 770.945 8,137 76.02 03330 ENDOSCOPY 0 0 0 0 0 0 76.03 0100 09000 CLI NIC 0 786,934 0 1,280,383 90.00 90.01 90.00 90.00 90.01 91.00 91.00 91.00 91.01 91.01 91.01 91.01 91.01 91.01 91.01 92.00 92.00 90 0 91.01 92.00 95.00 9			10, 711	001, 130				
74.00 07400 RENAL DI ALYSI S 929 0 0 387,288 929 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 0 0 76.00 76.01 03140 CARDIAC REHAB 1.582 775.099 0 1.959,188 1,552 76.01 76.02 03070 WOMEN'S CENTER 8.137 378,745 0 770,945 8,137 76.02 0 03000 0			0	0				
76. 00 03020 OTHER ANCI LLARY 0 0 0 0 76. 00 76. 01 03140 CARDI AC REHAB 1,582 775,099 0 1,959,188 1,582 76. 01 76. 02 03330 ENDOSCOPY 0 0 0 0 76. 02 76. 03 03330 ENDOSCOPY 0 0 0 0 76. 03 001794 BK.177 78, 745 0 1, 280, 383 0 90. 00 00.00 09000 CLI NI C 0 786, 934 0 1, 280, 383 0 90. 00 90. 01 09001 UTPATI ENT 3, 462 501, 199 0 1, 188, 348 3, 462 90. 01 91. 00 09101 SUBTOT STAY 0 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI ST INCT PART) 0 0 0 91. 01 95. 00 SPECI AL PURPOSE COST CENTERS 0 54, 922 0 104, 440 0 92. 00 9100. 00 FT, FLOWER, COFFEE SHOP & CANTEEN 0			0	0	0	0		
76. 01 03140 CARDIAC REHAB 1,582 775,099 0 1,959,188 1,582 76. 01 76. 02 0370 WOMEN'S CENTER 8,137 378,745 0 770,945 8,137 76. 02 76. 03 0330 ENDOSCOPY 0 <			929	0				
76. 02 03070 WOMEN'S CENTER 8, 137 378, 745 0 770, 945 8, 137 76. 02 76. 03 03330 ENDOSCOPY 0			1, 582	775, 099		-		
OUTPATI ENT SERVICE COST CENTERS 0 786, 934 0 1, 280, 383 0 90. 00 90. 01 090001 CLINIC 0 786, 934 0 1, 280, 383 0 90. 01 90. 01 09010 EMERGENCY 14, 305 2, 139, 394 0 3, 988, 820 14, 305 91. 00 91. 01 09101 SUBRT STAY 0 0 0 0 0 0 0 91. 01 92. 00 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 0 0 0 54, 922 0 104, 440 0 95. 00 SPECIAL PURPOSE COST CENTERS 0 54, 922 0 104, 440 0 95. 00 NORREI MBURSABLE COST CENTERS 0 54, 922 0 104, 440 0 95. 00 118. 00 NONREI MBURSABLE COST CENTERS 0 54, 922 0 104, 440 0 118. 00 192.00 192000 GITALS (SUM OF LINES 1 t	76.02	03070 WOMEN'S CENTER						
90. 00 09000 CLI NI C 0 786, 934 0 1, 280, 383 0 90. 00 90. 01 09001 UTPATI ENT 3, 462 501, 199 0 1, 188, 348 3, 462 90. 01 91. 00 09100 EMERGENCY 14, 305 2, 139, 394 0 3, 988, 820 14, 305 91. 00 0 0 0 0 0 0 0 91. 01 92. 00 0 0 0 0 0 0 0 92. 00 92. 00 92. 00 92. 00 92. 00 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 93. 03 94. 72 94. 72	76.03		0	0) C	0	0	76.03
90.01 09001 0UTPATIENT 3,462 501,199 0 1,188,348 3,462 90.01 91.00 09100 EMERGENCY 14,305 2,139,394 0 3,988,820 14,305 91.00 91.01 09101 SHORT STAY 0 0 0 0 0 0 91.01 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 92.00 07HER REI MBURSABLE COST CENTERS 0 54,922 0 104,440 0 95.00 SPECIAL PURPOSE COST CENTERS 0 54,922 0 104,440 0 95.00 NOREL MBURSABLE COST CENTERS 0 54,922 0 104,440 0 95.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 471,852 43,270,821 -21,717,320 109,091,073 247,450 118.00 192.00 19200 FFT, FLOWER, COFFEE SHOP & CANTEEN 6,043 213,215 0 616,219 6,043 192.02 192.01 19200 FFT, FLOWER, COFFEE SHOP & CANTEEN 0 0	90 00		0	786 934		1 280 383	0	
91. 01 09101 SHORT STAY 0 0 0 0 0 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 01 92. 02 92. 01 92. 02 92. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 02 192. 01 192. 02 192. 02 192. 02 192. 02 192. 02 192. 02 192. 02 192. 02			3, 462					
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 0THER REI MBURSABLE COST CENTERS 0 54,922 0 104,440 0 95.00 OPSCOLAL PURPOSE COST CENTERS 0 54,922 0 104,440 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 471,852 43,270,821 -21,717,320 109,091,073 247,450 118.00 NONREI MBURSABLE COST CENTERS 0 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 6,043 213,215 0 616,219 6,043 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 8,127 0 0 35,493,702 8,127 192.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFICES 8,127 0 0 192.00 192.02 192.			14, 305	2, 139, 394	C	3, 988, 820	14, 305	
OTHER REIMBURSABLE COST CENTERS 95.00 OP500 AMBULANCE SERVICES 0 54,922 0 104,440 0 95.00 SPECIAL PURPOSE COST CENTERS TI8.00 SUBTOTALS (SUM OF LINES 1 through 117) 471,852 43,270,821 -21,717,320 109,091,073 247,450 118.00 NONRET MBURSABLE COST CENTERS TO 0 0 616,219 6,043 190.00 616,219 6,043 190.00 192.01 192.00 192.01 6,043 213,215 0 616,219 6,043 190.00 192.00 PHSICIANS' PRIVATE OFFICES 8,127 0 0 35,493,702 8,127 192.01 192.01 FOUNDATI ON 0 16.043 192.02 192.02 CLINICS 0 0 0 0 192.01 192.02 192.02 CLINICS 0 0			0	C	C	0	0	
95.00 09500 AMBULANCE SERVICES 0 54,922 0 104,440 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 471,852 43,270,821 -21,717,320 109,091,073 247,450 118.00 NONREI MBURSABLE COST CENTERS 190.00 I9000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 6,043 213,215 0 616,219 6,043 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8,127 0 35,493,702 8,127 192.00 192.01 FOUNDATI ON 0 162,788 0 206,337 0 192.02 192.02 CLI NI CS 0 0 0 150 0 192.02 192.04 19207 WESTFI ELD SCHOOLS 0 0 1,109,511 0 192.04 192.05 19203 PRACTI CE MANAGEMENT 0 0 1,230,548 0 192.05 192.04 19204 MOB - NOBLESVI LLE	92.00							92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 471,852 43,270,821 -21,717,320 109,091,073 247,450 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 6,043 213,215 0 616,219 6,043 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 8,127 0 0 35,493,702 8,127 0 192.01 192.01 192.01 192.01 192.02 19202 CLI NI CS 0 102.02 19202 CLI NI CS 0 192.02 19202 CLI NI CS 0 0 192.02 19202 CLI NI CS 0 0 192.02 1920.03 1920.04 1920.03 1920.04 1920.02 1920.02 1920.02 1920.04 1920.02 1920.03 1920.04 1920.03 1920.04 1920.03 1920.04 1920.04 1920.04 1920.04 1920.04 1920.05 1920.04 1920.05 1920.05 1920.05 1920.05 1920.05 1920.05 1920.05 1920.05 1920.05 1920.05 1920.05 1920.05 <td>95.00</td> <td></td> <td>0</td> <td>54, 922</td> <td>2</td> <td>104, 440</td> <td>0</td> <td>95.00</td>	95.00		0	54, 922	2	104, 440	0	95.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 6,043 213,215 0 616,219 6,043 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 8,127 0 0 35,493,702 8,127 192.00 192.01 19201 FOUNDATI ON 0 162,788 0 206,337 0 192.01 192.02 19202 CLI NI CS 0 0 0 1,194,557 0 192.02 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0 192.03 192.04 192.03 192.04 192.03 192.04 192.03 192.04 192.03 192.04 192.03 192.04 192.04 192.04 192.04 192.04 192.04 192.04 192.05 192.04 192.04 192.05 192.05 192.04 192.05 192.04 192.05 192.04 192.06 192.04 192.06 192.06		SPECIAL PURPOSE COST CENTERS			1	1		
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 6,043 213,215 0 616,219 6,043 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8,127 0 0 35,493,702 8,127 192.00 192.01 19201 FOUNDATI ON 0 162,788 0 206,337 0 192.01 192.02 19202 CLI NI CS 0 0 0 1,194,557 0 192.02 192.03 19206 HOME HEALTH PARTNERSHI P 0 0 0 192.03 192.03 192.04 19207 WESTFI ELD SCHOOLS 0 0 0 192.03 192.05 19203 PRACTI CE MANAGEMENT 0 0 1,109,511 0 192.04 192.06 19204 MOB - NOBLESVI LLE SOUARE 0 0 1,230,548 0 192.05 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 173,105 0 192.08 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 192.08 <td< td=""><td></td><td></td><td>471, 852</td><td>43, 270, 821</td><td>-21, 717, 320</td><td>109, 091, 073</td><td>247, 450</td><td>118.00</td></td<>			471, 852	43, 270, 821	-21, 717, 320	109, 091, 073	247, 450	118.00
192.01 FOUNDATION 0 162,788 0 206,337 0 192.01 192.02 19202 CLINICS 0 0 0 1,194,557 0 192.02 192.03 19206 HOME HEALTH PARTNERSHIP 0 0 0 150 0 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 0 1,109,511 0 192.04 192.05 19203 PRACTICE MANAGEMENT 0 0 0 1,230,548 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 992,201 433,668 0 192.06 192.08 19205 RI VERVIEW MEDICAL ARTS 0 0 0 173,105 0 192.08 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00			6, 043	213, 215	i C	616, 219	6, 043	190. 00
192.02 CLINICS 0 0 1, 194, 557 0 192.02 192.03 19206 HOME HEALTH PARTNERSHIP 0 0 0 150 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 1, 109, 511 0 192.04 192.05 19203 PRACTICE MANAGEMENT 0 0 1, 230, 548 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 992, 201 0 433, 668 0 192.06 192.08 19205 RI VERVIEW MEDICAL ARTS 0 0 0 173, 105 0 192.08 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00			8, 127	0				
192.03 19206 HOME HEALTH PARTNERSHIP 0 0 150 192.03 192.04 19207 WESTFIELD SCHOOLS 0 0 1109,511 192.04 192.05 19203 PRACTICE MANAGEMENT 0 0 0 122.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 992,201 0 433,668 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 173,105 0 192.08 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00			0	162, 788				
192.04 19207 WESTFIELD SCHOOLS 0 0 1, 109, 511 0 192.04 192.05 19203 PRACTICE MANAGEMENT 0 0 0 1, 230, 548 0 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 992, 201 0 433, 668 0 192.06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 173, 105 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00			0	0	-			•
192.06 19204 MOB - NOBLESVI LLE SQUARE 0 992, 201 0 433, 668 0 192. 06 192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 173, 105 0 192. 08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193. 00	192.04	19207 WESTFIELD SCHOOLS	0	0		1, 109, 511	0	192.04
192.08 19205 RI VERVI EW MEDI CAL ARTS 0 0 173, 105 0 192.08 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00			0	0				
193.00 19300 NONPAID WORKERS 0 0 0 0 193.00			0	992, 201 n				
	193.00	19300 NONPAID WORKERS	0	0			0	193.00
	194.00	O7950 WORKMED	0	0) C	0	0	194.00

Health Financial Systems	RI VERVI EW H	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0059	Period:	Worksheet B-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 8:5	pared: 0 pm
Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFI TS	Reconciliatio	n ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	
	(SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	(SQUARE FEET)	
	1.00	4.00	5A	5.00	7.00	
194.01 07951 MEALS ON WHEELS	0	76, 293		0 213, 558	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)	14, 048, 785	8, 760, 644		21, 717, 320	13, 622, 896	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	28. 905657	0. 195920		0.145012	52.071310	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		80, 762		1, 124, 441	5, 388, 392	204.00
205.00 Unit cost multiplier (Wkst. B, Part		0. 001806		0.007508	20. 596254	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal th Financial Systems	RI VERVI EW		N 15 0050 D		u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2017 o 12/31/2017	Worksheet B-1 Date/Time Pre	narod
Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERIA	5/29/2018 8: 50 NURSI NG	
cost center bescription	LINEN SERVICE	(HOURS OF	(MEALS	(MAN	ADMI NI STRATI ON	
	(POUNDS OF LAUNDRY)	SERVI CE)	SERVED)	HOURS)	(DI RECT	
	8.00	9.00	10.00	11.00	NRSI NG HRS) 13.00	
GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FI 4.00 00400 EMPLOYEE BENEFITS DEPARTMEN						1.00 4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	73, 174					7.00 8.00
9.00 00900 HOUSEKEEPI NG	73, 174	1				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	3 28	77, 042 0	1, 140, 210		10. 00 11. 00
13. 00 01300 NURSING ADMINISTRATION		1	0	1, 140, 210	381, 544	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	550	1	0	37, 029	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY		25 5	0	73, 959 35, 469	0	15. 00 16. 00
17.00 01700 SOCIAL SERVICE	C	0	0	18, 068	0	17.00
23.00 02300 PARAMED ED PRGM PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CE		0	0	1, 419	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	22, 936	1	38, 593	225, 889	225, 889	30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	5, 347 5, 717	1	4, 135 18, 232	45, 799 48, 283	45, 799 48, 283	31.00 41.00
43.00 04300 NURSERY	C	0	0	0	0	43.00
44.00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	5, 307	60	16, 082	0	0	44.00
50.00 05000 OPERATI NG ROOM	7, 102	1 1	0	99, 822	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI 0L0GY-DI AGNOSTI C	4, 285	-	0	0 50, 996	0	52.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	592	1 1	0	10, 103	0	55.00
57.00 05700 CT SCAN 57.01 03630 ULTRA SOUND		0	0	7, 599	0	57.00 57.01
58.00 05800 MAGNETIC RESONANCE I MAGI NG	(MRI) C	1	0	5, 707	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	1, 888	1	0	18, 389	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0	0	97, 128 0	0	60. 00 60. 01
63.00 06300 BLOOD STORING, PROCESSING &	TRANS. C	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		3	0	0 30, 453	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	617	0	0	130, 365	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY			0	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	628	1	0	23, 716	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 72.00 07200 IMPL. DEV. CHARGED TO PATIE			0	0	0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY			0	0	0	74.00 76.00
76. 01 03140 CARDI AC REHAB	54	1	0	24, 108	0	76. 01
76. 02 03070 WOMEN' S CENTER 76. 03 03330 ENDOSCOPY	365	20 0	0	15, 226 0	0	76. 02 76. 03
OUTPATIENT SERVICE COST CENTERS		1 1				
90. 00 09000 CLI NI C 90. 01 09001 OUTPATI ENT	99 1, 988		0	27, 888 16, 262	0	90. 00 90. 01
91. 00 09100 EMERGENCY	9, 877		0	61, 573	61, 573	91.00
91. 01 09101 SHORT STAY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI	NCT PART)	0	0	0	0	91.01 92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS		0	0	2, 061	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1 t NONREI MBURSABLE COST CENTERS		893	77, 042	1, 117, 689		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & 192.00 19200 PHYSICIANS' PRIVATE OFFICES		1	0	13, 120		190. 00 192. 00
192. 01 19201 FOUNDATI ON	0,772	0	0	4, 692	0	192. 01
192. 02 19202 CLI NI CS 192. 03 19206 HOME HEALTH PARTNERSHI P	26	41	0	0		192. 02 192. 03
192. 04 19207 WESTFIELD SCHOOLS		0	0	0		192.03 192.04
192. 05 19203 PRACTI CE MANAGEMENT	24	0	0	0		192.05
192.06 19204 MOB - NOBLESVILLE SQUARE 192.08 19205 RIVERVIEW MEDICAL ARTS		0	0	0	0	192. 06 192. 08
193.00 19300 NONPALD WORKERS		0	0	0	0	193. 00
194.0007950 WORKMED 194.0107951 MEALS ON WHEELS		0	0	0 4, 709		194. 00 194. 01
200.00 Cross Foot Adjustments						200. 00

Heal th F	inancial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/29/2018 8:5	pared: 0 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	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, Part I)	559, 219	1, 986, 375	1, 740, 76	7 1, 510, 395	861, 549	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 642318	2, 124. 465241	22.59503	9 1. 324664	2. 258059	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	75, 285	72, 359	516, 67	3 12, 961	6, 611	204. 00
205.00	Unit cost multiplier (Wkst. B, Part II)	1. 028849	77. 389305	6. 70638	1 0. 011367	0. 017327	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost´multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	RIVERVIEW H	10SPI TAL Provi der CC	CN: 15-0059 P	In Lie Period:	u of Form CMS- Worksheet B-1	
			F	rom 01/01/2017 o 12/31/2017	Date/Time Pre	pared:
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCIAL SERVICE (TIME SPENT)	5/29/2018 8:5 PARAMED ED PRGM PHARMACY (ASSI GNED TI ME)	
	14.00	15.00	16.00	17.00	23.00	
GENERAL SERVICE COST CENTERS						1 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 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	374			$\begin{array}{c} 1. 00 \\ 4. 00 \\ 5. 00 \\ 7. 00 \\ 8. 00 \\ 9. 00 \\ 10. 00 \\ 11. 00 \\ 13. 00 \\ 14. 00 \\ 15. 00 \\ 16. 00 \end{array}$
17.00 01700 SOCIAL SERVICE	0	0	C		100	17.00
23. 00 02300 PARAMED ED PRGM PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	C	0	100	23.00
30. 00 03000 ADULTS & PEDIATRICS	0	0	90	4, 144	0	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0	21		0	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	0		458	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0	2	322	0	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	142		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0	0	C 1	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	9	0	0	
57. 00 05700 CT SCAN	0	0	C	0	0	57.00
57.01 03630 ULTRA SOUND 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	57.01 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60. 00 06000 LABORATORY	0	0	9	0	0	60.00
60. 01 06001 BLOOD LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	C	0	0	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0	72	0	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	6	0	0	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	100	0	C	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0 100		0	0	72.00 73.00
74. 00 07400 RENAL DI ALYSI S	0	0	C	0	0	1
76. 00 03020 OTHER ANCI LLARY	0	0	C	0	0	
76.01 03140 CARDIAC REHAB 76.02 03070 WOMEN'S CENTER	0	0		0	0	
76. 03 03330 ENDOSCOPY	0	0	0	0	0	•
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 90. 01 09001 OUTPATI ENT	0	0		0	0	
91. 00 09100 EMERGENCY	0	0	20	0	0	
91. 01 09101 SHORT STAY	0	0	C	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95.00
SPECIAL PURPOSE COST CENTERS	I					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	100	100	372	5, 165	100	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	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	2	0		192.02
192.04 19207 WESTFIELD SCHOOLS	0	0	C	o o	0	192. 04
192. 05 19203 PRACTI CE MANAGEMENT	0	0	C	0		192.05
192. 06 19204 MOB – NOBLESVILLE SQUARE 192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	0		0		192. 06 192. 08
193. 00 19300 NONPALD WORKERS	0	0	c c	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
	I		1	1	1	1-00.00

