This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0059 Worksheet S Peri od: From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: 5/28/2019 1: 23 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/28/2019 1:23 pm use only Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERVIEW HOSPITAL (15-0059) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	9
Date	

			Title XVIII				
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	-55, 828	-44, 157	0	-76, 990	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	-390	0		0	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	6, 017	0		0	7.00
200.00	Total	0	-50, 201	-44, 157	0	-76, 990	200.00

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

Health Financial Systems RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0059 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 1:23 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 395 WESTFIELD ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: NOBLESVILLE Zi p Code: 46060-County: HAMILTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal RIVERVIEW HOSPITAL 150059 26900 07/07/1966 Ν 0 3.00 1 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF RIVERVIEW HOSPITAL 15T059 26900 5 01/01/1994 N Ρ 0 5.00 REHAB 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF RIVERVIEW HOSPITAL SNF 155669 26900 10/26/1999 Ρ Ν 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 9 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost

reporting period different from the method used in the pirol cost							
reporting period? In column 2, enter "Y" for yes or	"N" for no).					
	In-State	In-State	Out-of	Out-of	Medi cai	d Other	
	Medi cai d	Medi cai d	State	State	HMO day	s Medicaid	
	pai d days	eligible	Medi cai d	Medi cai d		days	
	'	unpai d	paid days	el i gi bl e			
		days		unpai d			
	1.00	2.00	3.00	4. 00	5. 00	6.00	
24.00 If this provider is an IPPS hospital, enter the	320	1, 093	0	0	1, 0	24 0	24.00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							
		-	•		-	•	-

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provi der	CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/28/2019 1:2	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3.00	4. 00	5. 00	
 .00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) .01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 				0.00	0. 00	61.0
.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)05 Enter the difference between the baseline primary						61.0
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) .06 Enter the amount of ACA §5503 award that is being						61.0
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						01.0
	Pro	ogram Name	Program Coo	le Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
10 00 11 575 1 11 11 11 15		1. 00	2. 00	3.00	4. 00	
.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				0.00	0.00	61.1
FTE unweighted count. 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	61.2
					1. 00	
ACA Provisions Affecting the Health Resources and Ser .00 Enter the number of FTE residents that your hospital				eriod for which		62.0
your hospital received HRSA PCRE funding (see instruction). Old Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC process.	ctions) a Teachi	ng Health Co	enter (THC) in			62.0
Teaching Hospitals that Claim Residents in Nonprovide. 00 Has your facility trained residents in nonprovider se			cost reportin	a period? Enter	N	63.0
"Y" for yes or "N" for no in column 1. If yes, comple				tructions)	Ratio (col.	33.0
			FTEs Nonprovi de	FTEs in	1/ (col . 1 + col . 2))	

0.00

0.00

0.000000 64.00

period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care

resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

	1. 00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovid	er? N			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the mo	st		0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (s	ee			
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting peri	od.			
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	Y			75.00
subprovider? Enter "Y" for yes and "N" for no.				

alth Financial Systems RIVERVIEW HO		Peri od:		of Form		
SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0059		2018 2018	Worksheet S-2 Part I Date/Time Pre 5/28/2019 1:2		pare
			1. 00	2. 00	3. 00	1
OD If line 75 is yes: Column 1: Did the facility have an approve recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teac CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. indicate which program year began during this cost reporting	, 2004? Enter "Y" for yes ching program in accordar Column 3: If column 2 is	or "N" for ace with 42 ; Y,	N N	2.00	0	76.
				1. 0	0	
Long Term Care Hospital PPS OO Is this a long term care hospital (LTCH)? Enter "Y" for yes OO Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no. TEEDA Providers.		ng period? E	inter	N N		80. 81.
TEFRA Providers OU Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) OU Did this facility establish a new Other subprovider (excluder §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N		85. 86.
00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified under section	n		N		87.
[1000(d)/(1)/(d)/(1)/(2)/(d)/(1000(d)/(1)/(d)/(d)/(d)/(d)/(d)/(d)/(d)/(d)/(d)/(d		V 1.00		XI > 2. 0		
Title V and XIX Services OD Does this facility have title V and/or XIX inpatient hospital	I services? Enter "Y" for	· N		Υ		90.
yes or "N" for no in the applicable column. 100 Is this hospital reimbursed for title V and/or XIX through the		N		Υ		91.
full or in part? Enter "Y" for yes or "N" for no in the appl 00 Are title XIX NF patients occupying title XVIII SNF beds (duing transport of the particulations) Enter "Y" for you or "N" for no in the applications.	al certification)? (see			N		92
instructions) Enter "Y" for yes or "N" for no in the applical Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		. N		N		93
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for no in the	N		N		94
00 If line 94 is "Y", enter the reduction percentage in the appl 00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.		0. 00 N		0. 0 N		95 96
00 If line 96 is "Y", enter the reduction percentage in the appl 00 Does title V or XIX follow Medicare (title XVIII) for the in- stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	terns and residents post	0. 00 Y		0. 0 Y		97 98
O1 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Υ		98
O2 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.		Y		Υ		98
O3 Does title V or XIX follow Medicare (title XVIII) for a criticely mbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N		98
O4 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.		N ad		N		98
O5 Does title V or XIX follow Medicare (title XVIII) and add bar Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Υ		98
column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost of Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. Rural Providers		Y		Y		98
5.00 Does this hospital qualify as a CAH? 5.00 If this facility qualifies as a CAH, has it elected the all-	inclusive method of payme	N ent N				105 106
for outpatient services? (see instructions) 7.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	reimbursement for I&R 1. (see instructions) If	N				107
reimbursed. If yes complete Wkst. D-2, Pt. II. 3.00 s this a rural hospital qualifying for an exception to the						108

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provider CCN	l: 15-0059	From O		w of Form CMS Worksheet S- Part I Date/Time Pr 5/28/2019 1:	-2 repared:
						3/20/2019 1.	Z3 piii
					1. 00	2. 00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1.	If yes, and home	office co		Y		140.00
1.00		2. 00			3. 00		
If this facility is part of a cha			gh 143 th	ne name ar	nd address	of the home	
office and enter the home office			0	Ni			141 00
41. 00 Name: 42. 00 Street:	Contractor's Name: PO Box:		Contra	actor's Nu	imber:		141. 00
43. 00 Ci ty:	State:		Zip Co	ode:			143.00
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
						1. 00	
44.00 Are provider based physicians' co	sts included in Workshe	et A?				Y	144. 0
					1. 00	2.00	_
45.00 f costs for renal services are c	laimed on Wkst A line	7/ are the costs	for		Y	2.00	145.00
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i	" for yes or "N" for no clude Medicare utilizat for no in column 2. gy changed from the pre	in column 1. If coion for this cost viously filed cost	olumn 1 i reporting report?	1	N		146. 00
yes, enter the approval date (mm/		b. 13-2, Chapter 4	0, 34020)	''			
				1			
						1. 00	
47.00 Was there a change in the statist		,				N	147. 0
48.00 Was there a change in the order o				6		N	148.0
49.00 Was there a change to the simplif	ied cost finding method				itle V	N Title XIX	149. 0
		Part A 1,00	Part E 2.00	3 1	3.00	4.00	\dashv
Does this facility contain a prov	ider that qualifies for			ication (
or charges? Enter "Y" for yes or							
55. 00 Hospi tal		N	N		N	N	155. 0
56.00 Subprovi der - IPF		N	N		N	N	156. 0
57.00 Subprovi der – IRF		N	N		N	N	157. 0
58. OO SUBPROVI DER 59. OO SNF		N	NI.		N	N.	158. 0 159. 0
60.00HOME HEALTH AGENCY		N N	N N		N N	N N	160. 0
61. OOCMHC		I IV	N	ł	N	N N	161. 0
OT. OO CHALLO			14			14	101.0
						1.00	
Mul ti campus							
65.00 Is this hospital part of a Multic	ampus hospital that has	one or more campu	ses in di	fferent (BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4.00	5. 00	\dashv
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)							00166.0
						1.00	
Health Information Technology (HI	T) incentive in the Amo	rican Recovery and	Reinvest	tment Act		1. 00	
67.00 s this provider a meaningful use 68.00 f this provider is a CAH (line 1	r under §1886(n)? Ente	r "Y" for yes or "	N" for no).	er the	Y	167. 00 0168. 00
reasonable cost incurred for the							
68.01 If this provider is a CAH and is					dshi p		168. 0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y") a				enter the	9. 9	99169. 00
	/						
transition factor. (See Fistracti				Be	gi nni ng	Endi ng	
transition ractor. (see mistracti				Ве	gi nni ng 1. 00	Endi ng 2. 00	

Health Financial Systems	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DATA		Peri od: From 01/01/2018	Worksheet S-2 Part I)
			To 12/31/2018	Date/Time Pre	
				5/28/2019 1: 2	23 pm
			1. 00	2.00	
171.00 If line 167 is "Y", does this pr	rovider have any days for indiv	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans					
"Y" for yes and "N" for no in co	n				
1876 Medicare days in column 2.	(see instructions)				