Heal th Fi	nancial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2017	Worksheet B-1	
					Fo 12/31/2017	Date/Time Pre 5/29/2018 8:5	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE		
		SERVICES & SUPPLY (COSTED REQUIS.)	(COSTED REQUI S.)	RECORDS & LIBRARY (TIME SPENT)	(TIME SPENT)	PRGM PHARMACY (ASSIGNED TIME)	
		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, Part I)	16, 912, 571	18, 370, 322	2, 285, 320	5 1, 201, 293	290, 749	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	169, 125. 710000	183, 703. 220000	6, 110. 497320	232. 583349	2,907.490000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	295, 867	429, 450	168, 640	6 89, 852	9, 876	204.00
205.00	Unit cost multiplier (Wkst. B, Part	2, 958. 670000	4, 294. 500000	450. 925134	17. 396321	98. 760000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0. 000000	207. 00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	RI VERVI EW I	Provi der C	N. 15_0050	Peri od:	u of Form CMS-2 Worksheet C	2002
COMPUTATION OF RATIO OF COSTS TO CHARGES		FIOVICEI C	JN. 15-0054	From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre	pared:
		Title	XVIII	Hospi tal	5/29/2018 8:5 PPS	U pm
		, iiiii		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)		0.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	20, 996, 080		20, 996, 0	30 0	20, 996, 080	30.00
31. 00 03100 I NTENSI VE CARE UNI T	4, 352, 200		4, 352, 20		4, 352, 200	
41. 00 04100 SUBPROVIDER - IRF	4, 897, 719		4, 897, 7		4, 897, 719	
43. 00 04300 NURSERY	0		.,	0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	3, 670, 105		3, 670, 10	05 0	3, 670, 105	44.00
ANCI LLARY SERVI CE COST CENTERS						1
50.00 05000 OPERATING ROOM	9, 940, 177		9, 940, 1	77 0	9, 940, 177	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 988, 388		3, 988, 3		3, 988, 388	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 981, 471		1, 981, 4		1, 981, 471	
57.00 05700 CT SCAN	401, 565		401, 50		401, 565	
57. 01 03630 ULTRA SOUND	0			0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	364, 410		364, 4		364, 410	•
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	1, 487, 536 7, 996, 890		1, 487, 5		1, 487, 536 7, 996, 890	
60. 01 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	7, 996, 890		7, 996, 8	0 0	7, 996, 890	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	742, 284		742, 28	-	742, 284	•
64. 00 06400 I NTRAVENOUS THERAPY	, 42, 204		/ 72, 20	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 787, 117	0	1, 787, 1		1, 787, 117	
66. 00 06600 PHYSI CAL THERAPY	8, 578, 268	0			8, 578, 268	•
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0,010,000	
58.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 536, 942		2, 536, 9	42 0	2, 536, 942	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5 16, 912, 571		16, 912, 5	71 0	16, 912, 571	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 308, 330		1, 308, 3	30 0	1, 308, 330	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 661, 071		18, 661, 0	71 0	18, 661, 071	
74.00 07400 RENAL DIALYSIS	491, 823		491, 8		491, 823	
76.00 03020 OTHER ANCI LLARY	0			0 0	0	76.00
76. 01 03140 CARDI AC REHAB	2, 400, 508		2, 400, 50		2, 400, 508	
76. 02 03070 WOMEN' S CENTER	1, 371, 892		1, 371, 89		1, 371, 892	
76. 03 03330 ENDOSCOPY	0			0 0	0	76.03
0UTPATI ENT_SERVI CE_COST_CENTERS 90, 00 09000 CLI NI C	1, 503, 753		1, 503, 7	53 0	1, 503, 753	90.00
90. 00 09000 CLINIC 90. 01 09001 OUTPATI ENT	1, 592, 550		1, 503, 7		1, 592, 550	•
91. 00 09100 EMERGENCY	5, 910, 999		5, 910, 9		5, 910, 999	
91. 01 09101 SHORT STAY	3, 910, 999		0, 710, 7	0 0	3, 910, 999	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3		2, 525, 6	0	2, 525, 678	
OTHER REIMBURSABLE COST CENTERS	_, ====, ===; =; =; =; =; =; =; =; =; =; =; =; =		_, ==0, 0		_, ===, 0, 0	1
95. 00 09500 AMBULANCE SERVI CES	122, 315		122, 3	15 0	122, 315	95.00
200.00 Subtotal (see instructions)	126, 522, 642	0	126, 522, 64	42 0	126, 522, 642	
201.00 Less Observation Beds	2, 525, 678		2, 525, 6		2, 525, 678	
202.00 Total (see instructions)	123, 996, 964	0	123, 996, 90	64 0	123, 996, 964	202.00

COMPUT	Financial Systems ATION 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 01/01/2017	Part I	
					To 12/31/2017	Date/Time Pre 5/29/2018 8:5	epared:
				XVIII	Hospi tal	PPS	-
			Charges	T		TEEDA	
	Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other Ratio	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7100	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101.00	
30.00	03000 ADULTS & PEDI ATRI CS	25, 379, 402		25, 379, 40)2		30. 00
31.00	03100 INTENSIVE CARE UNIT	5, 601, 344		5, 601, 34	4		31.00
41.00	04100 SUBPROVIDER - IRF	6, 056, 758		6, 056, 75	8		41.00
43.00	04300 NURSERY	0			0		43.00
44.00	04400 SKILLED NURSING FACILITY	2, 328, 876		2, 328, 87	6		44.00
	ANCI LLARY SERVI CE COST CENTERS	1 1					
50.00	05000 OPERATING ROOM	24, 317, 543	41, 195, 431			0.00000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1,805,327	8, 353, 511	10, 158, 83		0.00000	
55.00	05500 RADI OLOGY-THERAPEUTI C	57,839	6, 372, 754			0. 000000	
	05700 CT SCAN	1, 931, 480	10, 579, 088	12, 510, 56		0. 000000	
57.01 58.00	03630 ULTRA SOUND	0 372, 917	0 3, 272, 619	3, 645, 53	0 0. 000000 6 0. 099961	0. 000000 0. 000000	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	7, 573, 023	3, 272, 619			0. 000000	
60.00	06000 LABORATORY	12, 573, 602	30, 865, 322			0. 000000	
60.00	06001 BLOOD LABORATORY	12, 573, 002	30, 803, 322		0 0. 000000	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,024,388	580, 196			0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	1, 021, 000	000,170	1,001,00	0 0.000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	5, 273, 402	1,003,197	6, 276, 59		0. 000000	
66.00	06600 PHYSI CAL THERAPY	10, 204, 710	13, 547, 231	23, 751, 94		0.00000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000	0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 734, 670	10, 976, 424	13, 711, 09	0. 185028	0. 000000	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 771, 964	18, 703, 407	35, 475, 37	0. 476741	0.00000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	6, 971, 487	5, 332, 587			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	12, 771, 253	34, 786, 972			0. 000000	
	07400 RENAL DI ALYSI S	473, 366	7, 067	480, 43		0. 000000	
	03020 OTHER ANCI LLARY	0	0		0 0.000000	0.00000	
76.01	03140 CARDI AC REHAB	419, 147	8, 728, 510			0.00000	
	03070 WOMEN' S CENTER	6, 576	5, 153, 566			0.00000	
76. 03		0	0		0 0.00000	0. 000000	76.03
90.00	OUTPATIENT SERVICE COST CENTERS	22.221	E 765 765	E 777 07	0. 260256	0. 000000	90.00
	09000 CLINIC 09001 OUTPATI ENT	22, 221 259, 992	5, 755, 755 4, 158, 731			0.00000	
	09100 EMERGENCY	3, 839, 269	4, 158, 731 23, 449, 620			0. 000000	
	09101 SHORT STAY	3, 039, 209	23, 449, 020 0	21,200,00	0 0. 210008	0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 678, 651	3, 678, 65		0. 000000	
,2.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	5, 575, 551	0,070,00	0.000377	0.00000	, , 2. 00
95.00	09500 AMBULANCE SERVICES	0	0		0 0.000000	0.00000	95.00
200.00		148, 770, 556	247, 851, 913	396, 622, 46			200.00
201.00							201.00
202.00		148, 770, 556	247, 851, 913	396, 622, 46	.0		202.00

	inancial Systems FION OF RATIO OF COSTS TO CHARGES	RIVERVIEW HO	Provi der CCN: 15-0059	Peri od:	of Form CMS-2552-10 Worksheet C	
COMPOTAT	TON OF RATIO OF COSTS TO CHARGES		Frow der con. 15-0039	From 01/01/2017 To 12/31/2017	Part I Date/Time Prepare 5/29/2018 8:50 pm	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient			113	
	obst ochter beschiptron	Ratio				
		11.00				
11	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS				30	
31.00 03	3100 INTENSIVE CARE UNIT				31	
41.00 04	4100 SUBPROVIDER - IRF				41	
	4300 NURSERY				43	
44.00 04	4400 SKILLED NURSING FACILITY				44	
	NCILLARY SERVICE COST CENTERS					
	5000 OPERATING ROOM	0. 151728			50	
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	
	5400 RADI OLOGY-DI AGNOSTI C	0. 392603			54	
55.00 0	5500 RADI OLOGY-THERAPEUTI C	0. 308132			55	
	5700 CT SCAN	0. 032098			57	
	3630 ULTRA SOUND	0. 000000			57	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 099961			58	
	5900 CARDI AC CATHETERI ZATI ON	0. 078605			59	
	6000 LABORATORY	0. 184095			60	
	6001 BLOOD LABORATORY	0. 000000			60	
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 462602			63	
	6400 I NTRAVENOUS THERAPY	0. 000000			64	
	6500 RESPI RATORY THERAPY	0. 284727			65	
	6600 PHYSI CAL THERAPY	0. 361161			66	
	6700 OCCUPATI ONAL THERAPY	0. 000000			67	
	6800 SPEECH PATHOLOGY	0. 000000			68	
	6900 ELECTROCARDI OLOGY	0. 185028			69	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 476741			71	
	7200 I MPL. DEV. CHARGED TO PATI ENT	0. 106333			72	
	7300 DRUGS CHARGED TO PATIENTS	0. 392384			73	
	7400 RENAL DI ALYSI S	1. 023708			74	
	3020 OTHER ANCI LLARY	0. 000000			76	
	3140 CARDI AC REHAB	0. 262418			76	
	3070 WOMEN' S CENTER	0. 265863			76	
	3330 ENDOSCOPY	0. 000000			76	
	UTPATIENT SERVICE COST CENTERS	0.000000				
	9000 CLINIC	0. 260256			90	
	9001 OUTPATI ENT	0. 360410			90	
	9100 EMERGENCY	0. 216608			91	
	9101 SHORT STAY	0. 210000			91	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686577			92	
	THER REIMBURSABLE COST CENTERS	0.000377			92	
	9500 AMBULANCE SERVICES	0. 000000			95	
200.00	Subtotal (see instructions)	0.00000			200	
200.00	Less Observation Beds				200 201	
201.00	Total (see instructions)				201	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	pared:
					5/29/2018 8:5	0 pm
			e XIX	Hospital Costs	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	20, 996, 080		20, 996, 08	0 0	20, 996, 080	30.00
31.00 03100 I NTENSI VE CARE UNI T	4, 352, 200		4, 352, 20		4, 352, 200	•
41. 00 04100 SUBPROVIDER - IRF	4, 897, 719		4, 897, 71		4, 897, 719	•
43. 00 04300 NURSERY	0			0 0	0	1
44.00 04400 SKILLED NURSING FACILITY	3, 670, 105		3, 670, 10	5 0	3, 670, 105	•
ANCI LLARY SERVI CE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	9, 940, 177		9, 940, 17	7 0	9, 940, 177	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 988, 388		3, 988, 38	8 0	3, 988, 388	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 981, 471		1, 981, 47	1 0	1, 981, 471	55.00
57.00 05700 CT SCAN	401, 565		401, 56	5 0	401, 565	57.00
57.01 03630 ULTRA SOUND	0			0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	364, 410		364, 41	0 0	364, 410	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 487, 536		1, 487, 53	6 0	1, 487, 536	59.00
60. 00 06000 LABORATORY	7, 996, 890		7, 996, 89	0 0	7, 996, 890	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	742, 284		742, 28	4 0	742, 284	
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 787, 117				1, 787, 117	
66. 00 06600 PHYSI CAL THERAPY	8, 578, 268				8, 578, 268	
67.00 06700 OCCUPATI ONAL THERAPY	0	-		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	-		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	2, 536, 942		2, 536, 94		2, 536, 942	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			16, 912, 57		16, 912, 571	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	1, 308, 330		1, 308, 33		1, 308, 330	
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 661, 071		18, 661, 07		18, 661, 071	
74.00 07400 RENAL DI ALYSI S	491, 823		491, 82		491, 823	
76.00 03020 OTHER ANCI LLARY	0			0 0	0	
76. 01 03140 CARDI AC REHAB	2, 400, 508		2, 400, 50		2, 400, 508	•
76. 02 03070 WOMEN' S CENTER 76. 03 03330 ENDOSCOPY	1, 371, 892		1, 371, 89		1, 371, 892	•
76. 03 03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS	0			0 0	0	76.03
90. 00 09000 CLINIC	1, 503, 753		1, 503, 75	3 0	1, 503, 753	90.00
90. 01 09001 OUTPATI ENT	1, 592, 550		1, 592, 55		1, 592, 550	•
91. 00 09100 EMERGENCY	5, 910, 999		5, 910, 99		5, 910, 999	
91. 01 09101 SHORT STAY	3, 710, 777			0 0	0, 910, 999	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 525, 678		2, 525, 67	-	2, 525, 678	
OTHER REIMBURSABLE COST CENTERS	2, 525, 676	1	2, 525, 07		2, 525, 576	12.00
95. 00 09500 AMBULANCE SERVICES	122, 315		122, 31	5 0	122, 315	95.00
200.00 Subtotal (see instructions)	126, 522, 642				126, 522, 642	
201.00 Less Observation Beds	2, 525, 678		2, 525, 67		2, 525, 678	
202.00 Total (see instructions)	123, 996, 964					
		· · · · ·				•

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	epared:
				e XIX	Hospi tal	5/29/2018 8:5 Cost	iO pm
			Charges		nospi tai	COST	
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	· · · · · ·					
30. 00	03000 ADULTS & PEDI ATRI CS	25, 379, 402		25, 379, 40			30.0
31.00	03100 I NTENSI VE CARE UNI T	5, 601, 344		5, 601, 34			31.0
41.00	04100 SUBPROVIDER - IRF	6, 056, 758		6, 056, 75	8		41.0
43.00	04300 NURSERY	0			0		43.0
44.00	04400 SKI LLED NURSI NG FACI LI TY	2, 328, 876		2, 328, 87	6		44.0
	ANCI LLARY SERVICE COST CENTERS	04 017 540	41 105 401	(5 510 07	0 151700	0.00000	50.0
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	24, 317, 543	41, 195, 431 0	65, 512, 97	4 0. 151728 0 0. 000000	0. 000000	
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 805, 327	-	10, 158, 83		0. 000000 0. 000000	
55.00	05500 RADI OLOGY - THERAPEUTI C	57,839	8, 353, 511 6, 372, 754	6, 430, 59		0. 000000	
57.00	05700 CT SCAN	1, 931, 480	10, 579, 088	12, 510, 56		0. 000000	
57.00	03630 ULTRA SOUND	1, 931, 480	10, 579, 088		0.000000	0. 000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	372, 917	3, 272, 619	3, 645, 53		0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 573, 023	11, 351, 274	18, 924, 29		0. 000000	
60.00	06000 LABORATORY	12, 573, 602	30, 865, 322	43, 438, 92		0. 000000	
60.01	06001 BLOOD LABORATORY	12,070,002	00,000,022	10, 100, 72	0 0.000000	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 024, 388	580, 196	1, 604, 58		0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	000, 170	1,001,00	0 0.000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	5, 273, 402	1,003,197	6, 276, 59		0. 000000	
66.00	06600 PHYSI CAL THERAPY	10, 204, 710	13, 547, 231	23, 751, 94		0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000	0.000000	67.0
68.00	06800 SPEECH PATHOLOGY	0	0		0 0.000000	0.000000	68.0
69.00	06900 ELECTROCARDI OLOGY	2, 734, 670	10, 976, 424	13, 711, 09	4 0. 185028	0.000000	69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 771, 964	18, 703, 407	35, 475, 37	0. 476741	0.000000	71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6, 971, 487	5, 332, 587	12, 304, 07	4 0. 106333	0.000000	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 771, 253	34, 786, 972	47, 558, 22	5 0. 392384	0.000000	73.0
74.00	07400 RENAL DIALYSIS	473, 366	7, 067	480, 43		0.000000	
76.00	03020 OTHER ANCI LLARY	0	0		0 0.000000	0.000000	76.0
76. 01	03140 CARDI AC REHAB	419, 147	8, 728, 510	9, 147, 65		0.000000	
76. 02	03070 WOMEN'S CENTER	6, 576	5, 153, 566	5, 160, 14		0.000000	
76. 03	03330 ENDOSCOPY	0	0		0 0.000000	0. 000000	76.0
	OUTPATIENT SERVICE COST CENTERS	1			-		
90.00	09000 CLINIC	22, 221	5, 755, 755	5, 777, 97		0.00000	
90.01		259, 992	4, 158, 731	4, 418, 72		0.00000	
91.00	09100 EMERGENCY	3, 839, 269	23, 449, 620	27, 288, 88		0.00000	
91.01	09101 SHORT STAY	0	0	2 / 70 / 5	0 0.000000	0.00000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 678, 651	3, 678, 65	0. 686577	0. 000000	92.0
		0			0 0.00000	0.000000	95.0
95.00	09500 AMBULANCE SERVICES	-	0			0. 000000	
200.00		148, 770, 556	247, 851, 913	396, 622, 46	9		200.0
201.00	Less Observation Beds	1 1					201.0

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	RIVERVIEW HO	Provider CCN: 15-0059	Peri od:	u of Form CMS-2552- Worksheet C
COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2017 To 12/31/2017	Part I Date/Time Prepared 5/29/2018 8:50 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			0031
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.0
31.00 03100 INTENSIVE CARE UNIT				31.0
41.00 04100 SUBPROVIDER - IRF				41.0
43. 00 04300 NURSERY				43.0
44.00 04400 SKILLED NURSING FACILITY				44.0
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.0
57. 00 05700 CT SCAN	0. 000000			57.0
57. 01 03630 ULTRA SOUND	0. 000000			57.0
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			59.0
60. 00 06000 LABORATORY	0.000000			60.0
	0.000000			
	1			60.0
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.0
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.0
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.0
67.00 06700 OCCUPATIONAL THERAPY	0. 000000			67.0
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.0
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT	0. 000000			72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
74. 00 07400 RENAL DIALYSIS	0. 000000			74.0
76.00 03020 OTHER ANCI LLARY	0. 000000			76.0
76. 01 03140 CARDI AC REHAB	0. 000000			76.0
76. 02 03070 WOMEN' S CENTER	0. 000000			76.0
76. 03 03330 ENDOSCOPY	0. 000000			76.0
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. C
90. 01 09001 OUTPATI ENT	0. 000000			90. C
91. 00 09100 EMERGENCY	0. 000000			91.0
91.01 09101 SHORT STAY	0. 000000			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.0
OTHER REI MBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0. 000000			95. C
200.00 Subtotal (see instructions)				200. C
201.00 Less Observation Beds				201. C
202.00 Total (see instructions)				202.0

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provider C	-	Period: From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/29/2018 8:5	pared: 0 pm
		Title	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. 26)		(col. 1 - col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 309, 777	0	4, 309, 77	7 14, 498	297.27	30.00
31.00 INTENSIVE CARE UNIT	776, 315		776, 31	5 2, 293	338.56	31.00
41.00 SUBPROVIDER - IRF	830, 504	0	830, 504	4 5, 643	147.17	41.00
43.00 NURSERY	0			0 0	0.00	43.00
44.00 SKILLED NURSING FACILITY	599, 449		599, 449	9 4, 022	149.04	44.00
200.00 Total (lines 30 through 199)	6, 516, 045		6, 516, 04	5 26, 456		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	5, 149					30.00
31.00 INTENSIVE CARE UNIT	929	• • • • • • • • • • • • • • • • • • • •	•			31.00
41.00 SUBPROVIDER - IRF	3, 599	529, 665				41.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	3, 146					44.00
200.00 Total (lines 30 through 199)	12, 823	2, 843, 710	1			200.00