	Financial Systems RIVERVIEW AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN. 1E 00E0		u of Form CMS	
HUSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pr	epared:
				Y/N	5/28/2019 1: Date	23 pm
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter I mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO ro	esponses. Ent	er all dates in	the	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in		i nstructi ons			1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in column ter		1. 00 N	2.00	3. 00	2. 00
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
	Total Colonia in por (odd Thota dott ond)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer- Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date available.	for Compiled,	N			4.00
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference on the filed financial statements? If yes, submit re-		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If was is t	he provider i	s N		6.00
0. 00	the legal operator of the program?	3	ne provider i	3 11		
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	N N		7. 00 8. 00		
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9. 00
10. 00 11. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than			N N		10.00
	Teaching Program on Worksheet A? If yes, see instructions.	T W TH WIT AP			Y/N	11.00
					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s soo instruc	tions		N	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N	13.00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14. 00
15. 00	Did total beds available change from the prior cost report	Par	t A	Par	t B	15.00
		Y/N 1.00	2. 00	Y/N 3. 00	<u>Date</u> 4. 00	
	PS&R Data	1.00	2.00	3.00	4.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/27/2019	Y	03/27/2019	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

lealth Financial Systems RIVERVIEW I				u of Form CMS-				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-0059	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/28/2019 1:2	epared:			
		i pti on	Y/N	Y/N				
20 00 lf line 1/ or 17 is yes were adjustments made to DCOD		0	1. 00 N	3.00	20.00			
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	N	20.00			
Report data for other. Beserve the other day astmortes.	Y/N	Date	Y/N	Date				
	1.00	2.00	3.00	4. 00				
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00			
				1. 00	-			
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPLTALS)		1.00				
Capital Related Cost	THE STATE OF THE S	11001 1 11120)			1			
22.00 Have assets been relifed for Medicare purposes? If yes, see					22.00			
23.00 Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ring the cost		23.00			
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered	ed into during	this cost re	eporting period?		24.00			
If yes, see instructions 25.00 Have there been new capitalized leases entered into during	the cost repo	orting period	? If yes, see		25. 00			
instructions. 26.00 Were assets subject to Sec.2314 of DEFRA acquired during th	ne cost report	ing period?	If yes, see		26.00			
instructions. 27.00 Has the provider's capitalization policy changed during the	e cost reporti	ng period? I	f yes, submit		27. 00			
copy. Interest Expense					+			
28.00 Were new Loans, mortgage agreements or Letters of credit er	ntered into du	iring the cos	t reporting		28.00			
29.00 Did the provider have a funded depreciation account and/or	period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
treated as a funded depreciation account? If yes, see instr 80.00 Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see		30.00			
<pre>instructions. 31.00 Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	s, see		31.00			
Purchased Services 32.00 Have changes or new agreements occurred in patient care ser		ned through co	ontractual		32.00			
arrangements with suppliers of services? If yes, see instru 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	itive bidding? If	,	33.00			
Provi der-Based Physi ci ans					1			
34.00 Are services furnished at the provider facility under an ar	rangement wit	h provi der-ba	ased physicians?		34.00			
If yes, see instructions.	oting ograsma	unto with the	provi don boood		25 00			
35.00 Iffine 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ents with the	provi der-based		35.00			
physicians during the cost reporting partod. IT yes, see it	istractions.		Y/N	Date				
			1.00	2. 00				
Home Office Costs								
36.00 Were home office costs claimed on the cost report?					36.00			
37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office	?		37.00			
If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the home off			f		38.00			
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to other			5,		39.00			
see instructions. 40.00 If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40.00			
That detrons.	1	00	2	00				
Cost Report Preparer Contact Information	1.	00	Ζ.	00				
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00			
	BLUE AND CO				42.00			
preparer. 43.00 Enter the telephone number and email address of the cost ;	317. 713. 7959		MALESSANDRI NI @	DI HEANDOO COM	43.0			
report preparer in columns 1 and 2, respectively.	311.113.1739		WALLSSANDKI NI @	DEDEMNDOU. COM	43.00			

Heal th	Financial Systems RIVERVIEW	I HOS	SPI TAL	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der CCN: 15-0059	eriod: rom 01/01/2018 o 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/28/2019 1:2	pared:	
			3.00				
	Cost Report Preparer Contact Information		3.00				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI F	RECTOR			41. 00	
42. 00	Enter the employer/company name of the cost report preparer.					42.00	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.					43. 00	

 Health Financial Systems
 RIVE

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0059

					Т	o 12/31/2018	Date/Time Pre 5/28/2019 1:2		
							1/P Days /	T	
							0/P Visits /		
							Tri ps		
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V		
		Line Number			Avai I abl e				
		1. 00		2. 00	3. 00	4. 00	5. 00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		94	33, 125	0. 00	0	1	. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
0.00	for the portion of LDP room available beds)		ŀ					١,	
2.00	HMO and other (see instructions)		ŀ						2.00
3. 00	HMO I PF Subprovi der								3. 00
4. 00	HMO I RF Subprovi der								. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	1 .	00
6.00	Hospital Adults & Peds. Swing Bed NF			0.4	22 125	0.00	0		. 00
7. 00	Total Adults and Peds. (exclude observation			94	33, 125	0. 00	0	′	. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00	ŀ	15	5, 475	0. 00	o		3. 00
9. 00	CORONARY CARE UNIT	31.00	ŀ	13	3,473	0.00		1 -	0.00
10.00	BURN INTENSIVE CARE UNIT		ŀ). 00
11. 00	SURGICAL INTENSIVE CARE UNIT								. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)		ŀ						. 00
13. 00	NURSERY	43.00					0		3. 00
14. 00	Total (see instructions)	43.00		109	38, 600	0.00			. 00
15. 00	CAH visits			107	00,000	0.00	ĺ		5. 00
16. 00	SUBPROVI DER - I PF						Ĭ		. 00
17. 00	SUBPROVI DER - I RF	41. 00		24	8, 760		0		. 00
18.00	SUBPROVI DER						-		3. 00
19.00	SKILLED NURSING FACILITY	44.00		25	9, 125		0	19	0.00
20.00	NURSING FACILITY							20	0.00
21.00	OTHER LONG TERM CARE							21	. 00
22.00	HOME HEALTH AGENCY							22	2. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23	3. 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							26	. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26	. 25
27.00	Total (sum of lines 14-26)			158					. 00
28. 00	Observation Bed Days						0	1	3. 00
29. 00	Ambulance Trips								. 00
30.00	Employee discount days (see instruction)								0.00
31.00	Employee discount days - IRF							1 .	. 00
32. 00	Labor & delivery days (see instructions)			0	C			1 .	2.00
32. 01	Total ancillary labor & delivery room							32	2. 01
00.00	outpatient days (see instructions)								
33.00	3								3. 00
33. UI	LTCH site neutral days and discharges		l		I			33	8. 01

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm

						5/28/2019 1:2	3 pm
	·	I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
		,		'		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 102	310	13, 377			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	2, 858	2, 016				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	681	220				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	5, 102	310	13, 377			7.00
	beds) (see instructions)	·					
8.00	INTENSIVE CARE UNIT	1, 165	0	2, 792			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		0	0			13.00
14.00	Total (see instructions)	6, 267	310	16, 169	0.00	1, 047. 43	14.00
15.00	CAH vi si ts	0	0	i			15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF	3, 471	0	5, 314	0.00	23. 54	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	3, 105	0	4, 574	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)			52			24. 10
25.00	CMHC - CMHC						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, 070. 97	
28.00	Observation Bed Days		0	1, 658			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	111	237			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	o					33. 01

Provi der CCN: 15-0059

				10) 12/31/2018	Date/IIMe Pre 5/28/2019 1:2	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	T	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 572	62	4, 084	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)			634	476		2.00
3. 00	HMO IPF Subprovider			034	476		3.00
4. 00	HMO IRF Subprovider				20		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				20		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						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						13.00
14.00	Total (see instructions)	0.00	0	1, 572	62	4, 084	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	326	0	476	17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	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)						24. 10
25.00	CMHC - CMHC						25.00
26. 00 26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 00 26. 25
26. 25	Total (sum of lines 14-26)	0.00					26. 25
28.00	Observation Bed Days	0.00					28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see Fristraction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32.00
02.01	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days	1		0			33.00
33. 01	LTCH site neutral days and discharges	1		0			33. 01
	· · · · · · · · · · · · · · · · · · ·	•					