Health Financial System	ns	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPAT	IENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		pared:
-			Title	e XVIII	Hospi tal	PPS	
Cost Cente	r Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVIC		1	1	1	_	1	
50.00 05000 OPERATI NG		1, 680, 574					
	OOM & LABOR ROOM	0	-	0.00000		0	
54.00 05400 RADI OLOGY-		522, 929				41, 030	54.00
55.00 05500 RADI OLOGY-	THERAPEUTI C	367, 586					
57.00 05700 CT SCAN		3, 093	12, 510, 568				
57.01 03630 ULTRA SOUN		0	-	0. 00000		-	
	ESONANCE IMAGING (MRI)	2,846	3, 645, 536				58.00
59.00 05900 CARDI AC CA		154, 564					
60.00 06000 LABORATORY		674,034	43, 438, 924	0. 01551	7 5, 155, 109	79, 992	60.00
60.01 06001 BLOOD LABO	RATORY	0	0	0. 00000	0 0	0	60.01
63.00 06300 BLOOD STOR	ING, PROCESSING & TRANS.	93, 602	1, 604, 584	0. 05833	4 266, 281	15, 533	63.00
64.00 06400 I NTRAVENOU	S THERAPY	0	0	0. 00000	0 0	0	64.00
65. 00 06500 RESPI RATOR	Y THERAPY	104, 428	6, 276, 599	0. 01663	8 1, 463, 478		
66.00 06600 PHYSI CAL T	HERAPY	93, 978	23, 751, 941	0. 00395	7 1, 109, 700	4, 391	66.00
67.00 06700 OCCUPATION	AL THERAPY	0	0	0. 00000	0 0		
68.00 06800 SPEECH PAT	HOLOGY	0	0	0. 00000	0 0	0	68.00
69.00 06900 ELECTROCAR	DI OLOGY	549, 142	13, 711, 094	0. 04005	1 1, 181, 974	47, 339	69.00
71.00 07100 MEDICAL SU	PPLIES CHARGED TO PATIENTS	295, 867	35, 475, 371	0.00834	0 7, 435, 064	62,008	71.00
72.00 07200 IMPL. DEV.	CHARGED TO PATIENT	8, 579	12, 304, 074	0. 00069			72.00
73.00 07300 DRUGS CHAR	GED TO PATIENTS	429, 450	47, 558, 225	0.00903	0 4, 507, 724	40, 705	73.00
74.00 07400 RENAL DIAL	YSI S	48, 895					74.00
76.00 03020 OTHER ANCI	LLARY	0				0	
76. 01 03140 CARDI AC RE	НАВ	96, 300	9, 147, 657	0. 01052	7 214, 844	2, 262	76.01
76.02 03070 WOMEN' S CE	NTER	411, 366		1			76.02
76.03 03330 ENDOSCOPY		0			0 0	0	
OUTPATI ENT SERVI	CE COST CENTERS				- <u>-</u>	I	
90.00 09000 CLINIC		11, 453	5, 777, 976	0.00198	2 13, 163	26	90.00
90. 01 09001 OUTPATI ENT		183, 974					
91.00 09100 EMERGENCY		769, 462					1
91.01 09101 SHORT STAY		0					1
	N BEDS (NON-DISTINCT PART)	518, 436	-	1			
OTHER REI MBURSAE		1 010, 400	0,070,001	0.11070		. 0	/2.00
95.00 09500 AMBULANCE							95.00
	es 50 through 199)	7, 020, 558	357, 256, 089		39, 980, 654	682, 247	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PAS	S THROUGH COST	S Provider C	CN: 15-0059	Period:	Worksheet D	
				From 01/01/2017 To 12/31/2017	Part III Date/Time Pre 5/29/2018 8:5	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	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	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	Ū	44.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	200.00
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Duys	0 001.0)	rrogram bays	
		minus col. 4)				
	4,00	5.00	6,00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	1.00	0,00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	14, 49	8 0.00	5, 149	30.00
31. 00 03100 I NTENSI VE CARE UNI T	J	0	2, 29			
41. 00 04100 SUBPROVI DER – I RF	0	0	5, 64			
43. 00 04300 NURSERY	0	0	3,0-	0 0.00		
44. 00 04400 SKILLED NURSING FACILITY		0	4, 02			
200.00 Total (lines 30 through 199)		0	26, 45			200.00
Cost Center Description	Inpati ent	0	20, 40	0	12, 023	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
-	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00

APPORT DWILENT OF INPATIENT /OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider COX: 15-0050 Period: From 01/01/2017 To 12/31/2017 Worksheet 0 From 01/01/2017 D 12/31/2017 Worksheet 0 From 01/01/2017 Prove 01/01/201	Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
TITLE XVIII Hospital PPS Cost Center Description Non Physica Nursing School Nursing School All Ide Health		RVICE OTHER PASS	6 Provider C		From 01/01/2017	Part IV Date/Time Pre	
Cost Center Description Non Physician Nursing School Nursing School Norsing School Allied Health Allied Health Cost Stepdown Adjustments Allied Health Post-Stepdown Adjustments ANCLLLARY SERVICE COST CENTERS 1.00 2A 3A MACLULARY SERVICE COST CENTERS 0 </td <td></td> <td></td> <td>Title</td> <td>2 XVIII</td> <td>Hospi tal</td> <td></td> <td></td>			Title	2 XVIII	Hospi tal		
Anesthetist Post-Stepdown Post-Stepdown Post-Stepdown ANCILLARY SERVICE COST CENTERS 0 0 0 3A 3.00 50.00 05000 (PERATI NG ROM 0 0 0 0 52.00 50.00 05000 (PERATI NG ROM 0 0 0 0 0 52.00 50.00 05000 (PERATI NG ROM 0 0 0 0 0 52.00 52.00 52.00 52.00 55.00 55.00 55.00 55.00 57.01 55.00 57.01 55.00 57.01 58.00 0	Cost Center Description	Non Physician					
Cost Adjustments Adjustments Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2.00 3A 3.00 S0.00 05000 (PERATING ROOM 0 0 0 0 50.00 52.00 052000 (PELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 50.00 52.00 05200 (RAD LOGY-DI AGNOSTIC 0 0 0 0 0 55.00 50.00 (S500 (RAD LOGY-THERAPEUTIC 0 0 0 0 57.01 55.00 57.01 (3530) (LTRA SOUND 0 0 0 0 0 0 57.01 58.00 (5800) MAGRATORY 0 0 0 0 0 0 0 58.00 60.01 (6000) LABORATORY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
ANCI LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
50 00 0000 0000 000000000000000000000000000000000000		1.00	2A	2.00	3A	3.00	
52.00 OS200 DELIVERY PROM & LABOR ROOM O O O O O O O O St.00 54.00 05400 RADIOLOGY-DIAGNOSTI C O O O O O O O St.00 57.00 05700 CT SCAN O O O O O O St.00							
54.00 05400 RADI OLOGY-JI AGNOSTI C 0 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 0 57.01 58.00 OS500 CARDI AC CATHETERI ZATI ON 0 0 0 0 58.00 59.00 OS000 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.01 BGODI BLODD LABORATORY 0 0 0 0 0 60.00 63.00 OS000 RESPI RATORY THERAPY 0 0 0 0 64.00 64.00 INTRAVENUS THERAPY 0 0 0 0 65.00 65.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 <td< td=""><td>50.00 05000 OPERATING ROOM</td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td>50.00</td></td<>	50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
55:00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 55:00 57:00 05700 CT SCAN 0 0 0 0 57:00 58:00 05800 MAGNETIC RESONANCE I MAGING (MR1) 0 0 0 0 57:00 59:00 05900 ARDIA C. CATHETERIZATION 0 0 0 0 58:00 60:01 06000 LABORATORY 0 0 0 0 60:00 61:00 06300 BLOOD LABORATORY 0 0 0 0 60:01 61:00 06300 BLOOD STORI NO, PROCESSI NG & TRANS. 0 0 0 0 66:00 65:00 06500 RESPI RATORY THERAPY 0 0 0 0 66:00 67:00 66:00	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 57.01 59.00 05900 CARDI AC CATHETERIZATI ON 0 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 0 60.00 64.00 DAGONO LABORATORY 0 0 0 0 60.01 63.00 DLODD STORING, PROCESSING & TRANS. 0 0 0 64.00 64.00 OKADON INTRAVENUUS THERAPY 0 0 0 65.00 65.00 DESDPI RATORY THERAPY 0 0 0 66.00 66.00 OK500 RESPI RATORY THERAPY 0 0 0 66.00 67.00 DG700 DCCUPATI ONAL THERAPY 0 0 0 66.00 67.00 OK500 RESPI RATORY THERAPY 0 0 0 67.	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
57. 01 03630 ULTRA SOUND 0 0 0 0 0 57. 01 58. 00 05800 CARDIAC CATHETERIZATION 0 0 0 0 58. 00 60.00 06000 LABORATORY 0	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C)	0 0	0	55.00
58.00 05800 MACNETIC RESONANCE I MAGING (MRI) 0 </td <td>57.00 05700 CT SCAN</td> <td>0</td> <td>C</td> <td>)</td> <td>0 0</td> <td>0</td> <td>57.00</td>	57.00 05700 CT SCAN	0	C)	0 0	0	57.00
59.00 05900 CARDIAC CATHETERIZATION 0	57.01 03630 ULTRA SOUND	0	0		0 0	0	57.01
60.00 06000 LABORATORY 0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.01 06001 BLOOD LABORATORY 0 </td <td>59. 00 05900 CARDI AC CATHETERI ZATI ON</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>59.00</td>	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 64.00 06400 INTRAVENUUS THERAPY 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 66.00 68.00 06900 CELETRICARDIOLOGY 0 0 0 68.00 69.00 06900 ELECTRICARDIOLOGY 0 0 0 69.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 73.00 00 0 74.00	60. 00 06000 LABORATORY	0	C)	0 0	0	60.00
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 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 OTOO MERAGED TO PATI ENTS 0 0 0 71.00 071.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 72.00 74.00 ORADO RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 0 76.01 76.02 03707 WOMEN'S CENTER 0 0 0 0 76.02 0.01 00100100 O	60.01 06001 BLOOD LABORATORY	0	C)	0 0	0	60.01
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 0COPATI ONAL THERAPY 0 0 0 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74.00 74.00 OR400 RENAL DI ALYSIS 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 76.02 03370	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C)	0 0	0	63.00
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 68.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 76.00 03200 OTHER ANCI LLARY 0 0 0 74.00 76.01 03140 CARHAB 0 0 0 76.02 76.02 03070 WOMEN'S CENTER 0 0 0 76.02 76.03 03330 ENOSCOPY 0 0	64.00 06400 INTRAVENOUS THERAPY	0	C)	0 0	0	64.00
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 0 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 72.00 74.00 07400 RENAL DI ALYSI S 0 0 0 74.00 76.01 03140 CARDI AC REHAB 0 0 0 76.01 76.02 03070 WOMEN'S CENTER 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 76.03 00.00 09000 CLINIC 0 0 0 0 90.01 90.01 09000 CLINIC 0 0 0 <td></td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>65.00</td>		0	C		0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0 </td <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 290,749 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 WMEN' S CENTER 0 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 0 90.00 90.00 O9000 CLI NI C 0 0 0 0 90.00 90.01 91.00 09001 UTPATI ENT 0 <td>67.00 06700 OCCUPATI ONAL THERAPY</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>67.00</td>	67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
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 0 290,749 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0 0 76.00 76.10 03140 CARDI AC REHAB 0 0 0 0 76.00 76.01 03140 CARDI AC REHAB 0 0 0 0 76.00 76.03 03330 ENDOSCOPY 0 0 0 0 0 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01	68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 290,749 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 76.03 0000 09000 CLI NI C 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 90.00 90.01 91.01 9000 EMERGENCY 0 0 0 0 90.01 91.01 90101 EMERGENCY 0 0 0 90.01 91.00 91.00 9	69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 290,749 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 76.03 0000 09000 CLI NI C 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 90.00 90.01 91.01 9000 EMERGENCY 0 0 0 0 90.01 91.01 90101 EMERGENCY 0 0 0 90.01 91.00 91.00 9	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
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 ENOSCOPY 0 0 0 0 76.02 76.03 03330 ENOSCOPY 0 0 0 0 76.03 00UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 OUTPATI ENT 0 0 0 90.01 90.01 91.00 PO00 EMERGENCY 0 0 0 0 91.00 91.01 O9100 EMERGENCY 0 0 0 0 91.00 92.00 OSESERVATI ON BEDS (NON-DI STI NCT PART)	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
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 03330 ENDOSCOPY 0 0 0 0 76.03 00UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 09001 OUTPATI ENT 0 0 0 90.01 90.01 91.00 PG000 EMERGENCY 0 0 0 0 90.01 91.01 90101 SHORT STAY 0 0 0 0 91.00 92.00 OSERVATI ON BEDS (NON-DI STI NCT PART) <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>290, 749</td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	290, 749	73.00
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 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 90. 01 09001 OUTPATI ENT 0 0 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 91. 01 91. 01 SPIOR STI NCT PART) 0 0 0 92. 00 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 0	74.00 07400 RENAL DIALYSIS	0	C		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 76.02 76.03 0UTPATI ENT SERVICE COST CENTERS 0 <td>76.00 03020 OTHER ANCI LLARY</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>76.00</td>	76.00 03020 OTHER ANCI LLARY	0	C		0 0	0	76.00
76.03 0330 ENDOSCOPY 0	76. 01 03140 CARDI AC REHAB	0	C		0 0	0	76.01
76.03 03330 ENDOSCOPY 0	76.02 03070 WOMEN' S CENTER	0	C		0 0	0	76.02
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 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 OTHER REI MBURSABLE COST CENTERS		0	C		0 0	0	76.03
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 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 OTHER REI MBURSABLE COST CENTERS	OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY 0 0 0 0 91.00 91.01 09101 SHORT STAY 0 0 0 0 91.01 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 950.0 MBULANCE SERVICES 95.00 95.00		0	C		0 0	0	90.00
91.00 09100 EMERGENCY 0 0 0 0 91.00 91.01 09101 SHORT STAY 0 0 0 0 91.01 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 950.0 MBULANCE SERVICES 95.00 95.00	90. 01 09001 OUTPATI ENT	0	C		0 0	0	90.01
91. 01 09101 SHORT STAY 0 0 0 0 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 950. 00		0	0		0 0	0	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 0 0 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 950. 00		0	C		0 0	0	91.01
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 95.00		0			0	0	
95. 00 09500 AMBULANCE SERVICES 95. 00							
							95.00
		0	C		0 0	290, 749	200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/29/2018 8:5	epared:
		Title	× XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
oust contor bescription	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		$(col \cdot 5 \div col \cdot$	
		4)	col. 2, 3 an		7)	
			4)		,	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	-	L				
50. 00 05000 OPERATI NG ROOM	0	0		0 65, 512, 974	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 10, 158, 838	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 6, 430, 593	0.000000	55.00
57.00 05700 CT SCAN	0	0		0 12, 510, 568	0.00000	57.00
57.01 03630 ULTRA SOUND	0	0		0 0	0.00000	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	l o		0 3, 645, 536	0, 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 18, 924, 297		59.00
60. 00 06000 LABORATORY	0	0		0 43, 438, 924		60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 604, 584		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 276, 599		
66. 00 06600 PHYSI CAL THERAPY	0			0 23, 751, 941		
67. 00 06700 OCCUPATI ONAL THERAPY	0			0 20,701,711		
68. 00 06800 SPEECH PATHOLOGY	0			0 0		
69. 00 06900 ELECTROCARDI OLOGY	0			0 13, 711, 094		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 35, 475, 371		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 12, 304, 074		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	290, 749	290, 74			
74. 00 07400 RENAL DI ALYSI S	0	2,0,747	270,7-	0 480, 433		
76. 00 03020 OTHER ANCI LLARY	0			0 400, 400		
76. 01 03140 CARDI AC REHAB	0			0 9, 147, 657		
76. 02 03070 WOMEN' S CENTER	0			0 5, 160, 142		
76. 03 03330 ENDOSCOPY	0	-		0 3, 100, 142		
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0.00000	/0.03
90. 00 09000 CLINIC	0	0		0 5, 777, 976	0.00000	90.00
90. 01 09001 OUTPATI ENT	0	-		0 4, 418, 723		•
91. 00 09100 EMERGENCY				0 27, 288, 889		
91. 01 09101 SHORT STAY	0			0 27, 288, 889		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 3, 678, 651		
OTHER REIMBURSABLE COST CENTERS	0	0	1	5, 070, 001	0.00000	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	290, 749	290, 74	9 357, 256, 089		200.00
	1	270,747	2,0,7	557,250,007	I	1200.00

Health Financial Systems	RI VERVI EW HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0059	Period: From 01/01/2017	Worksheet D Part IV	
				To 12/31/2017		pared: O pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM	0. 000000	10, 775, 065		0 13, 732, 238	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	797, 087		0 2, 200, 775	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	29, 798		0 2, 368, 803	0	55.00
57.00 05700 CT SCAN	0.000000	753, 312		0 3, 009, 797	0	57.00
57.01 03630 ULTRA SOUND	0. 000000	0		0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	146, 032		0 821, 990	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 563, 829		0 2, 206, 703	0	59.00
60. 00 06000 LABORATORY	0. 000000	5, 155, 109		0 3, 563, 573	0	60.00
60. 01 06001 BLOOD LABORATORY	0.000000	0		0 0	0	60.01
63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0. 000000	266, 281		0 151, 186	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 463, 478		0 829, 397	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0, 000000	1, 109, 700		0 49, 267	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0, 000000	1, 107, 700		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 181, 974		0 2,857,456		69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	0. 000000	7, 435, 064		0 4, 532, 452		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	2, 425, 995		0 1, 885, 854		72.00
73. 00 07200 DRUGS CHARGED TO PATIENTS	0.000000	4, 507, 724	27, 5			73.00
74. 00 07400 RENAL DIALYSIS	0. 0000114	4, 507, 724		0 13, 510, 643	02,004	74.00
74. 00 07400 RENAL DIALYSIS 76. 00 03020 OTHER ANCI LLARY	0. 000000	140, 769			0	76.00
	0. 000000	014 044		-	-	
		214, 844		0 3, 619, 649		76.01
76. 02 03070 WOMEN' S CENTER	0.000000	0		0 199, 652	0	76.02
76. 03 03330 ENDOSCOPY	0. 000000	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	0.000000	10 1/0	1	0 252 102	0	00.00
90. 00 09000 CLINIC	0. 000000	13, 163		0 252, 102		90.00
90. 01 09001 0UTPATI ENT	0. 000000	72, 374		0 638, 414		90.01
91. 00 09100 EMERGENCY	0. 000000	1, 929, 056		0 4, 616, 157	0	91.00
91.01 09101 SHORT STAY	0. 000000	0		0 0	0	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000	0		0 958, 395	0	92.00
OTHER REIMBURSABLE COST CENTERS	1		1			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		39, 980, 654	27, 5	62, 004, 503	82, 604	200.00

Health Financial Systems	RI VERVI EW		21 15 0050		u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	J VACCINE CUSI	Provider C	JN: 15-0059	Period: From 01/01/2017	Worksheet D Part V	
				To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
		Title	XVIII	Hospi tal	PPS	<u> </u>
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	0.00	(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 151728	13, 732, 238		0 0	2, 083, 565	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 151728			0 0	2,003,000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 392603			0 0	864, 031	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 392003			0 0	729, 904	
57. 00 05700 CT SCAN	0. 032098			0 0	96, 608	1
57. 01 03630 ULTRA SOUND	0. 032098			0 0	90,008	1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	821, 990		0 0	82, 167	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 078605			0 0	173, 458	1
60. 00 06000 LABORATORY	0. 184095			0 0	656, 036	
60. 01 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0. 184095			0 0	050, 030	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 462602			0 0	69, 939	
64. 00 06400 INTRAVENOUS THERAPY	0. 462602			0 0	69, 939 0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 284727			0 0	236, 152	
66. 00 06600 PHYSI CAL THERAPY	0. 361161	49, 267		0 0	17, 793	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	17, 733	1
68. 00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 185028			0 0	528, 709	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 476741	4, 532, 452		0 0	2, 160, 806	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 106333			0 0	200, 529	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 392384			0 11, 402	5, 301, 360	
74. 00 07400 RENAL DIALYSIS	1. 023708			0 0	0, 301, 300	
76. 00 03020 OTHER ANCI LLARY	0. 000000			0 0	0	
76. 01 03140 CARDI AC REHAB	0. 262418			0 0	949, 861	
76. 02 03070 WOMEN' S CENTER	0. 265863			0 0	53, 080	
76. 03 03330 ENDOSCOPY	0. 000000			0 0	00,000	1
OUTPATIENT SERVICE COST CENTERS	0.000000					1 01 00
90. 00 09000 CLINIC	0. 260256	252, 102		0 0	65, 611	90.00
90. 01 09001 OUTPATI ENT	0. 360410			0 0	230, 091	
91.00 09100 EMERGENCY	0. 216608			0 0	999, 897	
91. 01 09101 SHORT STAY	0. 000000			0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686577			0 0	658, 012	
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)		62, 004, 503		0 11, 402	16, 157, 609	200.00
			1			
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
201.00Less PBP Clinic Lab. Services-Program Only Charges202.00Net Charges (line 200 - line 201)				0 0 0 11, 402	16, 157, 609	

	nancial Systems	RI VERVI EW				u of Form CMS-	2552-10
APPORTI ON	IMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0059	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 8:5	epared: 50 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.)				
		6.00	7.00				
	CILLARY SERVICE COST CENTERS	-	-				
	000 OPERATING ROOM	0	0				50.00
	200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	500 RADI OLOGY-THERAPEUTI C	0	0				55.00
	700 CT SCAN	0	0				57.00
	630 ULTRA SOUND	0	0				57.01
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	000 LABORATORY	0	0				60.00
	001 BLOOD LABORATORY	0	0				60.01
	300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	400 I NTRAVENOUS THERAPY	0	0				64.00
	500 RESPI RATORY THERAPY	0	0				65.00
	600 PHYSI CAL THERAPY	0	0				66.00
	700 OCCUPATI ONAL THERAPY 800 SPEECH PATHOLOGY	0	0				67.00
	900 ELECTROCARDI OLOGY	0	0				68.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				69.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	300 DRUGS CHARGED TO PATIENTS	0	4, 474				73.00
	400 RENAL DIALYSIS	0	4,4/4				74.00
	020 OTHER ANCI LLARY	0	0				76.00
	140 CARDI AC REHAB	0	0				76.01
	070 WOMEN'S CENTER	0	0				76.02
	330 ENDOSCOPY	0	0				76.03
	TPATIENT SERVICE COST CENTERS						/0.00
	000 CLINIC	0	0				90.00
	001 OUTPATI ENT	0	0				90.01
	100 EMERGENCY	0	0				91.00
	101 SHORT STAY	0	0				91.01
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	0	4, 474				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	4, 474				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 01/01/2017	Part II	
		Component	CCN: 15-T059	To 12/31/2017	Date/Time Pre	pared:
		T: +1 a	W/LLL	Subprovider -	5/29/2018 8:5	<u>o pm</u>
		IITIE	e XVIII	IRF	PPS	
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.	· ·	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)			
	26)		, í			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 680, 574	65, 512, 974	0. 02565	53 165, 113	4, 236	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0,0000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	522, 929	-			4, 010	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	367, 586				329	55.00
57. 00 05700 CT SCAN	3, 093				16	57.00
57. 01 03630 ULTRA_SOUND	3,043		0.00022			57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	-	-			-	57.01
	2,846					
59. 00 05900 CARDI AC CATHETERI ZATI ON	154, 564					59.00
60. 00 06000 LABORATORY	674,034					60.00
60. 01 06001 BLOOD LABORATORY	0	, °	0.0000		0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	93, 602				918	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	104, 428				4, 844	65.00
66. 00 06600 PHYSI CAL THERAPY	93, 978	23, 751, 941			14, 019	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0			0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	549, 142	13, 711, 094	0. 04005	51 58, 545	2, 345	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	295, 867	35, 475, 371	0.00834	40 668, 461	5, 575	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 579	12, 304, 074	0.00069	97 16, 466	11	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	429, 450	47, 558, 225	0.00903	825, 647	7, 456	73.00
74.00 07400 RENAL DIALYSIS	48, 895	480, 433	0. 1017	130, 194	13, 250	74.00
76.00 03020 OTHER ANCI LLARY	0	0	0.0000	0 0	0	76.00
76. 01 03140 CARDI AC REHAB	96, 300	9, 147, 657	0. 01052	8, 624	91	76.01
76. 02 03070 WOMEN' S CENTER	411, 366				0	76.02
76. 03 03330 ENDOSCOPY	0				-	76.03
OUTPATIENT SERVICE COST CENTERS			0.0000		Ŭ	/ 01 00
90. 00 09000 CLINIC	11, 453	5, 777, 976	0.00198	32 4, 276	8	90.00
90. 01 09000 0LTNTC 90. 01 09001 0UTPATI ENT	183, 974				-	90.00
91. 00 09100 EMERGENCY	769, 462				1, 437	90.01
91. 01 09101 SHORT STAY	/69, 462		0.02819		1, 001	91.00
		-			-	
	0	3, 678, 651	0.0000		0	92.00
						05 00
95.00 09500 AMBULANCE SERVICES	(500 400	257 254 000		/ 011 117	70.000	95.00
200.00 Total (lines 50 through 199)	6, 502, 122	357, 256, 089	1	6, 811, 117	72, 809	200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Component	CCN: 15-T059	Period: From 01/01/2017 To 12/31/2017	5/29/2018 8:5	
		Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Nursing School Post-Stepdown Adjustments		ol Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS	-					
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
57.01 03630 ULTRA SOUND	0	C		0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENT	0	0		0 0	290, 749	
74. 00 07400 RENAL DIALYSIS	0	0		0 0	290, 749	74.00
76. 00 03020 OTHER ANCI LLARY	0	0		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0	0			0	76.00
76. 02 03070 WOMEN' S CENTER	0	0			0	76.02
76. 03 03330 ENDOSCOPY	0	0		0 0	0	76.02
OUTPATIENT SERVICE COST CENTERS			1		<u> </u>	/0.00
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	C		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS]
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	290, 749	200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2017		
			Component	CCN: 15-T059	To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
			Title	e XVIII	Subprovider -	PPS	
					IRF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	(8 1	7)	
				4)			
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS				0 (5 510 07)		1
50.00	05000 OPERATING ROOM	0	0		0 65, 512, 974		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 10, 158, 838		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 6, 430, 593		
57.00	05700 CT SCAN	0	0		0 12, 510, 568		
57.01	03630 ULTRA SOUND	0	0		0 0	0.000000	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 3, 645, 536		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 18, 924, 297		
60.00		0	0		0 43, 438, 924		
60.01	06001 BLOOD LABORATORY	0	0		0 0	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 604, 584		
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0			0 0 0 6, 276, 599	0.000000	
65.00 66.00	06600 PHYSI CAL THERAPY	0					
67.00	06700 OCCUPATIONAL THERAPY	0			0 23, 751, 941 0 0		
67.00 68.00	06800 SPEECH PATHOLOGY	0					
69.00	06900 ELECTROCARDI OLOGY	0			0 13, 711, 094		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 35, 475, 371		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 12, 304, 074		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	290, 749				
74.00	07400 RENAL DI ALYSI S	0	270,747		480, 433		
76.00	03020 OTHER ANCI LLARY	0			0 400, 433		
76.01	03140 CARDI AC REHAB	0			0 9, 147, 657		
76.02	03070 WOMEN' S CENTER	0			0 5, 160, 142		
76.03	03330 ENDOSCOPY	0			0 3,100,142		
/0.00	OUTPATIENT SERVICE COST CENTERS		<u>ــــــــــــــــــــــــــــــــــــ</u>	1	0	0.00000	/0.00
90.00	09000 CLINIC	0	0		0 5, 777, 976	0.00000	90.00
90.01	09001 OUTPATI ENT	0			0 4, 418, 723		
91.00	09100 EMERGENCY	0			0 27, 288, 889		
91.00	09101 SHORT STAY	0			0 27,200,007		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 3, 678, 651		
	OTHER REIMBURSABLE COST CENTERS				2, 2. 2, 001		1
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	290, 749	290, 74	9 357, 256, 089		200.00
	· · · · · · · · · · · · · · · · · · ·		•		•		-

Health Financial Systems	RIVERVIEW HO	OSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	
		Component (CCN: 15-T059	To 12/31/2017	Date/Time Pre 5/29/2018 8:5	pared:
		Title	XVIII	Subprovider -	PPS	
				IRF		
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	165, 113		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	77, 896		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	5, 764		0 0	0	55.00
57.00 05700 CT SCAN	0. 000000	66, 082		0 0	0	57.00
57.01 03630 ULTRA SOUND	0. 000000	0		0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	19, 968		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	20, 463		0 0	0	59.00
60. 00 06000 LABORATORY	0.000000	800, 433		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	15, 732		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	l o	64.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	291, 111		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0,000000	3, 542, 941		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	58, 545		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	668, 461		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0.000000	16, 466		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.006114	825, 647	5, 0		0	73.00
74. 00 07400 RENAL DIALYSIS	0.000000	130, 194		0 0	0	
76.00 03020 OTHER ANCI LLARY	0. 000000	0		0 0	0	
76. 01 03140 CARDI AC REHAB	0. 000000	8, 624		0 0	0	
76. 02 03070 WOMEN' S CENTER	0.000000	0, 024		0 0	0	76.02
76. 03 03330 ENDOSCOPY	0. 000000	0		0 0	0	76.02
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	70.03
90. 00 09000 CLINIC	0.000000	4, 276		0 0	0	90.00
90. 01 09001 0UTPATI ENT	0.000000	34, 507		0 0	0	90.00
91. 00 09100 EMERGENCY	0.000000	58, 894		0 0	0	91.00
91. 01 09101 SHORT STAY	0.000000	56, 694 0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	-	
0THER REIMBURSABLE COST CENTERS	0.000000	0	1	0 0	0	72.00
95. 00 09500 AMBULANCE SERVICES			1			95.00
200.00 Total (lines 50 through 199)		6, 811, 117	5, 0	48 0		200.00
	I I	0,011,117	J 5, 0	-0 0	0	1200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Component	CN: 15-0059 CCN: 15-5669	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 8:5	
		Title	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Nursing School Post-Stepdown Adjustments		ol Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS	-		-			
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
57.01 03630 ULTRA SOUND	0	C		0 0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	-	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0			0 0	290, 749	
74. 00 07400 RENAL DIALISIS 76. 00 03020 OTHER ANCI LLARY	0			0 0	0	74.00 76.00
76. 01 03140 CARDI AC REHAB	0			0 0	0	76.00
76. 02 03070 WOMEN' S CENTER	0			0 0	0	76.02
76. 03 03330 ENDOSCOPY	0			0 0	0	76.02
OUTPATIENT SERVICE COST CENTERS	0		1	0 0	0	70.03
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 0UTPATI ENT	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	
91. 01 09101 SHORT STAY	0	0		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS				- 1		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	290, 749	200. 00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2017		
			Component	CCN: 15-5669	To 12/31/2017		
			Ti +L c	e XVIII	Skilled Nursing	5/29/2018 8:5 PPS	iu pili
			nue		Facility	PP3	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost		Cost (sum of		$(col. 5 \div col.$	
			4)	col. 2, 3 and		7)	
			(4)			
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 65, 512, 974	0.00000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 03, 312, 7,4		
54.00	05400 RADI OLOGY - DI AGNOSTI C	0			0 10, 158, 838		
55.00	05500 RADI OLOGY - THERAPEUTI C	0			0 6, 430, 593		
		0					
57.00	05700 CT SCAN	0			0 12, 510, 568		
57.01	03630 ULTRA SOUND	0	0		0 0	0.00000	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 3, 645, 536		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 18, 924, 297		
60.00	06000 LABORATORY	0	0		0 43, 438, 924		
60. 01	06001 BLOOD LABORATORY	0	C		0 0	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 604, 584		
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 6, 276, 599		
66.00	06600 PHYSI CAL THERAPY	0	0		0 23, 751, 941		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.00000	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 13, 711, 094	0. 000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 35, 475, 371	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 12, 304, 074	0.00000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	290, 749	290, 74	9 47, 558, 225	0.006114	73.00
74.00	07400 RENAL DIALYSIS	0	0		0 480, 433	0.00000	74.00
76.00	03020 OTHER ANCI LLARY	0	0		0 0	0.00000	76.00
76.01	03140 CARDI AC REHAB	0	0		0 9, 147, 657	0. 000000	76.01
76.02	03070 WOMEN' S CENTER	0	0		0 5, 160, 142	0.000000	76.02
76.03	03330 ENDOSCOPY	0	0		0 0	0.00000	76.03
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	0	C		0 5, 777, 976	0.00000	90.00
90.01	09001 OUTPATI ENT	0			0 4, 418, 723		
91.00	09100 EMERGENCY	0			0 27, 288, 889		
91.01	09101 SHORT STAY	0			0 0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 3, 678, 651		
.2.00	OTHER REIMBURSABLE COST CENTERS					0.00000	1
95.00	09500 AMBULANCE SERVICES						95.00
200.00		0	290, 749	290, 74	9 357, 256, 089		200.00
_00.00				1 2,5,71		1	1-00.00

Health Financial Systems	RI VERVI EW HO	OSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	
		Component (CCN: 15-5669	To 12/31/2017	Date/Time Pre 5/29/2018 8:5	pared:
		Title	XVIII	Skilled Nursing		
		11110		Facility	110	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS			1		-	
50.00 05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	46, 871		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
57. 01 03630 ULTRA SOUND	0. 000000	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	17, 984		0 0	0	•
60. 00 06000 LABORATORY	0. 000000	941, 418		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	103, 254		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 415, 435		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	800		0 0	0	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	202, 535		0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS	0.000000	0	0.0	0	0	
	0.006114	1, 516, 829	9, 2		0	
74. 00 07400 RENAL DIALYSIS 76. 00 03020 OTHER ANCILLARY	0. 000000	0		0 0	0	
76. 00 03020 OTHER ANCI LLARY 76. 01 03140 CARDI AC REHAB	0. 000000 0. 000000	0 1, 532			0	76.00 76.01
76. 02 03070 WOMEN' S CENTER	0. 000000	1, 532			0	76.01
76. 03 03330 ENDOSCOPY	0. 000000	0			0	76.02
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	70.03
90. 00 09000 CLINIC	0. 000000	403		0 0	0	90.00
90. 01 09000 0LTNTC 90. 01 09001 0UTPATI ENT	0. 000000	403		0 0	0	
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
91. 01 09101 SHORT STAY	0. 000000	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
OTHER REIMBURSABLE COST CENTERS	0.000000	0	l	0 0	0	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		4, 247, 061	9, 2	74 0	0	200.00
$200.00 \qquad $	1	7,247,001	1 7, Z	0	ı 0	1200.00

	Financial Systems RIVERVIEW HOS ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Peri od:	Worksheet D-1	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2018 8:50 PPS	o pin
	Cost Center Description	1			
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				1
00	Inpatient days (including private room days and swing-bed days			14, 498	
00	Inpatient days (including private room days, excluding swing-			14, 498	
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). It you nave only pr	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be	ed days)		12, 754	4
00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	0	
~~	reporting period		01 6 11		
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private room	m davs) through December	- 31 of the cost	0	7
	reporting period				
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	a the Dragram (aveluding	r cwing bod and	5, 149	9
00	newborn days)		g swing-bed and	5, 149	7
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	room days)	0	10
~~	through December 31 of the cost reporting period (see instruction				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room davs)	0	12
	through December 31 of the cost reporting period	5			
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	am (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	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			0.00	10
	reporting period	Ũ			
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of 1	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions	s)		20, 996, 080	21
. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ting period (line	0	22
. 00	5 x line 17) Swing had east applicable to SNE type complete after December	21 of the east reporting	a ported (line (0	1 22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	ST OF THE COST TEPOLITY	ig period (Title 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing had east applicable to NE type conviges after December 1	21 of the cost reporting	r pariod (line 0	0	25
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)		j per lou (Trhe o	0	20
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		20, 996, 080	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		>	0	1
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed cr	harges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	31
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nue line 33)(coo inctrus	stions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin			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 a	and private room cost di	fferential (line	20, 996, 080	37
. 00	27 minus line 36)				-
					1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD JI	ISTMENTS			1
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 448. 21	38
. 00 . 00 . 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	instructions) 38)		1, 448. 21 7, 456, 833	

MPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2017	Worksheet D-1	- <u>2552</u> 1
				To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
Cost Conton Decerintian	Total		XVIII	Hospi tal	PPS	
Cost Center Description	Total Inpatient Costlr	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)	0	0	0. C	0 0	C) 42.
Intensive Care Type Inpatient Hospital Units	4 959 999		1 000 0	4 000	1 7/0 070	1 10
B. OO INTENSIVE CARE UNIT B. OO CORONARY CARE UNIT	4, 352, 200	2, 293	1, 898. C	929	1, 763, 279	9 43. 44.
5. 00 BURN INTENSIVE CARE UNIT						44.
b. 00 SURGICAL INTENSIVE CARE UNIT						46.
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
8.00 Program inpatient ancillary service cost (Wk	t D_3 col 3	line 200)			1. 00 10, 446, 251	1 48.
0.00 Total Program inpatient costs (sum of lines			ns)		19, 666, 363	
PASS THROUGH COST ADJUSTMENTS						
0.00 Pass through costs applicable to Program inpa	tient routine se	ervices (from	Wkst. D, sum	of Parts I and	1, 845, 165	5 50.
					700.007	
.00 Pass through costs applicable to Program inpa and IV)	itient ancillary	services (Tr	OM WKST. D, S	um of Parts II	709, 807	7 51.
2.00 Total Program excludable cost (sum of lines !	i0 and 51)				2, 554, 972	2 52.
8.00 Total Program inpatient operating cost exclude		ated, non-phy	sician anesth	etist, and	17, 111, 391	
medical education costs (line 49 minus line	2)					_
TARGET AMOUNT AND LIMIT COMPUTATION						
.00 Program discharges .00 Target amount per discharge) 54) 55
.00 Target amount (line 54 x line 55)					0.00	
.00 Difference between adjusted inpatient operat	ng cost and targ	get amount (I	ine 56 minus	line 53)	C	
.00 Bonus payment (see instructions)	-				C	
.00 Lesser of lines 53/54 or 55 from the cost re	orting period en	nding 1996, u	pdated and co	mpounded by the	0.00	59
market basket .00 Lesser of lines 53/54 or 55 from prior year of	ost report und	ated by the m	arket hasket		0.00	60
.00 If line 53/54 is less than the lower of line				the amount by	0.00	
which operating costs (line 53) are less than						
amount (line 56), otherwise enter zero (see	nstructions)					
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive paym	nt (coo instruct	tions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						03
.00 Medicare swing-bed SNF inpatient routine cos	s through Decem	per 31 of the	cost reporti	ng period (See	C	64.
instructions)(title XVIII only)						
6.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	s after December	- 31 of the c	ost reporting	period (See	C) 65.
b. 00 Total Medicare swing-bed SNF inpatient routin	e costs (line 64	4 plus line 6	5)(title XVII	lonly) For	C	66
CAH (see instructions)			0)(((((((((((((((((((((((((((((((((((((
7.00 Title V or XIX swing-bed NF inpatient routing	e costs through I	December 31 c	f the cost re	porting period	C) 67.
(line 12 x line 19)						
8.00 Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter Dec	cemper 31 or	the cost repo	rting period		68.
0.00 Total title V or XIX swing-bed NF inpatient	outine costs (li	ne 67 + line	68)		0	69.
PART III - SKILLED NURSING FACILITY, OTHER NU			,			
.00 Skilled nursing facility/other nursing facili	2		• •			70
. 00 Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71
 .00 Program routine service cost (line 9 x line 1 .00 Medically necessary private room cost application 		(line 14 v li	ne 35)			72
.00 Total Program general inpatient routine servi						74
.00 Capital-related cost allocated to inpatient	•			art II, column		75
26, line 45)						
.00 Per diem capital -related costs (line 75 ÷ lin						76
.00 Program capital-related costs (line 9 x line .00 Inpatient routine service cost (line 74 minu:						77
00 Aggregate charges to beneficiaries for excess		ovider record	s)			79
.00 Total Program routine service costs for compa	• •			us line 79)		80
.00 Inpatient routine service cost per diem limi						81
00 Inpatient routine service cost limitation (I	· · · · · · · · · · · · · · · · · · ·					82
.00 Reasonable inpatient routine service costs ()				83
.00 Program inpatient ancillary services (see in: .00 Utilization review - physician compensation		5)				84
.00 Total Program inpatient operating costs (sum						86
PART IV - COMPUTATION OF OBSERVATION BED PASS						
.00 Total observation bed days (see instructions)					1, 744	
8.00 Adjusted general inpatient routine cost per 6 9.00 Observation bed cost (line 87 x line 88) (se		ine 2)			1, 448. 21 2, 525, 678	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
		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	4, 309, 777	20, 996, 080	0. 20526	6 2, 525, 678	518, 436	90.00
91.00 Nursing School cost	0	20, 996, 080	0.00000	0 2, 525, 678	0	91.00
92.00 Allied health cost	0	20, 996, 080	0. 00000	0 2, 525, 678	0	92.00
93.00 All other Medical Education	0	20, 996, 080	0. 00000	0 2, 525, 678	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period:	Worksheet D-1	
		Component CCN: 15-T059	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 8:50	
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS			F (42	1 1
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing			5, 643 5, 643	
00	Private room days (excluding swing-bed and observation bed days)		ivate room davs	5, 043	
00	do not complete this line.			0	
00	Semi-private room days (excluding swing-bed and observation I			5, 643	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private re	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	boll days) at ter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo	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	3, 599	9
00	newborn days)		Sinnig bed and	0,077	'
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		oom days) atter	0	11
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12
	through December 31 of the cost reporting period			-	
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar			0	1.
. 00 . 00	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				
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 o	f the cost	0.00	17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	cas after December 31 of	the cost	0.00	19
. 00	reporting period			0.00	
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
1.00	reporting period Total general inpatient routine service cost (see instruction	ns)		4, 897, 719	21
2.00	Swing-bed cost applicable to SNF type services through Decem		ing period (line	0	
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	g period (line 6	0	23
1.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24
1. 00	7 x line 19)			0	1
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
5.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 4, 897, 719	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 20)	I	4,077,717	21
3. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
9.00	Private room charges (excluding swing-bed charges)			0	
0.00	Semi-private room charges (excluding swing-bed charges)	. Line 20)		0	
. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IIIC 20)		0. 000000 0. 00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi		tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
b. 00	Private room cost differential adjustment (line 3 x line 35)	and private rear+ "	fforontial (11-	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	irerential (line	4, 897, 719	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				1
	Adjusted general inpatient routine service cost per diem (see			867.93	
	Program general inpatient routine service cost (line 9 x line			3, 123, 680	
	Medically necessary private room cost applicable to the Program general inpatient routine service cost (line 34			0 3, 123, 680	
	Total Frequencial Theatrent Fourthe Service Cost (THE 3)	/ · · · · · · · · · · · · · · · · · · ·		5, 125, 060	1 4 1