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0059

Mart 1 Book Data Dat							o 12/31/2018	Date/Time Pre 5/28/2019 1:2	
Note 11 - MAGE DATA 1.00 2.00 3.00 4.00 5.00 6.00 1.00 2.00 3.00 4.00 5.00 6.00 1.00 2.00 3.00 4.00 5.00 6.00 1.00 2.00 3.00 4.00 5.00 6.00 1.00 2.00 3.00 4.00 5.00 6.00 1.00 3.00 1.00 1.00 3.00 1.00 1.00 3.00 1.00 1.00 1.00 3.00 1.00								Average	3 piii
PART 11 - WGC DATA SALARIES 1.00			Number	Reported					
DART T1 - WADE DATA SAURIES SA						, ·		`	
Part			1 00	2.00		4.00	5.00	6.00	
1.00 Total salaries (see 200.00 78,140,998 1,915,334 80,056,332 2,227,182,00 35,95 1,00		PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
2. 00 Non-physician anesthetist Part 3. 00 Non-physician anesthetist Part 4. 00 Non-physician anesthetist Part 5. 00 Non-physician anesthetist Part 6. 00 Non-physician anesthetist Part 7. 00 Non-physician anesthetist Part 8. 00 Non-p	1 00		200 00	79 140 000	1 015 224	90 056 222	2 227 102 00	25.05	1 1 00
3.00 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0	1.00		200.00	76, 140, 996	1, 915, 554	60, 056, 552	2, 227, 162.00	35. 95	1.00
4. 00 Physician-Part A - A - Touching	2. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
4. Min in strative () Physicians - Part A - Teaching () 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00	Non-physician anesthetist Part		0	О	0	0.00	0. 00	3.00
4. Min in strative () Physicians - Part A - Teaching () 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4 00	B Physician-Part A -		0	0	0	0.00	0.00	4 00
5.00 Physician and Mon		Admi ni strati ve			_	_			
6. Physician-Part B 6. On Non-Physician-Part B 7. On Non-Physician-Part B 7				-					
nospital - loased RHC and FOHC Services		Physician-Part B		_					
Interns & residents (in an approved programs)	6.00	hospital-based RHC and FQHC		0	0	0	0.00	0.00	6.00
Contracted interies and residents (in an approved programs) 8.00 Home office and/or related on one of one of one of one one of	7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7.00
residents (in an approved programs)	7. 01			0	0	0	0.00	0.00	7. 01
Home office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0		residents (in an approved							
9.00 SuF	8. 00			0	О	О	0.00	0.00	8.00
10.00 Excluded area salaries (see instructions) 10.00 195,275 30,210.099 616,841.00 48,98 10.00 10.0	9 00		44 00	0	_	_	0.00	0.00	0 00
OTHER WAGES & RELATED COSTS		Excluded area salaries (see	44.00	30, 014, 824	195, 275	30, 210, 099			
11.00 Contract labor: Direct Patient 264,632 0 264,632 7,248.00 36.51 11.00 Care									+
12.00 Contract labor: Top level management and other management and other management and administrative services 13.00 Contract labor: Physician-Part 6.35, 178 0 6.35, 178 2,960.00 214, 59 13.00 A - Administrative	11. 00	Contract Labor: Direct Patient		264, 632	0	264, 632	7, 248. 00	36. 51	11.00
management and other management and other management and admin istrative serVices	12. 00	1		0	0	0	0. 00	0.00	12.00
Services		management and other							
A - Administrative		-							
14.00	13.00			635, 178	0	635, 178	2, 960. 00	214. 59	13.00
wage-related costs	14. 00	Home office and/or related		0	0	О	0.00	0. 00	14.00
14. 01 Home office salaries 0 0 0 0.00 0.00 14. 01									
Home office: Physician Part A 0 0 0 0 0 0 0 0 0		Home office salaries		0	1	· -			
16.00 Administrative Home office and Contract Home office and Contract Physicians Part A - Teaching Home office Physician Part A - Teaching Home office Physician Part A - Teaching Home office Physician Part B Home office Physician Part B Home office Physician Part A Teaching Home office Physician Part A Paching Physician Part A Paching Physician Part B Part B Patt B Pat		, ,		0	1	·			
Physicians Part A - Teaching	1/ 00	- Administrative					0.00		
17. 00 Wage-related costs (core) (see instructions) 18. 00 1	16.00			U	0	0	0.00	0.00	16.00
Instructions Wage-related costs (other) (see instructions) 18.00 (see instructions) 18.00 Excluded areas 4,518,438 0 4,518,438 19.00 20.00 Non-physician anesthetist Part A 20.00 Non-physician anesthetist Part B 21.00 Non-physician anesthetist Part B 22.00 Physician Part A - Administrative Physician Part B 0 0 0 0 22.00 23.00 24.00 Wage-related costs (RHC/FOHC) 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 25.50 Home office wage-related (core) Home office: Physician Part A 0 0 0 0 0 25.53 25.53 Home office & Contract Physician Part A - Teaching - 0 0 0 0 0 0 0 0 0	17 00			0 545 514	I 0	0 545 514			17 00
(see instructions) 4,518,438 0 4,518,438 19.00 20.00 Non-physi ci an anestheti st Part A 0 0 0 0 0 21.00 Non-physi ci an anestheti st Part B 0 0 0 0 0 0 0 22.00 Physi ci an Part A - A 0 0 0 0 0 0 22.01 Physi ci an Part A - Teaching 0 0 0 0 0 0 23.00 Physi ci an Part B 0 0 0 0 0 0 24.00 Wage-rel ated costs (RHC/FOHC) 0 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 25.00 25.50 Rel ated organi zati on wage-rel ated (core) 0 0 0 0 25.51 25.52 Home office: Physici an Part A - A - Administrative - wage-rel ated (core) 0 0 0 0 0 25.53 Home office & Contract Physici ans Part A - Teaching - Physici ans Part A - Teaching - Description of the physici ans Part A - Teaching - Description of the physici ans Part A - Teaching - Description of the physici ans Part A - Teaching - Description of the physici ans Part A - Teaching - Description of the physici ans Part A	17.00			9, 545, 514		9, 545, 514			17.00
19. 00	18. 00			0	0	0			18.00
A 21.00 Non-physician anesthetist Part B 22.00 Physician Part A - Administrative 22.01 Physician Part A - Teaching 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19. 00	Excluded areas		4, 518, 438					
B C Physician Part A - Administrative C C Physician Part A - Teaching C C Physician Part B C C C C C C C C C	20. 00	Non-physician anesthetist Part A		0	0	0			20.00
Administrative 22.01 Physician Part A - Teaching 0 0 0 0 22.01 23.00 Physician Part B 0 0 0 0 23.00 24.00 Wage-related costs (RHC/FOHC) 0 0 0 24.00 25.00 Interns & residents (in an approved program) 40 Home office wage-related (core) 25.51 Related organization 0 0 0 0 0 25.51 40 Wage-related (core) 40 Wage-related (core) 40 Wage-related (core) 41 Wage-related (core) 42 Wage-related (core) 43 Wage-related (core) 44 Wage-related (core) 45 Wage-related (core) 46 Wage-related (core) 47 Wage-related (core) 48 Wage-related (core) 49 Wage-related (core) 40 Wage-related (core) 40 Wage-related (core) 40 Wage-related (core) 40 Wage-related (core) 41 Wage-related (core) 42 Wage-related (core) 43 Wage-related (core) 44 Wage-related (core) 45 Wage-related (core) 46 Wage-related (core) 47 Wage-related (core) 48 Wage-related (core)	21. 00	Non-physician anesthetist Part		0	0	0			21.00
Administrative 22.01 Physician Part A - Teaching 23.00 Physician Part B 0 0 0 24.00 Wage-related costs (RHC/FQHC) 1 Interns & residents (in an approved program) 25.50 Home office wage-related (core) 25.51 Related organization wage-related (core) 25.52 Home office: Physician Part A - Administrative - wage-related (core) 25.53 Home office & Contract Physicians Part A - Teaching -	22. 00	Physician Part A -		0	0	o			22. 00
23.00 Physician Part B 0 0 0 0 0 24.00 24.00 Wage-related costs (RHC/FQHC) 1 Interns & residents (in an approved program) 25.50 Home office wage-related (core) 25.51 Related organization wage-related (core) 25.52 Home office: Physician Part A - Administrative - wage-related (core) 25.53 Physicians Part A - Teaching -	22 ∩1	l .		0		_			22 01
25.00 Interns & residents (in an approved program) 25.50 Home office wage-related (core) 25.51 Related organization wage-related (core) 25.52 Home office: Physician Part A - Administrative - wage-related (core) 25.53 Home office & Contract Physicians Part A - Teaching -				0	Ö	ő			
approved program 25.50 Home office wage-related 0 0 0 0 25.50				0	0	·			
(core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching -		approved program)		U					
25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching -	25. 50			0	0	0			25.50
25.52 Home office: Physician Part A	25. 51	Related organization		0	0	0			25. 51
- Administrative - wage-related (core) 25.53 Home office & Contract 0 0 0 25.53 Physicians Part A - Teaching -	25. 52			0	0	О			25. 52
25. 53 Home office & Contract 0 0 0 0 25. 53 Physicians Part A - Teaching -		- Administrative -							
	25. 53			0	О	О			25. 53
TWARE-LEFTATER (COLE)		Physicians Part A - Teaching - wage-related (core)							
		and related (core)	!		I	I	ı	ļ	1

Provider CCN: 15-0059

					Ť	o 12/31/2018	Date/Time Pre 5/28/2019 1:2	
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	<u> Б</u>
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI					I		
26. 00	Employee Benefits Department	4. 00	687, 110			·		26.00
27. 00	Administrative & General	5. 00	8, 305, 878			·	28. 70	
28. 00	Administrative & General under		945, 944	0	945, 944	6, 570. 00	143. 98	28. 00
	contract (see inst.)		_	_	_			
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	1, 913, 458	ł	1, 913, 458		25. 97	
31. 00	Laundry & Linen Service	8. 00	49, 115	ŀ	49, 115	·	17. 45	
32. 00	Housekeepi ng	9. 00	957, 216	0	957, 216	·		32.00
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Dietary	10. 00	1, 143, 634	-830, 383	313, 251	20, 559. 00		34.00
35. 00	Dietary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	745, 037	745, 037	42, 953. 00	17. 35	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37.00
38.00	Nursing Administration	13. 00	469, 438	0	469, 438	9, 488. 00	49. 48	38.00
39.00	Central Services and Supply	14. 00	538, 863	94, 746	633, 609	33, 983. 00	18. 64	39.00
40.00	Pharmacy	15. 00	2, 754, 672	-109, 929	2, 644, 743	71, 688. 00	36. 89	40.00
41.00	Medical Records & Medical	16.00	813, 617	0	813, 617	32, 056. 00	25. 38	41.00
	Records Library							
42.00	Social Service	17. 00	605, 705	0	605, 705	15, 599. 00	38. 83	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

Health Financial Systems	RI VERVI EW HOSPI TAL		In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0059	Peri od:	Worksheet S-3

нозы	AL WAGE INDEX INFORMATION			Provider C		From 01/01/2018 To 12/31/2018		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	. Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		79, 086, 942	1, 915, 334	81, 002, 27	76 2, 233, 752. 00	36. 26	1.00
	instructions)							
2. 00	Excluded area salaries (see		30, 014, 824	195, 275	30, 210, 09	616, 841. 00	48. 98	2.00
	instructions)							
3.00	Subtotal salaries (line 1		49, 072, 118	1, 720, 059	50, 792, 17	77 1, 616, 911. 00	31. 41	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		899, 810	0	899, 81	10, 208. 00	88. 15	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		9, 545, 514	0	9, 545, 51	0.00	18. 79	5.00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		59, 517, 442					
7. 00	Total overhead cost (see		19, 184, 650	-181, 494	19, 003, 15	678, 928. 00	27. 99	7. 00
	instructions)							

RIVERVIEW HOSPITAL	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-0059	Peri od:	Worksheet S-3
	From 01/01/2018	
		Provider CCN: 15-0059 Period: From 01/01/2018

PART IV - WAGE RELATED COSTS 1.00		To 12/31/2018	Date/Time Pre 5/28/2019 1:2	
PART IV - WAGE RELATED COSTS				5 p
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 1, 187, 948 1.00 2.00			Reported	
Part A - Core List Part LEMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0 0 0 0 0 0 0 0 0	1.00	401K Employer Contributions	1, 187, 948	1.00
4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pl an Administration fees 0 5.00 6.00 Legal / Accounting / Management Fees-Pension Pl an 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 0 8.00 8.01 Health Insurance (Purchased or Self Funded) 0 8.00 8.02 Health Insurance (Self Funded with a Third Party Administrator) 0 8.01 8.03 Health Insurance (Self Funded with a Third Party Administrator) 0 8.02 8.03 Health Insurance (Purchased) 7,158,640 8.03 8.04 Health Insurance (Purchased) 7,158,640 8.03 8.05 Health Insurance (Purchased) 7,158,640 8.03 8.06 Health Insurance (Purchased) 7,158,640 8.03 8.07 Health Insurance (Purchased) 7,158,640 8.03 8.08 Health Insurance (Purchased) 7,158,640 8.03 8.09 Prescription Drug Plan 0 9,00 8.00 Dental, Hearing and Vision Plan 258,634 10.00 8.01 Life Insurance (If employee is owner or beneficiary) 3,536 11.00 8.02 Accident Insurance (If employee is owner or beneficiary) 0 12.00 8.03 Disability Insurance (If employee is owner or beneficiary) 257,070 14.00 8.00 Workers' Compensation Insurance 257,070 14.00 8.01 Chop-Term Care Insurance (If employee is owner or beneficiary) 257,070 14.00 8.02 Non cumulative portion) 18,00 8.03 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 8.01 Non cumulative portion only 4,986,474 17.00 8.02 State or Federal Unemployment Taxes 0 20.00 8.03 Tultion Rel mbursement 59,073 23.00 8.04 Chop Part B - Other than Core Rel ated Cost 24.00 8.05 Part B - Other than Core Rel ated Cost 24.00 8.06 Rel than Day Care Cost and Allowances 0 22.00 8.07 Rel than Day Care Cost and Allowances 0 22.00 8.08 Rel than Day Care Cost and Allowances 0 22.00 8.09 Part B - Other than Core Rel ated Cost 24.00 8.00 Rel tha	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
5.00	4.00		0	4.00
Co. Legal / Accounting / Management Fees-Pension Plan Employee Managed Carce Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
The color of the	5.00		0	5.00
HEALTH AND INSURANCE COST 8.00 Heal th Insurance (Purchased or Self Funded) 8.01 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.02 8.03 Heal th Insurance (Purchased) 7, 158, 640 8.03 9.00 Prescription Drug Plan 0 9.0	6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
Real th Insurance (Purchased or Self Funded) 8. 00 Real th Insurance (Self Funded without a Third Party Administrator) 0 8. 01 Real th Insurance (Self Funded without a Third Party Administrator) 0 8. 02 Real th Insurance (Self Funded with a Third Party Administrator) 0 8. 02 Real th Insurance (Purchased) 7, 158, 640 8. 03 Real th Insurance (Purchased) 7, 158, 640 8. 03 Real th Insurance (Purchased) 7, 158, 640 8. 03 Real th Insurance (Purchased) 7, 158, 640 8. 03 Real th Insurance (Purchased) 7, 158, 640 8. 03 Real th Insurance (Purchased) 7, 158, 640 8. 03 Real th Insurance (If employee is owner or beneficiary) 258, 634 10. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th Insurance (If employee is owner or beneficiary) 0 13. 00 Real th	7.00	Employee Managed Care Program Administration Fees	0	7.00
8.01 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Heal th Insurance (Self Funded with a Third Party Administrator) 0 8.02 8.03 Heal th Insurance (Purchased) 7,158,640 8.03 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 258,634 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 33,536 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 257,070 14.00 15.00 Workers' Compensation Insurance 118,461 15.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 18.00 17.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 18.00 17.00 Medicare Taxes - Employers Portion Only 0 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 4,116 19.00 20.00 OTHER 20.00 20.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see				l
Real th Insurance (Self Funded with a Third Party Administrator) 0 8.02	8.00		0	8.00
Heal th Insurance (Purchased) 7, 158, 640 8. 03 9. 00 Prescription Drug Plan 258, 634 10. 00 10	8. 01		0	8. 01
9.00 Prescription Drug Plan 0 9.00 10.	8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
10.00 Dental, Hearing and Vision Plan 258,634 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 33,536 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 12.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 257,070 14.00 Vorkers' Compensation Insurance 118,461 15.00 15.00 Non cumulative portion) 16.00 17.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 4,986,474 17.00 18.00 Medicare Taxes - Employers Portion Only 4,986,474 17.00 19.00 Unemployment Insurance 4,116 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00	8. 03	Health Insurance (Purchased)	7, 158, 640	8. 03
11.00	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	258, 634	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Tuition Reimbursement 13.00 13.00 14.00 15.00 14.00 15.00 118.			33, 536	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuition Reimbursement 24. 00 Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes O 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
16. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 30. Tuition Reimbursement 10. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00	14.00		257, 070	14.00
Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Part B - Other than Core Related Cost 17. 00 4, 986, 474 17. 00 18. 00 18. 00 19. 00 19. 00 20. 00 21. 00 22. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20. 00	15. 00		118, 461	15. 00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
17. 00 FI CA-Empl oyers Portion Only 4,986,474 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 4,116 19. 00 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 59,073 23. 00 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 25. 00 26.				ı
18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 18.00 4, 116 19.00 20.00 21.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 27.00 28.00 29.00 29.00 29.00 20				
19. 00 Unempl oyment Insurance 4, 116 19. 00 20. 00 State or Federal Unemployment Taxes 0 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 59, 073 23. 00 24. 00 Part B - Other than Core Related Cost			4, 986, 474	17. 00
20.00 State or Federal Unemployment Taxes 0 0 0THER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 59,073 23.00 24.00 Part B - Other than Core Related Cost			- 1	
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 21.00 22.00 22.00 22.00 23.00 14,063,952 24.00			4, 116	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 21.00 21.00 22.00 23.00 14,063,952 24.00	20.00		0	20.00
instructions) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 59,073 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost				l
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 59, 073 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 14, 063, 952 Part B - Other than Core Related Cost	21. 00		0	21. 00
23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 59, 073 23. 00 14, 063, 952 24. 00				l
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 14,063,952 24.00			0	
Part B - Other than Core Related Cost				
	24.00		14, 063, 952	24.00
25. 00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25. 00	25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Pre 5/28/2019 1:2	pared:
Cost Center Description		Contract Labor 1.00	Benefit Cost 2.00	

			3/20/2017 1.2	o piii
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	264, 632	14, 063, 952	1.00
2.00	Hospi tal	264, 632	14, 063, 952	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (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	Hospi tal -Based SNF	0	0	8.00
9.00	Hospi tal -Based NF			9.00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	0ther	0	0	18.00