UMPUT	ATION OF INPATIENT OPERATING COST		SPITAL Provider C	CN: 15-0059	Peri od:	eu of Form CMS- Worksheet D-	
			Component	CCN: 15-T059	From 01/01/2017 To 12/31/2017		
			Title	e XVIII	Subprovider - IRF	PPS	<u>50 pi</u>
	Cost Center Description	Total Inpatient CostIr	Total npatient Days		Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	0	0.	00 C		0 42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.	00 0		0 43.
. 00	CORONARY CARE UNI T						44.
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)						46
. 00	Cost Center Description	11				1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1.00	6 48
. 00	Total Program inpatient costs (sum of lines			ns)		5, 520, 996	
00	PASS THROUGH COST ADJUSTMENTS	ationt routing of	milano (from	What D an	m of Dorto I and	E20 (//	
. 00	Pass through costs applicable to Program inp	atient routine se	ervices (tron	IWKST. D, SU	n or Parts I and	529, 665	5 50
. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	77, 857	7 51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51				607, 522	2 52
2.00 3.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	4, 913, 474	
	medical education costs (line 49 minus line	5 1					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0 54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)						0 56
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	get amount (I	ine 56 minus	line 53)		0 57 0 58
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period er	nding 1996, u	pdated and c	ompounded by the		
	market basket		C				
). 00 I. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	0 60 0 61
1.00	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)			Ũ		
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instruct	tions)				0 62 0 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						01 03
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	e cost report	ing period (See	(0 64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reportin	a period (See		0 65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	4 plus line 6	5)(title XVI	II only). For	(0 66
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through [December 31 c	of the cost r	eporting period		0 67
	(line 12 x line 19)	Ũ					
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	cember 31 of	the cost rep	orting period		0 68
. 00	Total title V or XIX swing-bed NF inpatient	,					0 69
	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil	· · · ·			<u> </u>	1	
. 00 . 00	Adjusted general inpatient routine service c	5)		70
. 00	Program routine service cost (line 9 x line	71)					72
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•				73
. 00	Capital -related cost allocated to inpatient	•			Part II, column		74
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces	• •					79
. 00 . 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitatior	(line 78 mi	nus line 79)		80
. 00	Inpatient routine service cost per drem frim						82
. 00	Reasonable inpatient routine service costs (see instructions))				83
. 00	Program inpatient ancillary services (see in		-)				84
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	(0)			1	
	Total observation bed days (see instructions)					0 87
7.00	Adjusted general inpatient routine cost per	diam (1: 07 '	1 2 2 2			0.00	0 88

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 01/01/2017	Worksheet D-1	
		Component (To 12/31/2017		pared: D pm
		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	830, 504	4, 897, 719	0. 16957	0 0	0	90.00
91.00 Nursing School cost	0	4, 897, 719	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 897, 719	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 897, 719	0.00000	0 0	0	93.00

00 00 00 00 00 00 00 00 00 00	Cost Center Description PART I - ALL PROVIDER COMPONENTS NPATIENT DAYS Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roor reporting period Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor reporting period Total swing-bed NF type inpatient days (including private roor reporting period Total swing-bed NF type inpatient days (including private roor reporting period Solar swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line) Total inpatient days including private roor reporting period (if calendar year, enter 0 on this line) Solar 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 December 31 of the cost reporting period (if calendar year, ender SWING) Swing-bed NF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, ender SWING) Swing-bed NF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, ender SWING) Swing-bed NF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, ender year, ender SWING) Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	bed and newborn days) hys). If you have only prived how days) through December how days) after December 3 how days) after December 3 how days) after December 3 how the Program (excluding how	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and com days)	1.00 4,022 4,022 0 4,022 0 0 0 0 0 0 3,146 0	0 pn 1 2 3 4 5 6 7 8
00 00 00 00 00 00 00 00 00 00	ART I - ALL PROVIDER COMPONENTS NPATIENT DAYS Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line. Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private roo reporting period Total swing-bed SNF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	bed and newborn days) hys). If you have only prived how days) through December how days) after December 3 how days) after December 3 how days) after December 3 how the Program (excluding how	vate room days, r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and pom days)	4, 022 4, 022 0 4, 022 0 0 0 0 0 3, 146 0	2 3 4 5 6 7 8
00 00 00 00 00 00 00 00 00 00	NPATIENT DAYS Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	bed and newborn days) hys). If you have only prived how days) through December how days) after December 3 how days) after December 3 how days) after December 3 how the Program (excluding how	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and com days)	4, 022 4, 022 0 4, 022 0 0 0 0 0 3, 146 0	2 3 4 5 6 7 8
00 00 00 00 00 00 00 00 00 00	NPATIENT DAYS Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	bed and newborn days) hys). If you have only prived how days) through December how days) after December 3 how days) after December 3 how days) after December 3 how the Program (excluding how	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and com days)	4, 022 0 4, 022 0 0 0 0 0 3, 146 0	2 3 4 5 6 7 8
00 00 00 00 00 00 00 00 00 00 00 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. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruc Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruc Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruc Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	bed and newborn days) hys). If you have only prived how days) through December how days) after December 3 how days) after December 3 how days) after December 3 how the Program (excluding how	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and com days)	4, 022 0 4, 022 0 0 0 0 0 3, 146 0	2 3 4 5 6 7 8
00 1 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2 00 2	Private room days (excluding swing-bed and observation bed da do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	ys). If you have only prived days) nom days) through December nom days) after December 3 m days) through December 3 m days) after December 3 o the Program (excluding only (including private ro only (including private ro only (including private ro	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and com days)	0 4, 022 0 0 0 0 3, 146 0	3 4 5 6 7 8
00 00 00 00 00 00 00 . 00 2 . 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (see instruct Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (see V or XI through December 31 of the cost reporting period (see V or XI through December 31 of the cost reporting period (see V or XI through December 31 of the cost reporting period (see V or XI through December 31 of the cost reporting period (see V or XI through December 31 of the cost reporting period V or VI through December 31 of the cost reporting period (see V or XI	nom days) through December nom days) after December nom days) through December nom days) after December 3 o the Program (excluding nonly (including private ro nonly (including private ro nonly (including private ro nonly (including private ro	31 of the cost 31 of the cost 1 of the cost swing-bed and pom days)	0 0 0 3, 146 0	5 6 7 8
00 00 00 00 00 . 00 . 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	m days) through December m days) after December 3 o the Program (excluding only (including private ro stions) only (including private ro onter 0 on this line)	31 of the cost 1 of the cost swing-bed and com days)	0 0 3, 146 0	7
000 000 000 000 000 00 00 00 00 00	Total swing-bed NF type inpatient days (including private roo reporting period Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period (of calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	m days) after December 3 o the Program (excluding only (including private ro tions) only (including private ro onter 0 on this line)	1 of the cost swing-bed and com days)	0 3, 146 0	8
00 00 00 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	o the Program (excluding only (including private ro itions) only (including private ro onter 0 on this line)	swing-bed and com days)	3, 146 0	
00 00 00 00 1 00	Total inpatient days including private room days applicable t newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	nly (including private ro tions) nly (including private ro nter 0 on this line)	com days)	0	c
. 00 9 . 00 9	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	tions) nly (including private ro nter 0 on this line)			
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	enter 0 on this line)	som days) arter [0	
	through December 31 of the cost reporting period	A only (including private	a room dave)	0	
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	5 /	0	
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this line	e)	0	
00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0 0	
00 1	WING BED ADJUSTMENT Wedicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost	0.00	17
00 1	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to service reporting period	<u> </u>		0.00	
I	Medicaid rate for swing-bed NF services applicable to service reporting period		ne 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)		ng period (line	3, 670, 105 0	
00	swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23
	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	er 31 of the cost reportion	ng period (line	0	24
:	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, 670, 105	
	General inpatient routine service charges (excluding swing-be	d and observation bed cha	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 22 mi	nuc line 22) (cas instance	tions	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 24 x li			0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	110 31/		0.00 0	
00	General inpatient routine service cost net of swing-bed cost 7 minus line 36)	and private room cost di	fferential (line	3, 670, 105	
F	PART II - HOSPITÁL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
	Adjusted general inpatient routine service cost per diem (see				38
	Program general inpatient routine service cost (line 9 x line				39
	Medically necessary private room cost applicable to the Progr				40

ealth Financial Sys COMPUTATION OF INPA	tems TIENT OPERATING COST	RI VERVI EW	HOSPITAL Provider CO	N: 15-0059	In Lie Period:	eu of Form CMS- Worksheet D-1	
	TENT OF ENATING COST			CCN: 15-5669	From 01/01/2017 To 12/31/2017		
				XVIII		5/29/2018 8:5	
				XVIII	Skilled Nursing		
Cost Ce	nter 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	
	<u>e V & XIX only)</u> e Type Inpatient Hospital Un	i te					42.0
3. 00 I NTENSI VE CAI							43.0
4.00 CORONARY CAR							44.0
5.00 BURN INTENSI 6.00 SURGICAL INTI	/E CARE UNIT						45. 46.
7.00 OTHER SPECIAL							47.
Cost Ce	nter Description					1.00	
8.00 Program inpa	ient ancillary service cost	(Wkst. D-3, col. 3	, line 200)			1.00	48.
9.00 Total Program	n inpatient costs (sum of lin			ns)			49.
	COST ADJUSTMENTS costs applicable to Program	inpatient routine	services (from	Wkst D su	m of Parts I and		50.
111)		•					
1.00 Pass through and IV)	costs applicable to Program	inpatient ancillar	y services (fr	om Wkst. D,	sum of Parts II		51.
	n excludable cost (sum of lin	nes 50 and 51)					52.
	n inpatient operating cost ex		lated, non-phy	sician anest	hetist, and		53.
	ation costs (line 49 minus li AND LIMIT COMPUTATION	ne 52)					1
4.00 Program di scl							54.
	per discharge						55.
	t (line 54 x line 55) etween adjusted inpatient ope	arating cost and ta	raet amount (1	ino 56 minus	line 53)		56. 57.
	(see instructions)		rget anount (r	The 50 minus	THE 55)		58.
9.00 Lesser of li	nes 53/54 or 55 from the cost	reporting period	ending 1996, u	pdated and c	ompounded by the		59.
market baske 0.00 Lesser of li	: nes 53/54 or 55 from prior ye	ar cost roport up	dated by the m	arkat backat			60.
	is less than the lower of l						61.
	ng costs (line 53) are less		s (lines 54 x	60), or 1% o	f the target		
	56), otherwise enter zero (s nt (see instructions)	see instructions)					62.
	patient cost plus incentive p	bayment (see instru	ctions)				63.
	IENT ROUTINE SWING BED COST				iner realized (Con		1
	ng-bed SNF inpatient routine (title XVIII only)	costs through Dece	mber 31 of the	cost report	ing period (See		64.
	ng-bed SNF inpatient routine	costs after Decemb	er 31 of the c	ost reportin	g period (See		65.
	(title XVIII only) re swing-bed SNF inpatient ro	utine costs (line	64 nlus line 6	5)(title XVI	ll only) For		66.
CAH (see ins				5)((1110 XVI	rr on y). roi		00.
	X swing-bed NF inpatient rou	itine costs through	December 31 o	f the cost r	eporting period		67.
(line 12 x li 8.00 Title V or X	X swing-bed NF inpatient rou	utine costs after D	ecember 31 of	the cost rep	ortina period		68.
(line 13 x li	ne 20)				5 1 2		
	/ or XIX swing-bed NF inpatie ILLED NURSING FACILITY, OTHE						69.
	ng facility/other nursing fa)	3, 670, 105	70.
1.00 Adjusted gene	eral inpatient routine servic	ce cost per diem (l				912.51	
Ū	ne service cost (line 9 x li		(lipo 14 v li	no 2E)		2, 870, 756	
,	cessary private room cost app n general inpatient routine s	, C	•	ne 35)		2, 870, 756	
5.00 Capital -rela	ed cost allocated to inpatie			orksheet B,	Part II, column	0	
26, line 45) 6.00 Per diem capi	tal-related costs (line 75 ÷	line 2)				0.00	76.
	al-related costs (line 9 x l					0.00	
	utine service cost (line 74 m					0	
	arges to beneficiaries for ex n routine service costs for c				nus ling 70)	0	
5	itine service costs for c	•			1103 IIIE /7)	0.00	
2.00 Inpatient ro	utine service cost limitation	n (line 9 x line 81	•			0	82.
	npatient routine service cost	•	s)			2, 870, 756	
	cient ancillary services (see review - physician compensati		ns)			1, 426, 116	
	<u>inpatient operating costs (</u>					4, 296, 872	
PART IV - CON	PUTATION OF OBSERVATION BED	PASS THROUGH COST				1	
37.00 Total observa	ation bed days (see instructi eral inpatient routine cost p					0	87. 88.
8.00 Adjusted gene			line 20				

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 01/01/2017	Worksheet D-1	
		Component (CCN: 15-5669	To 12/31/2017		pared: O pm
		Title	XVIII	Skilled Nursing	PPS	
	1			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	0.0000	0 0	0	90.00
91.00 Nursing School cost	0	0	0.0000	0 0	0	91.00
92.00 Allied health cost	0	0	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000	0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	5/29/2018 8:5 Cost	u pi
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	ve oveluding nowhern)		14, 498	1 1
00	Inpatient days (including private room days, excluding swing- Inpatient days (including private room days, excluding swing-			14, 498	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(aveb bec		12, 754	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
~~	reporting period		04 6 4	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) atter December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	am dave) after Decomber (21 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	Sin days) arter becember s	of the cost	0	
00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	282	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	coom days)	0	10
	through December 31 of the cost reporting period (see instruc	ctions)	5,7	-	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar v			0	13
	Medically necessary private room days applicable to the Progr			0	
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	cos after December 21 of	the cost	0.00	10
. 00	reporting period	Les aiter December 31 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	20, 996, 080 0	
. 00	5 x line 17)	bei 51 01 the cost report	ing period (inte	0	
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportir	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24
	7 x line 19)	•	0 1 1		
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
	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)		20, 996, 080	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)		<u> </u>	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ THE 20)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		ctions)	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	20, 996, 080	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 448. 21	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			408, 395 0	
	Total Program general inpatient routine service cost (line 39			408, 395	

OMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0059	Peri od:	Worksheet D-1	- <u>2552</u> 1
					From 01/01/2017 To 12/31/2017		epare
						5/29/2018 8:5	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Costl				(col. 3 x col.	
		1.00		<u>col.2)</u>	4.00	4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00) 42
. 00	Intensive Care Type Inpatient Hospital Units	<u> </u>	0	0.0	0		7 72
. 00	I NTENSI VE CARE UNI T	4, 352, 200	2, 293	1, 898. (0 0) C	
. 00	CORONARY CARE UNIT						44
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						40
	Cost Center Description						
0.0			1.1 000)			1.00	10
. 00 . 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			nc)		252, 802	
. 00	PASS THROUGH COST ADJUSTMENTS	+1 through 40)(S		115)		001, 197	49
. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	C	50
. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	C	51
2. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				c	52
3.00	Total Program inpatient operating cost exclude		ated, non-phy	sician anestl	netist, and	0	
	medical education costs (line 49 minus line !	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00 . 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	C	
8. 00	Bonus payment (see instructions)					C	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ndi ng 1996, u	pdated and co	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report und	ated by the m	arket hasket		0.00	0 60
. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	f the target		
	amount (line 56), otherwise enter zero (see i	nstructions)					
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment	ent (see instruc	tions)) 62) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	C	64
	instructions)(title XVIII only)		04 6 11				
6. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the c	ost reportino	g period (See) 65
6. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	C	0 66
	CAH (see instructions)				•		
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	eporting period	C	0 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 rep	orting period	(68 (
5.00	(line 13 x line 20)			the cost rep	si ting por ou		
9.00						C) 69
	PART III - SKILLED NURSING FACILITY, OTHER NU				<u>,</u>	1	
). 00 I. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	2		• •)		70
2.00	Program routine service cost (line 9 x line			2)			72
8.00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	•					74
6.00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, H	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minus	,					78
. 00	Aggregate charges to beneficiaries for excess				$u_{\rm c}$ line 70		79
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		st i i i i i i i i a ti ON		IUS ITTE /9)		80
. 00	Inpatient routine service cost per drem rim						82
. 00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see in						84
6.00	Utilization review - physician compensation						85
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)			L	86
7.00	Total observation bed days (see instructions)					1, 744	4 87
3.00	Adjusted general inpatient routine cost per o		line 2)			1, 448. 21	
9.00							

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
		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	4, 309, 777	20, 996, 080	0. 20526	6 2, 525, 678	518, 436	90.00
91.00 Nursing School cost	0	20, 996, 080	0.00000	0 2, 525, 678	0	91.00
92.00 Allied health cost	0	20, 996, 080	0.00000	0 2, 525, 678	0	92.00
93.00 All other Medical Education	0	20, 996, 080	0. 00000			93.00

IVIPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Peri od:	Worksheet D-1	
		Component CCN: 15-T059	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 8:50	
		Title XIX	Subprovider - IRF	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		I	1.00	
	INPATIENT DAYS				1
	Inpatient days (including private room days and swing-bed da			5, 643	
00	Inpatient days (including private room days, excluding swing			5, 643	
00	Private room days (excluding swing-bed and observation bed d do not complete this line.	ays). It you have only pr	ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation	bed days)		5, 643	4
00	Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	0	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om davs) through Docombor	21 of the cost	0	7
50	reporting period	oni days) thi ough becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	49	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	nom davc)	0	10
00	through December 31 of the cost reporting period (see instru		uays)	0	
00	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,				
. 00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including privat	e room days)	0	12
.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including privat	a room dave)	0	13
00	after December 31 of the cost reporting period (if calendar			0	
00	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)		-	0	15
. 00	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	1 17
. 00	reporting period	ces through becember 51 0		0.00	
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	ces 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
00	reporting period			0.00	
	Total general inpatient routine service cost (see instructio			4, 897, 719	
00	Swing-bed cost applicable to SNF type services through Decem	nber 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	or 21 of the cost reportin	a ported (line 4	0	23
00	x line 18)	a si oi the cost reportin		0	2.
00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 897, 719	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		L		
	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0 0. 000000	30
	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	
	Average per diem private room charge differential (line 32 m		tions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35)		fforontial (line	0 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	36
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	. and private room cost di	inerential (IINe	4, 897, 719	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			1
00	Adjusted general inpatient routine service cost per diem (se			867.93	
				42, 529	39
. 00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog			42, 529	40

	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW HC		CN: 15-0059	In Lie Period:	eu of Form CMS- Worksheet D-	
				CCN: 15-T059	From 01/01/2017 To 12/31/2017	Date/Time Pre	epared
			Titl	e XIX	Subprovider - IRF	5/29/2018 8:5 Cost	<u>50 pm</u>
	Cost Center Description	Total Inpatient CostIr	Total npatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	0	C	0.	00 C) () 42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.	00 0		0 43.
4.00	CORONARY CARE UNI T	0	C C	0.			44.
	BURN INTENSIVE CARE UNIT						45.
6.00	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 21,985	5 48.
	Total Program inpatient costs (sum of lines			ons)		64, 514	
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine se	ervices (from	Wkst D su	m of Parts I and		50.
1.00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II		51.
2.00	Total Program excludable cost (sum of lines !						52.
3. 00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION		ited, non-phy	sician anest	hetist, and	0	53.
	Program discharges					(
5.00 5.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ng cost and tard	get amount (I	ine 56 minus	line 53)		
8. 00	Bonus payment (see instructions)	5			,	0	58.
9.00	Lesser of lines 53/54 or 55 from the cost rep	porting period er	nding 1996, u	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.
1.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 er n expected costs	nter the less	er of 50% of	the amount by	C	
2.00 3.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions) Allowable Inpatient cost plus incentive payme		tions)				0 62. 0 63.
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	e cost report	ing period (See		0 64.
	instructions)(title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	- 31 of the d	ost reportin	g period (See) 65.
5.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line 64	l plus line é	o5)(title XVI	II only). For	0	66.
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through [December 31 d	of the cost r	eporting period	0	67.
8.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after Dec	cember 31 of	the cost rep	orting period	0	68.
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient in DADT LL SKILED NUDELING FACULTY OTHER N			,			69.
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70.
I. 00	Adjusted general inpatient routine service co	J			, ,		71.
2.00 3.00	Program routine service cost (line 9 x line)		lipo 14 v li	po 25)			72.
4.00	Medically necessary private room cost applica Total Program general inpatient routine servi	0	•				74.
5.00	Capital-related cost allocated to inpatient 1 26, line 45)	routine service o			Part II, column		75.
5.00 7.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.
3. 00	Inpatient routine service cost (line 74 minus						78.
9.00	Aggregate charges to beneficiaries for excess	• •					79.
). 00	Total Program routine service costs for compa		st limitatior	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.
3.00	Reasonable inpatient routine service cost (1				83.
4.00	Program inpatient ancillary services (see in	structions)					84.
5.00	Utilization review - physician compensation						85.
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		Jugn 85)			I	86.
7.00	Total observation bed days (see instructions))				(
	Adjusted general inpatient routine cost per (•	ine 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	= instructions)				1 () 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 01/01/2017	Worksheet D-1	
		Component (To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
		Titl	e XIX	Subprovider -	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	830, 504	4, 897, 719	0. 16957	0 0	0	90.00
91.00 Nursing School cost	0	4, 897, 719	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 897, 719	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 897, 719			0	93.00

Cost Center Description	Title		From 01/01/2017 To 12/31/2017	Data /T:	
Cost Center Description	Title			Date/Time Pre 5/29/2018 8:5	
Cost Center Description		e XVIII	Hospi tal	PPS	
		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	+
00 03000 ADULTS & PEDIATRICS		-	7, 932, 323		30
. 00 03100 I NTENSI VE CARE UNI T			2, 206, 862		31
. 00 04100 SUBPROVI DER – I RF			135, 185		41
. 00 04300 NURSERY			133, 103		43
ANCI LLARY SERVICE COST CENTERS		1		L	1
00 05000 OPERATI NG ROOM		0. 15172	10, 775, 065	1, 634, 879	50
. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0.39260		312, 939	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 30813		9, 182	55
. 00 05700 CT SCAN		0.03209		24, 180	
. 01 03630 ULTRA SOUND		0.0000		0	
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.09996		14, 598	
. 00 05900 CARDI AC CATHETERI ZATI ON		0.07860			
. 00 06000 LABORATORY		0. 18409			
0. 01 06001 BLOOD LABORATORY		0.0000		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 46260	266, 281	123, 182	63
. 00 06400 I NTRAVENOUS THERAPY		0.00000	0 00	0	64
. 00 06500 RESPI RATORY THERAPY		0. 28472	27 1, 463, 478	416, 692	65
. 00 06600 PHYSI CAL THERAPY		0. 36116	51 1, 109, 700	400, 780	66
. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 00	0	67
00 06800 SPEECH PATHOLOGY		0.0000	0 00	0	68
. 00 06900 ELECTROCARDI OLOGY		0. 18502	28 1, 181, 974	218, 698	69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 47674	41 7, 435, 064	3, 544, 600	71
. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 10633	33 2, 425, 995	257, 963	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 39238	34 4, 507, 724	1, 768, 759	73
. 00 07400 RENAL DIALYSIS		1.02370		144, 106	
. 00 03020 OTHER ANCI LLARY		0.0000		0	
. 01 03140 CARDI AC REHAB		0. 2624		56, 379	
. 02 03070 WOMEN'S CENTER		0. 26586		0	
. 03 03330 ENDOSCOPY		0.0000	0 00	0	76
OUTPATIENT SERVICE COST CENTERS					4
		0. 26025			
		0.3604			
. 00 09100 EMERGENCY		0. 21660			
. 01 09101 SHORT STAY		0.00000		0	
. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 6865	77 0	0	92
OTHER REI MBURSABLE COST CENTERS		1			
. 00 09500 AMBULANCE SERVICES			20 000 / 54	10 444 051	95
0.00 Total (sum of lines 50 through 94 and 96 through 98)	$(\lim_{n \to \infty} (1))$		39, 980, 654	10, 446, 251	
1.00Less PBP Clinic Laboratory Services-Program only charge2.00Net charges (line 200 minus line 201)	s (The of)		39, 980, 654	ł	202

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr	ovider C	CN: 15-0059	Peri od:	Worksheet D-3	
		001 45 TOFO	From 01/01/2017		
	mponent	CCN: 15-T059	To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
	Ti tl €	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		j ů	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		1	1
D. 00 03000 ADULTS & PEDI ATRI CS			0		30
1. 00 03100 I NTENSI VE CARE UNI T			0		31
1. 00 04100 SUBPROVIDER - IRF			3, 943, 665		41
3. 00 04300 NURSERY					43
ANCI LLARY SERVICE COST CENTERS		0. 15172	145 112	25, 052	50
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 15172			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 39260			
5. 00 05500 RADI OLOGI - THERAPEUTI C		0. 39200			
7. 00 05700 CT_SCAN		0. 03209			
7. 01 03630 ULTRA SOUND		0.00000			
B. OO OS800 MAGNETIC RESONANCE IMAGING (MRI)		0. 09996		-	
0. 00 05900 CARDI AC CATHETERI ZATI ON		0.07860			
0. 00 06000 LABORATORY		0. 18409			
0. 01 06001 BLOOD LABORATORY		0.0000			
8. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.46260		7, 278	
1. 00 06400 I NTRAVENOUS THERAPY		0.0000			
5. 00 06500 RESPI RATORY THERAPY		0. 28472	27 291, 111	82, 887	65
0. 00 06600 PHYSI CAL THERAPY		0.36116	3, 542, 941	1, 279, 572	66
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000	0 00	0	67
3. 00 06800 SPEECH PATHOLOGY		0.0000	0 00	0	68
9. 00 06900 ELECTROCARDI OLOGY		0. 18502			
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 47674			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 10633			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 39238			
4. 00 07400 RENAL DIALYSIS		1.02370			
6. 00 03020 OTHER ANCI LLARY		0.0000		-	
5. 01 03140 CARDI AC REHAB		0. 2624			
5. 02 03070 WOMEN' S CENTER		0. 26580			
5. 03 03330 ENDOSCOPY OUTPATI ENT SERVICE COST CENTERS		0.0000	0 00	0	76
0. 00 09000 CLINIC		0.2602	56 4, 276	1, 113	90
0. 01 09001 0UTPATI ENT		0. 3604			
00 09100 EMERGENCY		0. 21660			
00 09100 EMERGENCE		0. 00000			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6865			
OTHER REI MBURSABLE COST CENTERS		0.0000		0	1 11
5. 00 09500 AMBULANCE SERVICES					95
00.00 Total (sum of lines 50 through 94 and 96 through 98)			6, 811, 117	2, 397, 316	
01.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201
02.00 Net charges (line 200 minus line 201)	/		6, 811, 117		202

leal th Financial Systems RIVERVIEW HOSPI NPATIENT ANCILLARY SERVICE COST APPORTIONMENT PI	TAL Tovider C	CN: 15-0059	Peri od:	eu of Form CMS- Worksheet D-3	
			From 01/01/2017		
Co	omponent	CCN: 15-5669	To 12/31/2017	Date/Time Pre 5/29/2018 8:5	
	Titl€	e XVIII	Skilled Nursing		
Cost Center Description		Ratio of Cos	Facility t Inpatient	Inpati ent	
COST CENTER DESCRIPTION		To Charges	Program	Program Costs	
		10 charges	Charges	$(col. 1 \times col.)$	
			ondrigoo	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-	
30. 00 03000 ADULTS & PEDI ATRI CS			C		30.0
31.00 03100 INTENSIVE CARE UNIT			C		31.0
11.00 04100 SUBPROVIDER - IRF			C		41.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0 1517	28 C	0	50 0
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 1517: 0. 0000			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3926			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 3920		18, 402	
7. 00 05700 CT SCAN		0. 0320			
7. 01 03630 ULTRA SOUND		0.0000			
8. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0999			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0786		-	
0. 00 06000 LABORATORY		0. 1840			
0. 01 06001 BLOOD LABORATORY		0.0000			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.4626		0	63.0
4. 00 06400 INTRAVENOUS THERAPY		0.0000	00 C	0	64. (
5. 00 06500 RESPI RATORY THERAPY		0. 2847	27 103, 254	29, 399	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 3611	61 1, 415, 435	511, 200	66. (
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000	DO C	0	67.0
8.00 06800 SPEECH PATHOLOGY		0.0000		0 0	
9.00 06900 ELECTROCARDI OLOGY		0. 1850			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4767			
2.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 1063		-	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 3923			
4.00 07400 RENAL DI ALYSI S		1.0237		-	
6. 00 03020 OTHER ANCI LLARY		0.0000		-	
6. 01 03140 CARDIAC REHAB 6. 02 03070 WOMEN' S CENTER		0.2624			
76. 03 03330 ENDOSCOPY		0. 2658 0. 0000			
OUTPATIENT SERVICE COST CENTERS		0.0000	<u> </u>	<u>1</u> 0	/0.0
0. 00 09000 CLINIC		0. 2602	56 403	105	90.
0. 01 09001 0UTPATI ENT		0. 3604			
1. 00 09100 EMERGENCY		0. 2166			
1. 01 09101 SHORT STAY		0.0000			
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6865			
OTHER REIMBURSABLE COST CENTERS					1
25. 00 09500 AMBULANCE SERVI CES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 247, 061	1, 426, 116	200. (
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		C		201.0
202.00 Net charges (line 200 minus line 201)			4, 247, 061		202.0

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	ovider C	CN: 15-0059	Period:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Data /Tima Dra	nor
			10 12/31/2017	Date/Time Pre 5/29/2018 8:5	
	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)	+
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	-
00 03000 ADULTS & PEDI ATRI CS			418, 801		30
00 03100 INTENSIVE CARE UNIT			24, 136		31
00 04100 SUBPROVIDER - IRF			0		41
00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS				•	
00 05000 OPERATING ROOM		0. 1517:	28 91, 081	13, 820	50
00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		-	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 3926			
00 05500 RADI OLOGY-THERAPEUTI C		0. 3081		3, 786	5
00 05700 CT SCAN		0. 0320		828	
01 03630 ULTRA SOUND		0.0000		0	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0999			
00 05900 CARDI AC CATHETERI ZATI ON		0. 07860			
00 06000 LABORATORY		0. 1840		33, 418	
01 06001 BLOOD LABORATORY		0.0000		0	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 46260			
00 06400 I NTRAVENOUS THERAPY		0.0000		0	
00 06500 RESPI RATORY THERAPY		0. 28472			
00 06600 PHYSI CAL THERAPY		0.3611		5, 364	
00 06700 OCCUPATI ONAL THERAPY		0.0000			
00 06800 SPEECH PATHOLOGY		0.0000		, s	-
00 06900 ELECTROCARDI OLOGY		0. 1850		5, 097	
00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 4767			
00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 1063		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 3923			
00 07400 RENAL DI ALYSI S		1.02370			
00 03020 OTHER ANCI LLARY 01 03140 CARDI AC REHAB		0.0000		0 7, 579	
02 03070 WOMEN'S CENTER					
03 03330 ENDOSCOPY		0. 2658			
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	- 1
00 09000 CLINIC		0. 2602	56 712	185	9
01 09001 0UTPATI ENT		0. 3604			
00 09100 EMERGENCY		0. 2166			
01 09101 SHORT STAY		0.0000			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6865		0	9
OTHER REIMBURSABLE COST CENTERS		·			1
00 09500 AMBULANCE SERVI CES					9
D.00 Total (sum of lines 50 through 94 and 96 through 98)			923, 084	252, 802	
.00 Less PBP Clinic Laboratory Services-Program only charges (1	ne 61)		0		20
2.00 Net charges (line 200 minus line 201)			923, 084		20

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0059	Peri od:	In Lie	Worksheet D-3	
			From 01/	01/2017		
	Component	CCN: 15-T059	To 12/	31/2017	Date/Time Pre 5/29/2018 8:5	
	Titl	e XIX	Subprov I R		Cost	o piii
Cost Center Description		Ratio of Cos		tient	Inpati ent	
· ·		To Charges	Prog	gram	Program Costs	
			Chai	rges	(col. 1 x col.	
					2)	
		1.00	2.	00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDIATRICS				0		30.0
31. 00 O3100 I NTENSI VE CARE UNI T				0		31.0
41.00 O4100 SUBPROVIDER - IRF				90, 149		41.0
				0		43.0
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 1517	20	0	0	50.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.1317		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3926		0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 3720		0	0	
57. 00 05700 CT SCAN		0.0320		0	0	
57. 01 03630 ULTRA SOUND		0.0000		0	0	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0999		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0786		0	0	
50. 00 06000 LABORATORY		0. 1840		2, 891	532	
50. 01 06001 BLOOD LABORATORY		0.0000		0	0	1
53.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4626		0	0	63. C
64. 00 06400 I NTRAVENOUS THERAPY		0.0000	00	0	0	64. C
65. 00 06500 RESPI RATORY THERAPY		0. 2847	27	34, 286	9, 762	65. C
56. 00 06600 PHYSI CAL THERAPY		0.3611	61	3, 189	1, 152	66. C
57.00 06700 OCCUPATI ONAL THERAPY		0.0000	00	0	0	67.0
58.00 06800 SPEECH PATHOLOGY		0.0000		0	0	
59. 00 06900 ELECTROCARDI OLOGY		0. 1850		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4767		18, 146	8, 651	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT		0. 1063		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3923		4, 811	1, 888	
74.00 07400 RENAL DIALYSIS		1.0237		0	0	
76.00 03020 OTHER ANCI LLARY		0.0000		0	0	
76. 01 03140 CARDI AC REHAB 76. 02 03070 WOMEN' S CENTER		0.2624		0	0	
76. 03 03300 ENDOSCOPY		0. 2658 0. 0000		0	0	
OUTPATIENT SERVICE COST CENTERS		0.0000	00	0	0	/0.0
001PATTENT SERVICE COST CENTERS		0.2602	56	0	0	90.0
20. 01 09001 0UTPATI ENT		0.3604		0	0	
91. 00 09100 EMERGENCY		0. 2166		0	0	
91. 01 09101 SHORT STAY		0.2100		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6865		0	0	
OTHER REIMBURSABLE COST CENTERS		0.0000	•••	0	0	1 /2.0
95. 00 09500 AMBULANCE SERVICES						95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)				63, 323	21, 985	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)			0	,	201.0
202.00 Net charges (line 200 minus line 201)	. ,			63, 323		202.0

	Financial Systems RIVERVIEW HO ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	In Lie Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prep 5/29/2018 8:50	pared
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00	DRG Amounts Other than Outlier Payments		_	0	-
. 01	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1 ((see	0	1.0
. 02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	12, 576, 154	1.0
	instructions)			,,	
. 03	DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1.0
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1.0
	October 1 (see instructions)			C C	
. 00	Outlier payments for discharges. (see instructions)			115, 931	
. 01	Outlier reconciliation amount	(and)		0	
. 02 . 00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	TONS)		0	2.0
. 00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	100. 12	
	Indirect Medical Education Adjustment				
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.0
. 00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the cap	0.00	6.0
	for new programs in accordance with 42 CFR 413.79(e)		on to the sup	0100	
. 00	MMA Section 422 reduction amount to the IME cap as specified			0.00	
. 01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7.
. 00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro	ograms for	0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413.				
	1998), and 67 FR 50069 (August 1, 2002).				
. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.
. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0.00	8.
	under § 5506 of ACA. (see instructions)		0		
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	ues (8, 8,01 and 8,02) ((see	0.00	9.0
0.00	FTE count for allopathic and osteopathic programs in the curr	ent vear from vour recor	ds	0.00	10.
1.00	FTE count for residents in dental and podiatric programs.			0.00	
2.00	Current year allowable FTE (see instructions)			0.00	
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	ar onded on or after Ser	tombor 20 1007	0.00 0.00	
4.00	otherwise enter zero.		Jtelliber 30, 1997,	0.00	14.
5.00	Sum of lines 12 through 14 divided by 3.			0.00	15.
6.00	Adjustment for residents in initial years of the program			0.00	
7.00 8.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	isure		0. 00 0. 00	
9.00	Current year resident to bed ratio (line 18 divided by line 4	.).		0.00000	
0.00	Prior year resident to bed ratio (see instructions)			0. 000000	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	
2.01	Indirect Medical Education Adjustment for the Add-on for § 42	2 of the MMA		0	22.
3.00	Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.0
	(f)(1)(iv)(C).				
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or line	21 (500	0.00 0.00	
5.00	instructions)	Tower of Trife 23 of Trife	24 (366	0.00	25.
6. 00	Resident to bed ratio (divide line 25 by line 4)			0.00000	
7.00	IME payments adjustment factor. (see instructions)			0.000000	
8.00 8.01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions	.)		0	
9.00	Total IME payment (sum of lines 22 and 28)	·/		0	
9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
0 0-	Disproportionate Share Adjustment				1.05
0.00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	2.43	
1.00 2.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			16. 15 18. 58	
3.00	Allowable disproportionate share percentage (see instructions)		4.83	
4 00	Disproportionate share adjustment (see instructions)			151, 857	34.