Heal th	Financial Systems RIVERVIEW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
PROSPE	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der Co		eriod: rom 01/01/2018 o 12/31/2018		pared:
						•
1.00	If this facility contains a hospital-based SNF, were all p or was there no Medicare utilization? Enter "Y" for yes in			1. 00	2.00	1.00
2. 00	complete the rest of this worksheet. Does this hospital have an agreement under either section swing beds? Enter "Y" for yes or "N" for no in column 1.					2. 00
	date (mm/dd/yyyy) in column 2.	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3. 00		RUX	0			3. 00
4. 00 5. 00		RUL RVX	11 0			4. 00 5. 00
6. 00		RVL	Ö			6. 00
7. 00		RHX	0			7. 00
8. 00 9. 00		RHL RMX	0 0			8. 00 9. 00
10.00		RML	o o			10.00
11. 00		RLX	0			11.00
12. 00 13. 00		RUC RUB	931 1, 213			12. 00 13. 00
14. 00		RUA	605			14. 00
15. 00		RVC	91	0		15. 00
16. 00 17. 00		RVB RVA	87 52	0		16. 00 17. 00
18. 00		RHC	3			18. 00
19.00		RHB	39			19.00
20. 00 21. 00		RHA RMC	9			20. 00 21. 00
22. 00		RMB	1			22. 00
23.00		RMA	0			23.00
24. 00 25. 00		RLB RLA	0 0			24. 00 25. 00
26.00		ES3	0	0	0	26. 00
27. 00		ES2	0			27. 00
28. 00 29. 00		ES1 HE2	0 0			28. 00 29. 00
30.00		HE1	0	0	0	30. 00
31.00		HD2	0			31.00
32. 00 33. 00		HD1 HC2	5 0			32. 00 33. 00
34.00		HC1	0	0	0	34.00
35. 00 36. 00		HB2 HB1	0 0			35. 00 36. 00
37.00		LE2	0			37.00
38. 00		LE1	0			38. 00
39. 00 40. 00		LD2 LD1	0 3			39. 00 40. 00
41. 00		LC2	0			41. 00
42.00		LC1	0			42.00
43. 00 44. 00		LB2 LB1	0 0			43.00 44.00
45.00		CE2	0	0	0	45.00
46. 00 47. 00		CE1 CD2	0 0			46. 00 47. 00
48.00		CD2 CD1	7			47.00
49.00		CC2	0	0	0	49. 00
50. 00 51. 00		CC1 CB2	12 0	0		50. 00 51. 00
52.00		CB1	12	0	12	52.00
53.00		CA2	0	0		53.00
54. 00 55. 00		CA1 SE3	4 0			54. 00 55. 00
56.00		SE2	0	0	0	56. 00
57.00		SE1	0			57.00
58. 00 59. 00		SSC SSB	0 0			58. 00 59. 00
60.00		SSA	0	0	0	60.00
61.00		I B2	0			61.00
62. 00 63. 00		I B1 I A2	0 0			62. 00 63. 00
64.00		I A1	0	0	0	64.00
65.00		BB2	0			65.00
66. 00 67. 00		BB1 BA2	0 0			66. 00 67. 00
68. 00		BA1	0			

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	VERVIEW HOSPITAL Provider C	CN: 15-0059	Peri od:	Worksheet S-7	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/28/2019 1:2	
	Group	SNF Days	Swing Bed SNF		
			Days	col. 2 + 3)	
	1. 00	2.00	3. 00	4. 00	
69. 00	PE2		0 0	0	69.00
70. 00	PE1		0 0	0	70.00
71. 00	PD2		0 0	0	71.00
72. 00	PD1		o c	0	72.00
73. 00	PC2		o c	0	73.00
74. 00	PC1		1	11	74.00
75. 00	PB2		ol d	0	75.00
76. 00	PB1		0		
77. 00	PA2			1	
78. 00	PA1		1		
199. 00	AAA		o o		199.00
200. 00 TOTAL	7001	3, 10	-		200.00
200.00 101/12		0,10	CBSA at	CBSA on/after	
			Beginning of	October 1 of	
			Cost	the Cost	
			Reporting	Reporting	
			Peri od	Period (if	
				applicable)	
			1. 00	2, 00	
SNF SERVICES			1. 00	2. 00	
SNF SERVICES 201.00 Enter in column 1 the SNF CBSA code or 5 character	non-CBSA code if a ru	ral facility,	1.00	2. 00	201.00
					201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character	eriod. Enter in column	2, the code			201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting po	eriod. Enter in column	2, the code			201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting po	eriod. Enter in column	2, the code ble).	26900	26900	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting po	eriod. Enter in column	2, the code ble).	26900	26900 Associ ated	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting po	eriod. Enter in column	2, the code ble).	26900	26900 Associated with Direct	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting po	eriod. Enter in column	2, the code ble).	26900	26900 Associated with Direct Patient Care	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting point effect on or after October 1 of the cost reportion of the cost	eriod. Enter in column ing period (if applica	2, the code ble). Expenses	26900 Percentage	Associ ated with Direct Patient Care and Rel ated Expenses?	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting point effect on or after October 1 of the cost reportion of the cost reportion and the cost reportion of the cost	eriod. Enter in column ing period (if applica 68, No. 149 August 4,	2, the code ble). Expenses 1.00 2003 provi ded	26900 Percentage 2.00 for an increase	Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting point effect on or after October 1 of the cost reportion of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting effect on or after October 1 of the cost reporting effect of the cos	eriod. Enter in column ing period (if applica 58, No. 149 August 4, nis increase to be use	2, the code ble). Expenses 1.00 2003 provided for direct	26900 Percentage 2.00 for an increase patient care and	Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG d related	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting point effect on or after October 1 of the cost reportion of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect on or after October 1 of the cost reporting point effect of the cost reporting point effec	eriod. Enter in column ing period (if applica 58, No. 149 August 4, his increase to be use nn 1 the amount of the	2, the code ble). Expenses 1.00 2003 provided d for direct expense for	26900 Percentage 2.00 for an increase patient care and each category.	26900 Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG d related Enter in	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting point effect on or after October 1 of the cost reportion of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect of the cos	eriod. Enter in columning period (if applica 58, No. 149 August 4, is increase to be use nn 1 the amount of the category to total SNF	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from	26900 Percentage 2.00 for an increase patient care and each category. If worksheet G-2,	26900 Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG drelated Enter in Part I, line	201.00
201.00 Enter in column 1 the SNF CBSA code or 5 character in effect at the beginning of the cost reporting point effect on or after October 1 of the cost reportion of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect on or after October 1 of the cost reportion effect of the cost reporting point effect of the cost reporting point effect of the cost reportion effect of the cost reportio	eriod. Enter in columning period (if applica 58, No. 149 August 4, his increase to be use mn 1 the amount of the category to total SNF for no if the spendin	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from g reflects in	26900 Percentage 2.00 for an increase patient care and each category. If worksheet G-2,	26900 Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG drelated Enter in Part I, line	201.00
A notice published in the Federal Register Volume of payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column 2 the percentage of total expenses for each 7, column 3. In column 3, enter "Y" for yes or "N" direct patient care and related expenses for each of the cost reportion.	eriod. Enter in columning period (if applica 58, No. 149 August 4, his increase to be use mn 1 the amount of the category to total SNF for no if the spendin	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from g reflects in	26900 Percentage 2.00 for an increase patient care and each category. If worksheet G-2,	26900 Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG drelated Enter in Part I, line	
A notice published in the Federal Register Volume of payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column 2 the percentage of total expenses for each 7, column 3. In column 3, enter "Y" for yes or "N" direct patient care and related expenses for each column 2.	eriod. Enter in columning period (if applica 58, No. 149 August 4, his increase to be use mn 1 the amount of the category to total SNF for no if the spendin	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from g reflects in	26900 Percentage 2.00 for an increase patient care and each category. If worksheet G-2, creases associar 0 0.00	Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG drelated Enter in Part I, line ted with	202.00
A notice published in the Federal Register Volume of payments beginning of total expenses. For lines 202 through 207: Enter in column 2 the percentage of total expenses for each 7, column 3. In column 3, enter "Y" for yes or "N" direct patient care and related expenses for each column 200 Staffing 203.00 Recruitment	eriod. Enter in columning period (if applica 58, No. 149 August 4, his increase to be use mn 1 the amount of the category to total SNF for no if the spendin	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from g reflects in	26900 Percentage 2.00 for an increase patient care and each category. Worksheet G-2, creases associa	Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG drelated Enter in Part I, line ted with	
A notice published in the Federal Register Volume of payments beginning 10/01/2003. Congress expected the expenses. For lines 202 through 207: Enter in column 2 the percentage of total expenses for each 7, column 3. In column 3, enter "Y" for yes or "N" direct patient care and related expenses for each column 2.	eriod. Enter in columning period (if applica 58, No. 149 August 4, his increase to be use mn 1 the amount of the category to total SNF for no if the spendin	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from g reflects in	26900 Percentage 2.00 for an increase patient care and each category. If worksheet G-2, creases associar 0 0.00	Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG d related Enter in Part I, line ted with	202. 00 203. 00 204. 00
A notice published in the Federal Register Volume of payments beginning of total expenses for each 7, column 3. In column 3, enter "Y" for yes or "N" direct patient care and related expenses for each column 2 the patient care and related expenses for each 202.00 Staffing 203.00 Recruitment	eriod. Enter in columning period (if applica 58, No. 149 August 4, his increase to be use mn 1 the amount of the category to total SNF for no if the spendin	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from g reflects in	26900 Percentage 2.00 for an increase patient care and each category. If worksheet G-2, creases association 0.00 0.00 0.00	Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG d related Enter in Part I, line ted with	202. 00 203. 00
A notice published in the Federal Register Volume of payments beginning of total expenses. For lines 202 through 207: Enter in column 2 the percentage of total expenses for each 7, column 3. In column 3, enter "Y" for yes or "N" direct patient care and related expenses for each column 200 Staffing 203.00 Recruit ment 204.00 Retention of employees	eriod. Enter in columning period (if applica 58, No. 149 August 4, his increase to be use mn 1 the amount of the category to total SNF for no if the spendin category. (see instruc	2, the code ble). Expenses 1.00 2003 provided for direct expense for revenue from g reflects in	26900 Percentage 2.00 for an increase patient care and each category. Worksheet G-2, creases associa: 0 0.00 0 0.00 0 0.00	26900 Associated with Direct Patient Care and Related Expenses? 3.00 e in the RUG drelated Enter in Part I, line ted with	202. 00 203. 00 204. 00

IUSPI I	Financial Systems RIVERVIEW HOSTAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO	N: 15 0050	Period:	u of Form CMS-2 Worksheet S-1	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider Co	JN: 15-0059	From 01/01/2018		U
				To 12/31/2018	Date/Time Pre	pared
					5/28/2019 1: 2	3 piii
					1. 00	
00	Uncompensated and indigent care cost computation	-1:: -11 1	202	0)	0.200570	1 .
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 c Medicaid (see instructions for each line)	arvided by it	ne 202 coi ur	ın 8)	0. 298578	1.
. 00	Net revenue from Medicaid				7, 629, 617	2.
. 00	Did you receive DSH or supplemental payments from Medicaid?				7,029,017 Y	3.
. 00	If line 3 is yes, does line 2 include all DSH and/or suppleme	ental pavment	s from Medio	cai d?	Ϋ́	4.
00	If line 4 is no, then enter DSH and/or supplemental payments				0	5.
. 00	Medi cai d charges				37, 950, 993	6.
. 00	Medicaid cost (line 1 times line 6)				11, 331, 332	7.
00	Difference between net revenue and costs for Medicaid program	m (line 7 mir	nus sum of li	nes 2 and 5; if	3, 701, 715	8.
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions</pre>	for each lir	ne)			
00	Net revenue from stand-alone CHIP	TOT CUCHTITI	10)		0	9.
	Stand-alone CHIP charges				0	10.
1. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.
2. 00	Difference between net revenue and costs for stand-alone CHIF	P (line 11 mi	nus line 9;	if < zero then	0	12.
	enter zero)			,		
	Other state or local government indigent care program (see in					1 1 2
3.00	Net revenue from state or local indigent care program (Not in				0	13.
. 00	Charges for patients covered under state or local indigent callo)	are program i	(Not included	i ili ililes o oi	0	14.
5. 00	State or local indigent care program cost (line 1 times line	14)			0	15.
5. 00			e program (Li	ne 15 minus line	0	
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, Cinstructions for each line)	CHIP and stat	e/Local indi	gent care progra	ams (see	
7 00	Private grants, donations, or endowment income restricted to	fundi ng char	rity care			
					1 0	17
5. 00	Government grants, appropriations or transfers for support of				0	
	Total unreimbursed cost for Medicaid , CHIP and state and loc	f hospital op	perations	ns (sum of lines	0	18.
		f hospital op	perations	ns (sum of lines	0	18.
	Total unreimbursed cost for Medicaid , CHIP and state and loc	f hospital op	perations care progran		0 3, 701, 715 Total (col. 1 + col. 2)	18.
	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16)	f hospital op	perations care program Uninsured	Insured	0 3, 701, 715 Total (col. 1	18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line)	f hospital op cal indigent	perations care program Uninsured patients 1.00	Insured patients 2.00	0 3,701,715 Total (col. 1 + col. 2) 3.00	18. 19.
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f	f hospital op cal indigent	perations care progran Uninsured patients	Insured patients 2.00	0 3,701,715 Total (col. 1 + col. 2) 3.00	18. 19.
0. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line)	f hospital op cal indigent	perations care program Uninsured patients 1.00	Insured patients 2.00	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119	18. 19.
9. 00 0. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions)	f hospital op cal indigent	Uni nsured pati ents 1.00 6,505,6	Insured patients 2.00	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119	18. 19.
9. 00 0. 00 1. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously written	f hospital opcal indigent facility counts (see	Uni nsured pati ents 1.00 6,505,6	Insured patients 2.00	0 3, 701, 715 Total (col. 1 + col. 2) 3.00 7, 820, 119 3, 256, 933	18. 19. 20. 21.
0.00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care	f hospital opcal indigent facility counts (see	Uninsured patients 1.00 6,505,6 1,942,4	I nsured pati ents 2.00 21 1,314,498 0 0	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0	18. 19. 20. 21.
0.00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously written	f hospital opcal indigent facility counts (see	Uni nsured pati ents 1.00 6,505,6	I nsured pati ents 2.00 21 1,314,498 0 0	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0	18. 19. 20. 21.
0.00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22)	f hospital opcal indigent facility counts (see en off as	Uninsured patients 1.00 6,505,6 1,942,4	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0	18. 19. 20. 21.
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22)	f hospital opcal indigent facility counts (see en off as	Uninsured patients 1.00 6,505,6 1,942,4	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0 3, 256, 933	20. 21. 22. 23.
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patiin mposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond	f hospital opcal indigent facility counts (see en off as	Uninsured patients 1.00 6,505,6 1,942,4 /ond a length	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0 3, 256, 933	20. 21. 22. 23.
). 00 0. 00 1. 00 2. 00 4. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient patients covered by Medicaid or other indigent car lifline 24 is yes, enter the charges for patient days beyond stay limit	f hospital operation of the indigent of the in	Uninsured patients 1.00 6,505,6 1,942,4 //ond a length	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0 3, 256, 933 1. 00 N	20. 21. 22. 23.
). 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patiinposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond stay limit Total bad debt expense for the entire hospital complex (see i	f hospital operations of the following facility counts (see the en off as following facility for the indigent of the indigent instructions)	Uni nsured pati ents 1.00 6,505,6 1,942,4 7,942,4 7,942,4 7,942,4	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0 3, 256, 933 1. 00 N	20. 21. 22. 23. 24. 25.
99. 00 11. 00 22. 00 44. 00 55. 00 66. 00 77. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patiinposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond stay limit Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital complex	f hospital opcal indigent facility counts (see en off as en off	Uninsured patients 1.00 6,505,6 1,942,4 1,942,4 vond a length	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498	0 3, 701, 715 Total (col. 1 + col. 2) 3. 00 7, 820, 119 3, 256, 933 0 3, 256, 933 1. 00 N 0 12, 305, 083 68, 361	20. 21. 22. 23. 24. 25. 26. 27.
99. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patiinposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond stay limit Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital complex	f hospital opcal indigent facility counts (see en off as en off	Uninsured patients 1.00 6,505,6 1,942,4 1,942,4 vond a length	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498	0 3, 701, 715 Total (col. 1 + col. 2) 3.00 7, 820, 119 3, 256, 933 0 3, 256, 933 1.00 N 0 12, 305, 083 68, 361 105, 170	20. 21. 22. 23. 24. 25. 26. 27. 27.
9. 00 11. 00 12. 00 33. 00 44. 00 6. 00 7. 00 7. 01 88. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patiimposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond stay limit Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital complex Non-Medicare bad debt expense (see instructions)	f hospital operations of the indigent facility counts (see en off as feet facility the indigent facility facili	Uninsured patients 1.00 6,505,6 1,942,4 //ond a length tructions)	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498 n of stay limit	0 3, 701, 715 Total (col. 1 + col. 2) 3.00 7, 820, 119 3, 256, 933 0 3, 256, 933 1.00 N 0 12, 305, 083 68, 361 105, 170 12, 199, 913	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
9. 00 0. 00 1. 00 2. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire f (see instructions) Cost of patients approved for charity care and uninsured discinstructions) Payments received from patients for amounts previously writte charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patiinposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond stay limit Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital complex	f hospital operations of the indigent facility counts (see en off as feet facility the indigent facility facili	Uninsured patients 1.00 6,505,6 1,942,4 //ond a length tructions)	Insured patients 2.00 21 1,314,498 35 1,314,498 0 0 35 1,314,498 n of stay limit	0 3, 701, 715 Total (col. 1 + col. 2) 3.00 7, 820, 119 3, 256, 933 0 3, 256, 933 1.00 N 0 12, 305, 083 68, 361 105, 170	20. 21. 22. 23. 24. 25. 26. 27. 28. 29.