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2017	Worksheet E Part A	
			To 12/31/2017		pare
		Title XVIII	Hospi tal	PPS	<u>o piii</u>
			Prior to 10/1		
	Uncompensated Care Adjustment		1.00	2.00	
	Total uncompensated care amount (see instructions)		0	0	35.
	Factor 3 (see instructions)		0. 000000000	0. 00000000	
	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (see	e 494, 085	850, 363	35.
[instructions)				
5.03	Pro rata share of the hospital uncompensated care payment and		369, 548	214, 338	
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di		583, 886		36.
0.00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.
	652, 682, 683, 684 and 685 (see instructions)	<u>j</u>			
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41.
1 01	instructions)				41
1. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGS 652, 682, 683, 684	0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adiustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0		43.
ſ	instructions)				
4.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
5.00	days) Average weekly cost for dialysis treatments (see instructions	5)	0.00		45.
6.00	Total additional payment (line 45 times line 44 times line 4		0.00		46.
7.00	Subtotal (see instructions)		13, 427, 828		47.
8.00	Hospital specific payments (to be completed by SCH and MDH, \ensuremath{sc}	small rural hospitals	0		48.
	only. (see instructions)				
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instructions	5)		13, 427, 828	49.
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			1, 092, 561	50.
1.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51
2.00	Direct graduate medical education payment (from Wkst. E-4, li	ine 49 see instructions).		0	52.
3.00 4.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 1, 036	53. 54.
4.00	Islet isolation add-on payment			1, 030	54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	69)		0	55
6.00	Cost of physicians' services in a teaching hospital (see intr			0	56
7.00	Routine service other pass through costs (from Wkst. D, Pt. I		nrough 35).	0	57
8.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		27, 560	
9.00 0.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			14, 548, 985 0	59 60
1.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		14, 548, 985	
2.00	Deductibles billed to program beneficiaries			1, 465, 576	
3.00	Coinsurance billed to program beneficiaries			28, 623	63
	Allowable bad debts (see instructions)			99, 625	
	Adjusted reimbursable bad debts (see instructions)			64, 756	
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)	tructions)		32,624	
7.00 8.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se	e instructions)	13, 119, 542 0	67 68
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70
0.50	Rural Community Hospital Demonstration Project (§410A Demonst	, ,	nstructions)	0	70
0.87	Demonstration payment adjustment amount before sequestration			0	70
0.88 0.89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		0	70 70
0.89	HSP bonus payment HVBP adjustment amount (see instructions)			0	
	HSP bonus payment HRR adjustment amount (see instructions)			0	
0.91				Ő	70
	Bundled Model 1 discount amount (see instructions)			01	1,0
0. 92	HVBP payment adjustment amount (see instructions)			35, 942	

al th Financial Systems RIVERVIEW HOSP	Providor (CN: 15-0059	Peri od:	Worksheet E	255
LCULATION OF REIMBORSEMENT SETTLEMENT		314. 15-0039	From 01/01/2017		
			To 12/31/2017	Date/Time Pre	
	T: +1 -		11	5/29/2018 8:5	0 p
	<u> </u>	XVIII	Hospital	PPS	
		FFI	<u>′ (уууу)</u> 0	Amount 1.00	-
96 Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70
the corresponding federal year for the period prior to 10/1)	001 41111 0		0	Ū	
.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in	column O		0	0	70
the corresponding federal year for the period ending on or afte	er 10/1)				
.98 Low Volume Payment-3				0	70
99 HAC adjustment amount (see instructions)				0	70
.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			13, 155, 484	
.01 Sequestration adjustment (see instructions)				263, 110	
. 02 Demonstration payment adjustment amount after sequestration				0	
00 Interim payments				12, 868, 767	
. 00 Tentative settlement (for contractor use only)	70				73
.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 73)	72, and			23, 607	74
.00 Protested amounts (nonallowable cost report items) in accordance	o with			173, 153	75
CMS Pub. 15-2, chapter 1, §115.2	ewith			175, 155	1
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					1
.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instr	uctions)			0	90
.00 Capital outlier from Wkst. L, Pt. I, line 2	· · ·			0	9
.00 Operating outlier reconciliation adjustment amount (see instruc	tions)			0	92
.00 Capital outlier reconciliation adjustment amount (see instructi	ons)			0	93
.00 The rate used to calculate the time value of money (see instruc	tions)			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 instructi	ons)			0	96
			Prior to 10/1		
			1.00	2.00	-
HSP Bonus Payment Amount			0	0	1100
0.00 HSP bonus amount (see instructions)			0	0	100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions)			0.000000000	0. 0000000000	101
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 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 			0.000000000	0. 000000000 0 0. 0000	101 102 103
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 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra 0.00 Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 5.00 Medicare to Medicare Part A Inpatient Reimbursement 	od under t 49) ïrst year	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 203 203 204 204 205
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 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra 0.00 Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 	od under t 49) ïrst year actions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 207 208
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 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) 4.00 Medicare target amount 5.00 Case-mix adjustment routine cost cap (line 202 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 	od under t 49) irst year ictions) ine 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 102 201 202 203 204 205 206 207 208 207 208 207 208 207 208 207 208 207
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra 0.00 Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 0.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare Part A IPPS payments (from line 21 	od under t 49) irst year ictions) ine 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211 212
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra 0.00 Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 0.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) 0.00 Medicare target amount 0.00 Medicare inpatient routine cost cap (line 202 times line 204) 0.00 Medicare Part A Inpatient Reimbursement 0.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 0.00 Reserved for future use 0.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 	od under t 49) irst year uctions) ine 59) 1)	of the curre	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0 0 crati on	101 102 103 104 200 201 202 203 204 205 206 207 207 208

w vo	LUME CALCULATION EXHIBIT 4			Provider C	-	Period: From 01/01/2017 Fo 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/29/2018 8:50	pare
		W/S E, Part A line 0	Amounts (from <u>E, Part A)</u> 1.00	Title Pre/Post Entitlement 2.00	XVIII Period Prior to 10/01 3.00	Hospital Period On/After 10/01 4.00	PPS Total (Col 2 through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0) (0 0	0	1
D1	payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	0	0) (D	0	1
)2	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	12, 576, 154	0		12, 576, 154	12, 576, 154	1
13	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0) (D	0	1
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1
00	Outlier payments for	2.00	115, 931	0		0 115, 931	115, 931	2
)1	discharges (see instructions) Outlier payments for	2.02	0	0		o o	0	2
00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0		0	0	3
00	reconciliation Managed care simulated payments	3.00	0	0)		0	
	Indirect Medical Education Adju			0.00000				
0	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	0	6
1	IME payment adjustment for managed care (see instructions)	22. 01	0	0		0 0	0	e
~	Indirect Medical Education Adju							
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0.00000	0. 000000		7
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
0	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	ç
00	Disproportionate Share Adjustme Allowable disproportionate	ant 33.00	0. 0483	0. 0483	0.048	0. 0483		10
	share percentage (see instructions)							
00	Disproportionate share adjustment (see instructions)	34.00	151, 857	0) (0 151, 857	151, 857	11
01	Uncompensated care payments	36.00	583, 886		369, 548	3 214, 338	583, 886	11
00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	ເບັbeneficiary ດ	di scharges 0		0 0	0	12
00	(see instructions) Subtotal (see instructions)	47.00	13, 427, 828	0		-	13, 427, 828	
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	13, 427, 828	0	(0	13, 427, 828 0	
00	(see instructions) Total payment for inpatient operating costs (see	49.00	13, 427, 828	0	369, 548	3 13, 058, 280	13, 427, 828	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 092, 561	0) (1, 092, 561	1, 092, 561	16
00	Special add-on payments for new technologies	54.00	1, 036	0		0 1, 036	1, 036	
01 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17 17

	Financial Systems		RI VERVI EW				u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/29/2018 8:5	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.0
10 00	SUBTOTAL			0	369, 54	8 14, 151, 877	14, 521, 425	10 0
17.00	SOBTOTAL	W/S L, line	(Amounts from L)				14, 021, 420	17.00
		0	1.00	2.00	3.00	4,00	5,00	
20.00	Capital DRG other than outlier	1.00	1, 019, 806	0		0 1, 019, 806	1,019,806	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	33, 696	0		0 33, 696	33, 696	21.0
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0383	0. 0383	0. 038	3 0. 0383		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	39, 059	0		0 39, 059	39, 059	25.0
26.00	Total prospective capital payments (see instructions)	12.00	1, 092, 561	0		0 1, 092, 561	1, 092, 561	26. 0
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.00000	0 0.00000		27.0
8. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96				0	0	28.0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. C
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 8:50	pared:
				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	1.01	0		0	0	1. 01
1.02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 02	12, 576, 154		12, 576, 154	12, 576, 154	1. 02
1.03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0		O	0	1.04
2.00	October 1 Outlier payments for discharges (see instructions)	2.00	115, 931		0 115, 931	115, 931	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	21.00	0. 000000	0.0000	0. 000000		5.00
5.00	(see instructions) IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
5.00	IME payment adjustment for managed care (see	22.00	0			0	6.01
5. 0.	instructions)	22101				, , , , , , , , , , , , , , , , , , ,	0.0.
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0. 000000		7.00
3.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
3. 01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. O [^]
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	9.0
10.00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0483	0. 048	0. 0483		10.00
10.00	(see instructions)	33.00	0.0403	0.040	0. 0403		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	151, 857		0 151, 857	151, 857	11.00
11.01	Uncompensated care payments	36.00	583, 886	369, 54	18 214, 338	583, 886	11.0
10.00	Additional payment for high percentage of ESF						10.01
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	13, 427, 828	369, 54	13, 058, 280	13, 427, 828	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 (see instructions)	49.00	13, 427, 828	369, 54	13, 058, 280	13, 427, 828	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 092, 561		0 1, 092, 561	1, 092, 561	16.00
17.00	Special add-on payments for new technologies	54.00	1, 036		0 1,036	1, 036	
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.01 17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
19.00				369, 54	14, 151, 877	14, 521, 425	19 00

	Financial Systems TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	RIVERVIEW	Provider C	N: 15-0059	Period:	eu of Form CMS- Worksheet E	2552-10
				N. 10 0007	From 01/01/2017 To 12/31/2017	Part A Exhibi	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, 019, 806		0 1, 019, 806	1, 019, 806	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	33, 696		0 33, 696	33, 696	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. 0383	0.03	83 0. 0383		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	39, 059		0 39, 059	39, 059	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 092, 561		0 1, 092, 561	1, 092, 561	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		0	0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		C	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	35, 942		0 35, 942	35, 942	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30. 01
31.00		70.94	0		0 0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99			0 C	0	32.00
100.00	Visit de HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems RIVERVIEW HOSPI ATION OF REIMBURSEMENT SETTLEMENT Pr	rovider CCN: 15-0059	Period: From 01/01/2017	u of Form CMS-2 Worksheet E Part B	
			To 12/31/2017	Date/Time Pre 5/29/2018 8:50	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction	nc)		4, 474 16, 075, 005	
00	OPPS payments	115)		13, 848, 396	
00	Outlier payment (see instructions)			95, 704	
01	Outlier reconciliation amount (see instructions)			0	
00 00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	ons)		0. 000 0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		82, 604	
). 00 . 00	Organ acquisitions			0 4, 474	
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			4,474	
	Reasonable charges				
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	40)		11, 402 0	
	Total reasonable charges (sum of lines 12 and 13)	09)		11, 402	
	Customary charges			117102	
5.00	Aggregate amount actually collected from patients liable for pay			0	
6.00	Amounts that would have been realized from patients liable for public outputs that would have been realized from patients liable for public states and such payment been made in accordance with 42 CEP S412 12(a)	ayment for services c	n a chargebasis	0	16. (
. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.0
3.00				11, 402	
9.00	Excess of customary charges over reasonable cost (complete only	ifline 18 exceeds li	ne 11) (see	6, 928	19. (
). 00	instructions) Excess of reasonable cost over customary charges (complete only	ifling 11 overade li	no 19) (coo	0	20. (
0.00	instructions)	IT THE IT exceeds IT	ne io) (see	0	20.1
. 00	Lesser of cost or charges (see instructions)			4, 474	21. (
	Interns and residents (see instructions)			0	
3.00 1.00	Cost of physicians' services in a teaching hospital (see instruc Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tions)		0 14, 026, 704	
F. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			14, 020, 704	24.0
5.00	Deductibles and coinsurance (for CAH, see instructions)			0	
b. 00	Deductibles and Coinsurance relating to amount on line 24 (for C			2, 688, 167	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu: instructions)	s the sum of lines 22	and 23] (See	11, 343, 011	27.0
3. 00	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28. (
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
). 00 . 00	Subtotal (sum of lines 27 through 29) Primary payer payments			11, 343, 011	
	Subtotal (line 30 minus line 31)			2, 513 11, 340, 498	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES))			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
F. 00 5. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			97, 085 63, 105	
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		55, 434	
. 00	Subtotal (see instructions)			11, 403, 603	
	MSP-LCC reconciliation amount from PS&R			-345	
9.00 9.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50 9.97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.
9. 98	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	
9. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 9
0.00	Subtotal (see instructions)			11, 403, 948	
). 01). 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			228, 079 0	
	Interim payments			11, 202, 353	
2.00	Tentative settlement (for contractors use only)			0	
3.00	Balance due provider/program (see instructions)			-26, 484	
1.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44. (
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
00	Original outlier amount (see instructions)			0	90. (
). 00				0	91.0
. 00	Outlier reconciliation adjustment amount (see instructions)			-	1
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. (93. (

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0059	Period: From 01/01/2017 To 12/31/2017		parec
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 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 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)		12, 724, 6	0	11, 031, 544 0	1. (2. (3. (
	Program to Provider					
. 01 . 02 . 03 . 04 . 05	ADJUSTMENTS TO PROVIDER	12/31/2017 07/07/2017	112, 4 31, 7		170, 809 0 0 0 0	3. 3. 3. 3. 3.
	Provider to Program					
. 50 . 51 . 52 . 53 . 54 . 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines		144, 1	0 0 0 0	0 0 0 0 170, 809	3. 3. 3.
99	3. 50-3. 98)		144, 1	00	170, 609	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		12, 868, 7	67	11, 202, 353	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					
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	
03				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0	
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	
00 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		23, 6	07	0	6
01	SETTLEMENT TO PROVIDER		23,0	0	26, 484	6
00	Total Medicare program liability (see instructions)		12, 892, 3	74	11, 175, 869	
			<u> </u>	Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	C)	1.00	2.00	8

IAL Y S	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0059 CCN: 15-T059	Period: From 01/01/201 To 12/31/201		epare
		Title	XVIII	Subprovider - IRF	PPS	
		Inpatien	t Part A		rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Tatal interim normanta naid ta manidan	1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5, 923, 0	0	C	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	C	3.
02	ADJUSTINENTS TO TROVIDER			0		
)3				0		
)4				0	C) 3
)5				0	C) 3
	Provider to Program		[
50 51	ADJUSTMENTS TO PROGRAM			0		
52				0		-
53				0		-
54				0		
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	C	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)		5, 923, 0	07	C	4
	TO BE COMPLETED BY CONTRACTOR		<u> </u>			
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	C	5 5
)2				0	C) 5
)3				0	C) 5
	Provider to Program					
50 51	TENTATI VE TO PROGRAM			0		
52				0		
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	C	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER			0	C	
02	SETTLEMENT TO PROGRAM		16, 1		C	
00	Total Medicare program liability (see instructions)		5, 906, 8		C) 7
				Contractor	NPR Date (Mo/Day/Yr)	
				Number	(MO/Day/YF)	

VALTS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent	CN: 15-0059 CCN: 15-5669	Period: From 01/01/201 To 12/31/201		epared
		Title	e XVIII	Skilled Nursin Facility		o pii
		Inpatien	it Part A		nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Tatal interim nerments naid to marridon	1.00	2.00 1,611,6	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		, i, oii, o	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		1	0	0	3.
02				0	0	
03				0	0	3.
04				0	0	
)5				0	0) 3
50	Provider to Program ADJUSTMENTS TO PROGRAM		1	0	0	3
50 51	ADJUSTIMENTS TO PROGRAM			0	0	
52				0	0	-
53				0	0	
54				0	0	3 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, 611, 6	95	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
)3				0	0) 5
- 0	Provider to Program					
50 51	TENTATI VE TO PROGRAM			0	0	
52				0		
99	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		9, 0	88	0	
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		1, 620, 7		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	

From 01/01/2017 Part To 12/31/2017 Date Title XVIII Hospital	prksheet E-1 art II ate/Time Prepared: /29/2018 8:50 pm PPS
	PPS
	1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

	Financial Systems RIVE	RVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552- <u>1</u> 0
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prep	pared:
		Title XVIII	Subprovider -	5/29/2018 8:50 PPS	u piii
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1.00	Net Federal PPS Payment (see instructions)			5, 990, 415	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0127	
3.00	Inpatient Rehabilitation LIP Payments (see instruction	ons)		93, 450	
4.00	Outlier Payments			55, 224	
5.00	Unweighted intern and resident FTE count in the most to November 15, 2004 (see instructions)		0 1	0.00	
5.01	Cap increases for the unweighted intern and resident program or hospital closure, that would not be counte CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instruction	ed without a temporary cap adjus		0.00	5.0
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding teaching program" (see instructions)			0.00	
8.00	Current year's unweighted I&R FTE count for residents teaching program" (see instructions)	1 3 3		0.00	
9.00	Intern and resident count for IRF PPS medical educati	on adjustment (see instructions	5)	0.00	
10.00	Average Daily Census (see instructions)			15. 460274 0. 000000	
11.00 12.00	Teaching Adjustment Factor (see instructions) Teaching Adjustment (see instructions)			0.000000	12.0
13.00	Total PPS Payment (see instructions)			6, 139, 089	
14.00	Nursing and Allied Health Managed Care payments (see	instruction)		0, 139, 009	
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.00
16.00	Cost of physicians' services in a teaching hospital ((see instructions)		0	16.00
17.00	Subtotal (see instructions)			6, 139, 089	17.0
18.00	Primary payer payments				18.0
19. 00	Subtotal (line 17 less line 18).			6, 139, 089	
20.00	Deducti bl es			92, 080	
21.00	Subtotal (line 19 minus line 20)			6, 047, 009	
22.00 23.00	Coinsurance			24,675	
23.00	Subtotal (line 21 minus line 22) Allowable bad debts (exclude bad debts for profession	al services) (see instructions)		6, 022, 334 0	
25.00	Adjusted reimbursable bad debts (see instructions)			0	
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	
27.00	Subtotal (sum of lines 23 and 25)			6, 022, 334	
28.00	Direct graduate medical education payments (from Wkst	. E-4, line 49)		0	
29.00	Other pass through costs (see instructions)			5, 048	29.0
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
31.50	Pioneer ACO demonstration payment adjustment (see ins			0	
31.99	Demonstration payment adjustment amount before seques			0	
32.00	Total amount payable to the provider (see instruction	IS <i>)</i>		6, 027, 382	
32. 01 32. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequest	ration		120, 548 0	
33.002	Interim payments			5, 923, 007	
34.00	Tentative settlement (for contractor use only)			0, 723, 007	1
35.00	Balance due provider/program (line 32 minus lines 32.	01, 32.02, 33, and 34)		-16, 173	
36.00	Protested amounts (nonallowable cost report items) ir §115.2		chapter 1,	28, 243	
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line	2 4		55, 224	50.00
50.00					
50.00 51.00 52.00	Outlier reconciliation adjustment amount (see instruc The rate used to calculate the Time Value of Money	ctions)		0	51.00 52.00

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-5669	Period: From 01/01/2017 To 12/31/2017		pared:
		Title XVIII	Skilled Nursing Facility	PPS	<u>o piii</u>
				1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTL	EMEMENT - ALL OTHER HEALTH SERVICES FOR	TITLE XVIII PART A	A PPS SNF	
	SERVICES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)			1, 808, 264	
2.00	Routine service other pass through costs			0	2.00
3.00	Ancillary service other pass through costs			9, 274	
4.00	Subtotal (sum of lines 1 through 3)			1, 817, 538	4.00
F 00	COMPUTATION OF NET COST OF COVERED SERVICES Medical and other services (Do not use this	line op vogeine opete one included in li	no 1 of W/C F		E OC
5.00	Part B. This line is now shaded.)	The as vaccine costs are included in II	THE I OT W/SE,		5.00
6.00	Deductible			0	6.00
7.00	Coinsurance			163, 678	
8.00	Allowable bad debts (see instructions)			0	
9.00	Reimbursable bad debts for dual eligible ber	eficiaries (see instructions)		0	
10.00	Adjusted reimbursable bad debts (see instruc			0	
11.00	Utilization review			0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 ar	d 7, plus lines 10 and 11)(see instructi	ons)	1, 653, 860	12.00
13.00	Inpatient primary payer payments		,	0	
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF	Y)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment	(see instructions)		0	
14.99	Demonstration payment adjustment amount befo	re sequestration		0	14.99
	Subtotal (see instructions			1, 653, 860	
	Sequestration adjustment (see instructions)			33, 077	
15. 02	Demonstration payment adjustment amount after	r sequestration		0	
	Interim payments			1, 611, 695	
	Tentative settlement (for contractor use onl			0	
	Balance due provider/program (line 15 minus				18.00
19.00	Protested amounts (nonallowable cost report §115.2	items) in accordance with CMS 19 Pub. 1	5-2, chapter 1,	0	19.00

	Financial Systems RIVERVIEW HOST ATION OF REIMBURSEMENT SETTLEMENT	PITAL Provider CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUL	ATTON OF REFWOORSEWENT SETTLEWENT		From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre 5/29/2018 8:50	pared
		Title XIX	Hospi tal	Cost	u piii
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X	I X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
. 00	Inpatient hospital/SNF/NF services		661, 197		1.0
. 00	Medical and other services			0	
. 00	Organ acquisition (certified transplant centers only)		0		3.0
. 00	Subtotal (sum of lines 1, 2 and 3)		661, 197	0	
. 00 . 00	Inpatient primary payer payments Outpatient primary payer payments		0	0	5.0
. 00	Subtotal (line 4 less sum of lines 5 and 6)		661, 197	0	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES		001, 177	0	, · ·
	Reasonable Charges				1
. 00	Routine service charges		442, 937		8.0
. 00	Ancillary service charges		923, 084	0	9. (
0. 00	Organ acquisition charges, net of revenue		0		10.
1. 00	Incentive from target amount computation		0		11.
2.00	Total reasonable charges (sum of lines 8 through 11)		1, 366, 021	0	12.
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.
1 00	basis	normant for convious		0	11
4.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		in O	0	14.
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CIR 9413. 13(e)	0, 000000	0.000000	15
6.00	Total customary charges (see instructions)		1, 366, 021	0.000000	
7.00	Excess of customary charges over reasonable cost (complete onl)	vifline 16 exceeds	704, 824	0	
	line 4) (see instructions)				
8.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lir	ie 0	0	18.
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	
0.00	Cost of physicians' services in a teaching hospital (see instr		0	0	
1. 00	Cost of covered services (enter the lesser of line 4 or line 1		661, 197	0	21.
2 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be a	completed for PPS provi		0	1 22
2.00 3.00	Other than outlier payments Outlier payments		0	0	
4.00	Program capital payments		0	0	23.
5.00	Capital exception payments (see instructions)		0		25.
6.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
8. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.
9.00	Titles V or XIX (sum of lines 21 and 27)		661, 197	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		r		
0.00	Excess of reasonable cost (from line 18)		0	0	
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		661, 197	0	
2.00	Deductibles		0	0	
3.00	Coinsurance		0	0	
4.00	Allowable bad debts (see instructions)		0	0	
5.00 6.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	22)	661, 197	0	35. 36.
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	557	001, 197	0	
8.00	Subtotal (line 36 ± line 37)		661, 197	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		001,177	0	39.
0.00	Total amount payable to the provider (sum of lines 38 and 39)		661, 197	0	
1.00	Interim payments		442, 766	0	41.
2.00	Balance due provider/program (line 40 minus line 41)		218, 431	0	
3.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				1

al th	ATION OF REIMBURSEMENT SETTLEMENT	V HOSPITAL Provider CCN: 15-0059	Peri od:	Worksheet E-3	2552
		Component CCN: 15-T059	From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre 5/29/2018 8:5	pare
		Title XIX	Subprovider -	Cost	<u>u pi</u>
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH COMPUTATION OF NET COST OF COVERED SERVICES	1 SERVICES FOR TITLES V OR X	IX SERVICES		-
00	Inpatient hospital/SNF/NF services		64, 514		1 1
00	Medical and other services		01,011	0	
00	Organ acquisition (certified transplant centers only)		0	-	
00	Subtotal (sum of lines 1, 2 and 3)		64, 514	0	4
00	Inpatient primary payer payments		0		1
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		64, 514	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
00	Reasonabl e Charges Routi ne servi ce charges		90, 149		8
00	Ancillary service charges		63, 323	0	
. 00	Organ acquisition charges, net of revenue		03, 323	0	1
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		153, 472	0	
	CUSTOMARY CHARGES				
8.00	Amount actually collected from patients liable for paymen	t for services on a charge	0	0	1:
	basi s			_	
. 00	Amounts that would have been realized from patients liable	1 5	n 0	0	14
00	a charge basis had such payment been made in accordance wi Ratio of line 13 to line 14 (not to exceed 1.000000)	ith 42 CFR §413.13(e)	0,000000	0.000000	1
. 00 . 00	Total customary charges (see instructions)		0. 000000 153, 472	0.000000	
. 00	Excess of customary charges over reasonable cost (complete	e only if line 16 exceeds	88, 958	0	
. 00	line 4) (see instructions)	e only if the to exceeds	00, 700	0	l '
3. 00	Excess of reasonable cost over customary charges (complete	e only if line 4 exceeds lin	e 0	0	18
	16) (see instructions)	-			
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see i		0 64, 514	0	
. 00	0 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide			0	2'
00		y be completed for PPS provi		0	1 -
. 00 . 00	Other than outlier payments Outlier payments		0	0	
. 00	Program capital payments		0	0	2
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services onl	l y)	0	0	2
. 00	Titles V or XIX (sum of lines 21 and 27)		64, 514	0	2
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	
. 00		nd 6)	64, 514	0	
	Deducti bl es		0	0	-
. 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00 . 00	Utilization review		0	0	3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	2 and 33)	64, 514	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 00	Subtotal (line 36 ± line 37)			0	
. 00	Direct graduate medical education payments (from Wkst. E-4	4)	64, 514 0	-	3
. 00	Total amount payable to the provider (sum of lines 38 and		64, 514	0	4(
. 00	Interim payments		26, 410	0	4
. 00	Balance due provider/program (line 40 minus line 41)		38, 104	0	
3.00		ordance with CMS Pub 15-2,		0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0059	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	
		General Fund	Specific Purpose Fund	Endowment Fund	5/29/2018 8:5 Plant Fund	50 pm
		1.00	2.00	3.00	4.00	-
00	CURRENT ASSETS Cash on hand in banks	11, 618, 039		0 0		0 1.
00	Temporary investments	011, 010, 037				
00	Notes receivable	0		0 0		
00	Accounts receivable	38, 097, 899		0 0	o o	4.
00	Other receivable	574, 442		0 0	0 0	
00	Allowances for uncollectible notes and accounts receivable	0		0 0	0 0	
00	Inventory	4, 187, 488		0 0		
00 00	Prepaid expenses Other current assets	17 002 202				
. 00	Due from other funds	17, 883, 382				
. 00	Total current assets (sum of lines 1-10)	72, 361, 250				
. 00	FIXED ASSETS	72, 301, 230			<u></u>	4
. 00	Land	15, 961, 384		0 0	0 0	12.
. 00	Land improvements	2, 892, 112		0 0	o o) 13.
. 00	Accumulated depreciation	-3, 735, 678		0 0	0 0) 14.
	Bui I di ngs	101, 109, 834		0 0	0 0	
	Accumulated depreciation	-61, 411, 615		0 0		
. 00	Leasehold improvements	1, 391, 274		0 0		
. 00	Accumulated depreciation	0		0 0		
. 00 . 00	Fixed equipment Accumulated depreciation	76, 121, 992 -31, 039, 674				
	Automobiles and trucks	-31, 039, 074				
	Accumulated depreciation	0		0 0		
	Major movable equipment	97, 448, 063		0 0		
	Accumulated depreciation	-57, 276, 559		0 0	0	24
. 00	Minor equipment depreciable	0		0 0	0 0	25
. 00	Accumulated depreciation	0		0 0	0 0	
	HIT designated Assets	0		0 0	0 0	
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0		
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	141, 461, 133		0 0	0 0	30
. 00	Investments	57, 999, 760		0 0	0 0	31
. 00	Deposits on Leases	0		0 0		
. 00	Due from owners/officers	2, 153, 069		0 0	o o	33
. 00	Other assets	8, 487, 531		0 0	o o	34
. 00	Total other assets (sum of lines 31-34)	68, 640, 360		0 0	0 0	35
. 00	Total assets (sum of lines 11, 30, and 35)	282, 462, 743		0 0	0 0	<u>)</u> 36
	CURRENT LI ABI LI TI ES		1	- 1		4
	Accounts payable	9, 912, 591		0 0		
. 00	Salaries, wages, and fees payable	10, 157, 618				
. 00 . 00	Payroll taxes payable Notes and Loans payable (short term)	0 5, 073, 393		0 0		
	Deferred income	5,075,375				
. 00	Accel erated payments	0		0	Ĩ	42
. 00	Due to other funds	0		0 0	o o	
. 00	Other current liabilities	65, 715, 786		0 0	o o	44
. 00	Total current liabilities (sum of lines 37 thru 44)	90, 859, 388		0 0	0 0) 45
	LONG TERM LIABILITIES					
. 00	Mortgage payable	0		0 0		
. 00	Notes payable Unsecured Loans	46, 331, 134		0 0	°	
. 00 . 00	Other long term liabilities	832, 307				
. 00	Total long term liabilities (sum of lines 46 thru 49)	47, 163, 441		0 0	-	
	Total liabilities (sum of lines 45 and 50)	138, 022, 829		0 0		
	CAPITAL ACCOUNTS		1	-		
. 00	General fund balance	144, 439, 914				52
00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted			0	ע ע	54
. 00	Donor created - endowment fund balance - unrestricted			0	2	55
. 00	Governing body created - endowment fund balance			0	1	56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	144, 439, 914		0 0	ol o	59
. 00						

Heal th	Financial Systems	RI VERVI EW H	OSPI TAL			In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-0059		iod: m 01/01/2017 12/31/2017	Worksheet G- Date/Time Pre 5/29/2018 8:5	epared:
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	I
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	135, 827, 457 8, 612, 456 144, 439, 913 144, 439, 914 144, 439, 914 0			0 0 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		144, 439, 914			0		19.00
		Endowment Fund	PI ant	Fund			1	
		6.00	7.00	8.00				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0	0 0 0 0 0 0 0		0 0 0 0			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$
13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0		0 0			13.00 14.00 15.00 16.00 17.00 18.00 19.00

MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0059	Peri od:	Worksheet G-2	
			From 01/01/2017 To 12/31/2017	Parts I & II Date/Time Pre 5/29/2018 8:5	
Cost Center Description		I npati ent	Outpati ent	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					-
General Inpatient Routine Services					
Hospi tal		25, 379, 40)2	25, 379, 402	
SUBPROVIDER - IPF				/ 0F/ 7F0	2.0
SUBPROVI DER – I RF SUBPROVI DER		6, 056, 75	8	6, 056, 758	3.0
Swing bed - SNF			0	0	
Swing bed - NF			0	0	1
SKILLED NURSING FACILITY		2, 328, 87	76	2, 328, 876	
NURSING FACILITY		2, 020, 0,	0	2, 020, 070	8.0
OTHER LONG TERM CARE					9.0
Total general inpatient care services (sum of lines 1-9)		33, 765, 03	36	33, 765, 036	
Intensive Care Type Inpatient Hospital Services		1	- <u> </u>		
INTENSIVE CARE UNIT		5, 601, 34	4	5, 601, 344	11. C
CORONARY CARE UNIT					12.0
BURN INTENSIVE CARE UNIT					13.0
SURGICAL INTENSIVE CARE UNIT					14.0
OTHER SPECIAL CARE (SPECIFY)					15. (
Total intensive care type inpatient hospital services (s	um of lines	5, 601, 34	4	5, 601, 344	16.0
11-15)					
Total inpatient routine care services (sum of lines 10 a	nd 16)	39, 366, 38		39, 366, 380	
Ancillary services		105, 282, 69		316, 091, 850	
0 Outpatient services		4, 121, 48		41, 164, 239	
RURAL HEALTH CLINIC			0 0	0	
FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.
AMBULANCE SERVICES			0	0	
CMHC			0	0	24.0
AMBULATORY SURGICAL CENTER (D. P.)					25.
HOSPICE					26.
PHYSI CANS' PRI VATE OFFI CES			0 44, 101, 076	44, 101, 076	
CLINICS			0 1, 326, 706	1, 326, 706	27.0
PHYSICIAN PROFESSIONAL FEES			0 8, 003, 362	8, 003, 362	27.
DIABETIC EDUCATION		33, 32	5, 030	38, 355	27.
Total patient revenues (sum of lines 17-27)(transfer col	umn 3 to Wkst.	148, 803, 88	301, 288, 087	450, 091, 968	28.
G-3, line 1)					
PART II - OPERATING EXPENSES		1	400 000 505		
Operating expenses (per Wkst. A, column 3, line 200)			192, 389, 535		29.
ADD (SPECIFY)			0		30. 31.
			0		31.
			0		33.
			0		34.
			0		35.
Total additions (sum of lines 30-35)			0		36.
DEDUCT (SPECIFY)			0		37.
			0		38.
			0		39.
			0		40.
			0		41.
Total deductions (sum of lines 37-41)			0		42.
Total operating expenses (sum of lines 29 and 36 minus I	ine 42)(transfer		192, 389, 535		43.
to Wkst. G-3, line 4)					1

STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0059 Period: Tom 01/01/2017 To 12/31/2017 Worksheet G-3 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1.00 1.00 1.00 2.00 Less contractual allowances and discounts on patients' accounts 270, 403, 697 2.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 179, 688, 271 3.00 4.00 Less contractual allowances and discounts on patients' accounts 179, 688, 271 3.00 0.01 Less total operating expenses (from Wkst. G-2, Part II, line 43) 192, 389, 535 4.00 0.00 Income from investments 0 6.00 6.00 6.00 6.989, 006 7.00 0.00 Parenues from tileybone and other miscellaneous communication services 0 6.00 0 10.00 0.00 Purchase discounts 0 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 12.00 1	Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
To 12/31/2017 Date/Time Prepared: 5/29/2018 8:50 pm 1.00 1.00 1.00 1.00 2.00 Less contractual allowances and discounts on patients' accounts 450.091.968 1.00 2.00 Less contractual allowances and discounts on patients' accounts 270,403.697 2.00 3.00 Net patient revenues (line 1 minus line 2) 179,688.271 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 192.389,535 4.00 0.01 Income from service to patients (line 3 minus line 4) -12.701,264 5.00 0.01 Income from investments 0 6.00 0.00 0.00 Purchase discounts 0 6.00 0 6.00 0	STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0059		Worksheet G-3	
5/29/2018 8:50 pm 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 450,091,968 1.00 3.00 Net patient revenues (line 1 minus line 2) 179,688,271 3.00 450,091,968 179,688,271 3.00 5.00 Net patient revenues (line 1 minus line 2) 179,688,271 3.00 5.00 Net income from service to patients (line 3 minus line 4) -12,701,264 5.00 0THER INCOME 6.00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 6.898,006 7.00 8.00 8.00 Revenue from telephone and other miscellaneous communication services 0 9.00 9.00 Revenue from telephone and other miscellaneous communication services 0 9.00 10.00 Revenue from telephone and guests 0 11.00 12.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 11.00 Revenue from laundry and linen service 0 13.00 14.00 12.00 Revenue from sale of medical exponses 0					Dato/Timo Pro	narod
1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)450,091,9681.002.00Less contractual al lowances and discounts on patients' accounts270,403,6972.003.00Net patient revenues (line 1 minus line 2)179,688,2713.004.00Less total operating expenses (from Wkst. G-2, Part II, line 43)192,389,5354.000.00Net income from service to patients (line 3 minus line 4)-12,701,2645.000.00Contributions, donations, bequests, etc06.006.000.00Revenues from television and radio service06.008.000.00Purchase discounts09.0000.01Revenue from television and radio service09.000.00Purchase discounts011.001.00Revenue from rental of Living quarters011.001.00Revenue from rental of Living quarters013.001.00Revenue from sale of medical and surgical supplies to other than patients014.001.00Revenue from sale of medical necords and abstracts018.001.00Revenue from sale of medical necords and abstracts012.001.00Revenue from gifts, flowers, coffee shops, and canteen022.002.00Revenue from gifts, flowers, coffee shops, and canteen022.002.00Revenue from sale of medical necords and abstracts013.022.00Revenue from gifts, flowers, coffee shops, and canteen022.00				10 12/31/2017	5/29/2018 8:5	0 pm
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18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 NON-OPERATING REVENUE AND EXPENSE 884, 438 24.00 24.01 OTHER OPERATING REVENUE 13, 531, 276 24.01 25.00 Total other income (sum of lines 6-24) 21, 313, 720 25.00 26.00 Total (line 5 plus line 25) 8, 612, 456 26.00 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						
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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 884, 438 24.00 24.01 OTHER OPERATING REVENUE 13, 531, 276 24.01 25.00 Total other income (sum of lines 6-24) 25.00 25.00 26.00 Total (line 5 plus line 25) 8, 612, 456 26.00 27.00 PROFESSIONAL FEES 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						
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 884, 438 24.00 24.01 OTHER OPERATING REVENUE 13, 531, 276 24.01 25.00 Total other income (sum of lines 6-24) 21, 313, 720 25.00 26.00 Total (line 5 plus line 25) 8, 612, 456 26.00 27.00 PROFESSI ONAL FEES 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						
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23.00 Governmental appropriations 0 23.00 24.00 NON-OPERATING REVENUE AND EXPENSE 884,438 24.00 24.01 OTHER OPERATING REVENUE 13,531,276 24.01 25.00 Total other income (sum of lines 6-24) 13,531,276 24.01 26.00 Total (line 5 plus line 25) 8,612,456 26.00 27.00 PROFESSIONAL FEES 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00					-	
24.00 NON-OPERATING REVENUE AND EXPENSE 884,438 24.00 24.01 OTHER OPERATING REVENUE 13,531,276 24.01 25.00 Total other income (sum of lines 6-24) 21,313,720 25.00 26.00 Total (line 5 plus line 25) 8,612,456 26.00 27.00 PROFESSIONAL FEES 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						
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27.00 PROFESSIONAL FEES 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						
28.00Total other expenses (sum of line 27 and subscripts)028.00						
			ints)			
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AL CITE	Financial Systems RIV ATION OF CAPITAL PAYMENT	VERVIEW HOSPITAL Provider CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet L	2002-
NLCOL			From 01/01/2017 To 12/31/2017	Parts I-III	
		Title XVIII	Hospi tal	PPS	o pin
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				-
00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			1 010 00/	1 1.
00				1, 019, 806	1
01	Model 4 BPCI Capital DRG other than outlier			Ű	
00	Capital DRG outlier payments			33, 696	
01	Model 4 BPCI Capital DRG outlier payments			0	
00	Total inpatient days divided by number of days in the	he cost reporting period (see ins	structions)	41.58	
00	Number of interns & residents (see instructions)			0.00	
00	Indirect medical education percentage (see instruct			0.00	
00	Indirect medical education adjustment (multiply line 1.01) (see instructions)	5		0	6
00	Percentage of SSI recipient patient days to Medicard 30) (see instructions)		E, part A line	2.43	
00	Percentage of Medicaid patient days to total days (see instructions)		16. 15	
00	Sum of lines 7 and 8			18. 58	
. 00	Allowable disproportionate share percentage (see in:	structions)		3.83	10
. 00	Disproportionate share adjustment (see instructions))		39, 059	11
. 00	Total prospective capital payments (see instruction	s)		1, 092, 561	12
				1.00	<u> </u>
				1.00	
00	PART II - PAYMENT UNDER REASONABLE COST	tiana)		0	1 1
00	Program inpatient routine capital cost (see instruct			-	
00	Program inpatient ancillary capital cost (see instru-			0	-
00	Total inpatient program capital cost (line 1 plus li	ine 2)		0	-
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line	4)		0	5
				1.00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			-	1.
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary c			0	
00	Net program inpatient capital costs (line 1 minus li	ine 2)		0	-
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x li			0	
00	Percentage adjustment for extraordinary circumstance			0.00	
00	Adjustment to capital minimum payment level for ext	raordinary circumstances (line 2	x line 6)	0	
00	Capital minimum payment level (line 5 plus line 7)			0	-
00	Current year capital payments (from Part I, line 12)			0	
. 00			,	0	
. 00	Carryover of accumulated capital minimum payment le Worksheet L, Part III, line 14)	vel over capital payment (from pr	ior year	0	11.
	Net comparison of capital minimum payment level to			0	12
8. 00	Current year exception payment (if line 12 is posit	ive, enter the amount on this lir	ne)	0	13
	Carryover of accumulated capital minimum payment le			0	14
. 00	(if line 12 is negative, enter the amount on this l		51		
1.00	(IT THE IZ IS NEGATIVE, ENTED THE AMOUNT OF THIS I				
	Current year allowable operating and capital payment			0	15
. 00		t (see instructions)		0	