Heal th	Financial Systems	RIVERVIEW H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Period: From 01/01/2018 To 12/31/2018	Worksheet A Date/Time Pre 5/28/2019 1: 2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	рш
		1. 00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				_		
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		17, 277, 160				
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	687, 110	5, 858, 041	6, 545, 15			
5.00	00500 ADMINISTRATIVE & GENERAL	8, 305, 878	26, 346, 952	34, 652, 830			5.00
7.00	00700 OPERATION OF PLANT	1, 913, 458	4, 731, 828	6, 645, 28		6, 644, 996	
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	49, 115 957, 216	383, 491 716, 050	432, 600 1, 673, 260		432, 606 1, 673, 266	1
10.00	01000 DI ETARY	1, 143, 634	1, 957, 705	3, 101, 33		844, 895	1
11. 00	01100 CAFETERI A	1, 143, 034	1, 757, 705	3, 101, 33	2, 020, 413		
13. 00	01300 NURSI NG ADMI NI STRATI ON	469, 438	112, 114	581, 55			1
14.00	01400 CENTRAL SERVICES & SUPPLY	538, 863	888, 016	1, 426, 87			1
15.00	01500 PHARMACY	2, 754, 672	19, 903, 177	22, 657, 849	9 -162, 767	22, 495, 082	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	813, 617	697, 325	1, 510, 94	2 0	1, 510, 942	16.00
17.00	01700 SOCIAL SERVICE	605, 705	181, 885	787, 590	0	787, 590	
23. 00	02300 PARAMED ED PRGM PHARMACY	0	0		119, 246	119, 246	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	7 475 050	4 0/0 0/4	0.700 /4/	154 504	0 007 000	00.00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 475, 258	1, 263, 361	8, 738, 619		8, 287, 088 2, 570, 460	
31. 00 41. 00	04100 SUBPROVI DER – I RF	2, 342, 821 1, 316, 469	501, 054 1, 153, 670	2, 843, 87 2, 470, 13		2, 380, 898	1
43.00	04300 NURSERY	1, 310, 409	1, 155, 670	2,470,13	0 -09, 241	2, 300, 676	43.00
	04400 SKILLED NURSING FACILITY	0	2, 110, 076	2, 110, 07	-	_	1
	ANCILLARY SERVICE COST CENTERS		=,				1
50.00	05000 OPERATING ROOM	2, 796, 739	17, 381, 199	20, 177, 93	-11, 847, 556	8, 330, 382	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 681, 285	815, 037	2, 496, 32		2, 498, 444	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	413, 677	596, 691	1, 010, 36			
57.00	05700 CT SCAN	266, 475	193, 541	460, 01		360, 259	1
57. 01	03630 ULTRA SOUND	194, 675	17, 724				1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	252, 433	31, 985	284, 418			
59.00	05900 CARDI AC CATHETERI ZATI ON	742, 891	1, 855, 307	2, 598, 198		1, 604, 227	1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2, 823, 247	3, 741, 346	6, 564, 59	3 -38, 036	6, 526, 557 0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	554, 029	554, 029	9 0	554, 029	
64. 00	06400 I NTRAVENOUS THERAPY	o	0.027	334, 02	0	0.027	1
65. 00	06500 RESPI RATORY THERAPY	1, 145, 369	275, 363	1, 420, 73	2 285, 015	_	1
66.00	06600 PHYSI CAL THERAPY	4, 570, 200	2, 774, 326	7, 344, 52			1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	698, 668	160, 090	858, 758	144, 054	1, 002, 812	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	908, 585	908, 58	5 0	908, 585	
	07300 DRUGS CHARGED TO PATIENTS	0	224 104	227 10	1 122		73.00
	07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY	0	326, 104	326, 10	-1, 422 0 0	324, 682	76.00
76. 00	03140 CARDI AC REHAB	763, 829	1, 102, 559		-		1
76. 02	03070 WOMEN' S CENTER	394, 551	151, 759	546, 310		464, 105	
76. 03	03330 ENDOSCOPY	0	0		0 02,200	0	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	348, 245	142, 881	491, 120	6 -48, 978		
90. 01	09001 OUTPATI ENT	588, 537	664, 371	1, 252, 90			1
90. 02	09002 NEUROPSYCHOLOGY	94, 173	15, 619	109, 79		109, 792	1
91.00	09100 EMERGENCY	2, 294, 395	3, 084, 011	5, 378, 40			
91. 01	09101 SHORT STAY	0	0	(0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	57, 403	46, 809	104, 21:	2 0	104, 212	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	37, 403	40, 007	104, 21.	2 0	104, 212	73.00
118.00		49, 500, 046	118, 921, 241	168, 421, 28	7 -469, 790	167, 951, 497	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	175, 072	160, 668	335, 740	0 0	335, 740	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	24, 851, 849	11, 274, 436	36, 126, 28	5 235, 279	36, 361, 564	192. 00
	19201 FOUNDATI ON	167, 172	12, 466	179, 63		179, 638	
	19202 CLINICS	1, 258, 316	257, 754	1, 516, 070		1, 515, 563	1
	19206 HOME HEALTH PARTNERSHIP	1 077 175	1, 489	1, 489			192.03
	19207 WESTFI ELD SCHOOLS	1, 077, 175	129, 799	1, 206, 97		1, 206, 716	
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE	483, 936	296, 022 -18, 110	779, 958 -18, 110		779, 958 -18, 110	1
	19205 RIVERVIEW MEDICAL ARTS	0	137, 098	137, 098		137, 098	1
	19300 NONPAID WORKERS	0	137, 070		0		193. 00
	07950 WORKMED	627, 432	312, 712	940, 14	-	940, 144	
	07951 MEALS ON WHEELS	0	0 12, 7.12		235, 276		
200.00		78, 140, 998	131, 485, 575	209, 626, 57			

 Health Financial
 Systems
 RIVERVI

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0059

Period: Worksheet A From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm

				5/28/2019 1: 2	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		6. 00	Allocation 7.00	-	
	GENERAL SERVICE COST CENTERS	6.00	7.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-42, 331	17, 021, 223	3	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-103, 408	6, 619, 049		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-10, 542, 862	22, 852, 579		5.00
7.00	00700 OPERATION OF PLANT	-1, 997	6, 642, 999		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	432, 606	5	8. 00
9.00	00900 HOUSEKEEPI NG	0	1, 673, 266	1	9. 00
10.00	01000 DI ETARY	0	844, 895	1	10.00
11. 00	01100 CAFETERI A	-758, 966	1, 261, 447		11.00
13. 00	01300 NURSING ADMINISTRATION	0	580, 354	l .	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-3, 364	16, 535, 367	1	14.00
	01500 PHARMACY	-5, 524, 682	16, 970, 400		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1, 703	1, 509, 239	1	16.00
17. 00	01700 SOCIAL SERVICE	0	787, 590	l .	17.00
23. 00	02300 PARAMED ED PRGM PHARMACY NPATIENT ROUTINE SERVICE COST CENTERS	0	119, 246		23. 00
30. 00	03000 ADULTS & PEDIATRICS	-1, 000	8, 286, 088	2	30.00
31. 00	03100 INTENSIVE CARE UNIT	-1,000	2, 570, 460		31.00
41. 00	04100 SUBPROVI DER – I RF	0	2, 380, 898		41.00
43. 00	04300 NURSERY	o o	2,000,070		43.00
44. 00	04400 SKILLED NURSING FACILITY	0	2, 056, 989		44.00
	ANCILLARY SERVICE COST CENTERS		,		
50.00	05000 OPERATING ROOM	-3, 674, 424	4, 655, 958	3	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-2, 650	2, 495, 794		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 063, 123	3	55.00
57. 00	05700 CT SCAN	0	360, 259		57.00
57. 01	03630 ULTRA SOUND	0	211, 121	1	57. 01
58. 00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	278, 815	·	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	-735, 000	869, 227	1	59.00
60.00	06000 LABORATORY	-108, 611	6, 417, 946	1	60.00
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	554, 029		64.00
65. 00	06500 RESPIRATORY THERAPY	-310, 000	1, 395, 747	7	65.00
66. 00	06600 PHYSI CAL THERAPY	-310,000	7, 337, 136	1	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o o	7, 337, 130		67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDI OLOGY	-67, 586	935, 226	ó	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	908, 585	5	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400 RENAL DI ALYSI S	0	324, 682	2	74.00
	03020 OTHER ANCI LLARY	0	0	1	76. 00
76. 01	03140 CARDI AC REHAB	0	1, 722, 116	1	76. 01
	03070 WOMEN' S CENTER	0	464, 105	1	76. 02
76. 03	03330 ENDOSCOPY	0	0)	76. 03
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	-4. 908	427 240		1 00 00
90. 00 90. 01	09001 OUTPATI ENT	-4, 908 -22, 063	437, 240 1, 072, 767	1	90.00
90.01	09002 NEUROPSYCHOLOGY	-22,003	1,072,767		90.01
91.00	09100 EMERGENCY	-1, 100, 000	4, 083, 367	1	91.00
	09101 SHORT STAY	0	4, 003, 307		91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-3, 290	100, 922	2	95.00
	SPECIAL PURPOSE COST CENTERS				1
118.00		-23, 008, 845	144, 942, 652	2	118. 00
400 -	NONREI MBURSABLE COST CENTERS	. 1	20= =		100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	335, 740	1	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	36, 361, 564	1	192.00
	19201 FOUNDATION	0	179, 638	1	192.01
	19202 CLINICS	0	1, 515, 563		192. 02 192. 03
	19206 HOME HEALTH PARTNERSHIP	_	1, 489		1
	19207 WESTFI ELD SCHOOLS	0	1, 206, 716		192. 04 192. 05
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE		779, 958 -18, 110		192.05
	19205 RI VERVI EW MEDI CAL ARTS	0	- 18, 110 137, 098		192.08
	19205 RIVERVIEW MEDICAL ARTS		137, 098		193. 00
	07950 WORKMED	0	940, 144		194. 00
	07951 MEALS ON WHEELS	0	235, 276	1	194.00
200.00		-23, 008, 845			200.00
				•	

| Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provi der CCN: 15-0059

					То	12/31/2018	Date/Time Prepared: 5/28/2019 1:23 pm
		Increases					072072017 1.20 piii
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - CAFETERI A	44.00	7.5 007	1 075 074			1.00
1. 00	CAFETERI A	11.00	74 <u>5, 037</u>	<u>1, 275, 376</u>			1.00
	TOTALS		745, 037	1, 275, 376			
1. 00	B - MOW MEALS ON WHEELS	194. 01	85, 346	149, 930			1 00
1.00	TOTALS	194.01	85, 346	149, 930			1.00
	C - I NSURANCE		05, 540	147, 730			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	213, 606			1.00
1.00	TOTALS			213, 606			1.00
	D - MED SUPPLY			=			
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	15, 017, 106			1.00
2.00		0.00	o	0			2.00
3.00		0.00	0	0			3.00
4.00		0. 00	0	0			4.00
5. 00		0. 00	0	0			5. 00
6. 00		0.00	0	0			6. 00
7.00		0.00	0	0			7.00
8. 00		0.00	0	0			8.00
9. 00 10. 00		0. 00 0. 00	0	0			9. 00 10. 00
11. 00		0.00	0	0			11.00
12. 00		0.00	0	0			12.00
13. 00		0.00	o	0			13. 00
14. 00		0.00	Ö	0			14.00
15. 00		0.00	o	Ö			15. 00
16. 00		0. 00	o	Ö			16.00
17.00		0.00	0	0			17.00
18.00		0.00	O	0			18. 00
19.00		0. 00	0	0			19.00
20.00		0.00	0	0			20.00
21. 00		0. 00	0	0			21.00
22. 00		0. 00	0	0			22.00
23.00		0.00	0	0			23.00
24.00		0.00	0	0			24.00
25. 00 26. 00		0. 00 0. 00	0	0			25. 00 26. 00
27. 00		0.00	0	0			27.00
28. 00		0.00	0	0			28.00
20.00	TOTALS — — — —		- — — 	15, 017, 106			20.00
	E - RSMA		<u> </u>	10,017,100			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	177, 306	0			1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	94, 746	0			2.00
3.00	OPERATING ROOM	50.00	1, 901, 553	$ \frac{0}{0}$			3.00
	TOTALS		2, 173, 605	0			
	F - PHYSICIAN PROFESSIONAL FE						
1. 00	OPERATING ROOM	50. 00	0	18, 000			1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	14, 100			2.00
3.00	RADI OLOGY-THERAPEUTI C	55. 00	0	52, 800			3.00
4. 00 E. 00	LABORATORY THERADY	60.00	0	61, 454			4.00
5.00	RESPIRATORY THERAPY	65. 00 69. 00	0	350, 000 151, 308			5.00
6. 00 7. 00	ELECTROCARDI OLOGY OUTPATI ENT	90. 01	0	40, 000			6. 00 7. 00
8. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	783, 333			8.00
0.00	TOTALS	172.00		1, 470, 995			3.00
	H - PARAMED ED		٦	1, 170, 773			
1. 00	PARAMED ED PRGM PHARMACY	23. 00	109, 929	9, 317			1.00
	TOTALS		109, 929	9, 317			
	I - COMMUNITY RELATIONS		•	·			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	<u>258, 2</u> 71			1.00
	TOTALS		0	258, 271			
500.00	Grand Total: Increases		3, 113, 917	18, 394, 601			500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provi der CCN: 15-0059

							Date/Time Prepared: 5/28/2019 1:23 pm
		Decreases				;	3/20/2019 1.23 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA	40.00	7.5 007	1 075 077			4.00
1. 00	DI ETARY	1000	74 <u>5, 037</u>	<u>1, 275, 376</u>		0	1.00
	TOTALS B - MOW		745, 037	1, 275, 376)		
1. 00	DI ETARY	10. 00	85, 346	149, 930		0	1.00
1.00	TOTALS		85, 346	149, 930		9	1.00
	C - I NSURANCE		337 3.10	1177 700			
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	213, 606	1.	2	1.00
	FI XT						
	TOTALS		0	213, 606)		
	D - MED SUPPLY	7 00				al	4.00
1.00	OPERATION OF PLANT	7. 00	0	290		0	1.00
2. 00 3. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	755 1, 198		0	2. 00 3. 00
4. 00	PHARMACY	15. 00	0	43, 521	1	0	4.00
5. 00	ADULTS & PEDIATRICS	30. 00	o	451, 531		0	5. 00
6. 00	INTENSIVE CARE UNIT	31. 00	o	273, 415		o o	6.00
7.00	SUBPROVI DER - I RF	41.00	О	89, 241		o	7. 00
8.00	SKILLED NURSING FACILITY	44. 00	O	53, 087	'	0	8.00
9. 00	OPERATING ROOM	50. 00	0	11, 593, 504		0	9. 00
10. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	11, 978		0	10.00
11.00	RADI OLOGY-THERAPEUTI C	55. 00	0	45		0	11.00
12.00	CT SCAN	57. 00 57. 01	0	99, 757		0	12.00
13. 00 14. 00	ULTRA SOUND MAGNETIC RESONANCE I MAGING	57. 01 58. 00	0	1, 278 5, 603		0	13. 00 14. 00
14.00	(MRI)	56.00	J	5, 003	'	o _l	14.00
15. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	993, 971		o	15. 00
16.00	LABORATORY	60.00	0	99, 490		o	16.00
17.00	RESPI RATORY THERAPY	65. 00	О	64, 985	5	o	17.00
18.00	PHYSI CAL THERAPY	66. 00	0	7, 390)	o	18.00
19. 00	ELECTROCARDI OLOGY	69. 00	0	7, 254		0	19. 00
20. 00	RENAL DI ALYSI S	74. 00	0	1, 422		0	20.00
21.00	CARDI AC REHAB	76. 01	0	144, 272		0	21.00
22. 00 23. 00	WOMEN'S CENTER CLINIC	76. 02 90. 00	O O	82, 205 48, 978		0	22. 00 23. 00
24. 00	OUTPATI ENT	90.00	0	198, 078			24.00
25. 00	EMERGENCY	91. 00	0	195, 039		ol	25. 00
26. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	548, 054		ol .	26.00
27.00	CLINICS	192. 02	0	507	,	o	27.00
28. 00	WESTFIELD SCHOOLS	192. 04	0	258		<u>o</u>	28. 00
	TOTALS		0	15, 017, 106)		
	E - RSMA	50.00		0 170 (05		al	4.00
1.00	OPERATING ROOM	50. 00 0. 00	0	2, 173, 605		0	1.00
2. 00 3. 00		0.00	0	0		0	2.00
3.00	TOTALS — — — —			2, 173, 605		<u> </u>	3.00
	F - PHYSICIAN PROFESSIONAL FEE	S		27 1707 000			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 470, 995	,	0	1.00
2.00		0. 00	0	0		0	2. 00
3.00		0. 00	0	0		0	3.00
4. 00		0. 00	0	0)	0	4. 00
5. 00		0. 00	0	0		0	5.00
6. 00 7. 00		0. 00 0. 00	0	0		0	6. 00 7. 00
8. 00		0.00	0	0		0	8.00
0.00	TOTALS — — — —			1, 470, 995		5	0.00
	H - PARAMED ED		٥	1, 770, 773	1		
1. 00	PHARMACY	15. 00	109, 929	9, 317	1	0	1.00
	TOTALS		109, 929	9, 317		<u> </u>	
	I - COMMUNITY RELATIONS						
1. 00	ADMI NI STRATI VE & GENERAL		258, 271	0		0	1.00
E00.00	TOTALS		258, 271	0 300 035		4	F00 00
500.00	Grand Total: Decreases		1, 198, 583	20, 309, 935	1		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RI VERVI EW HOSPI TAL Provi der CCN: 15-0059

| Period: | Worksheet A-7 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:

				Ic	12/31/2018	Date/lime Pre 5/28/2019 1:2	
				Acqui si ti ons		0,20,201, 112	<u> Б</u>
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	15, 961, 384	0	0	0	0	1.00
2. 00	Land Improvements	2, 892, 112	96, 033	0	96, 033	· ·	2.00
3.00	Buildings and Fixtures	102, 501, 108	32, 724, 385	0	32, 724, 385	379, 853	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5. 00	Fixed Equipment	41, 000, 763	1, 847, 338	0	1, 847, 338	231, 919	5.00
6. 00	Movable Equipment	132, 569, 292	10, 806, 931	0	10, 806, 931	2, 610, 743	
7. 00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	294, 924, 659	45, 474, 687	0	45, 474, 687	3, 231, 498	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	294, 924, 659	45, 474, 687	0	45, 474, 687	3, 231, 498	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
	DART I ANNUALO OF GUANGES IN CARLEY AGOS	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		al				4 00
1.00	Land	15, 961, 384	0				1.00
2. 00	Land Improvements	2, 979, 162	0				2.00
3.00	Buildings and Fixtures	134, 845, 640	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equi pment	42, 616, 182	0				5.00
6. 00	Movabl e Equi pment	140, 765, 480	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	337, 167, 848	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	337, 167, 848	0				10.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018		pared:
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	15, 533, 459	0	1, 389, 10	354, 596	0	1.00
3.00	Total (sum of lines 1-2)	15, 533, 459	0	1, 389, 10	354, 596	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	17, 277, 160			·	1.00
3. 00	Total (sum of lines 1-2)	0	17, 277, 160				3.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 Fo 12/31/2018		
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	134, 845, 640	0	134, 845, 640	1. 000000	0	1.00
3.00	Total (sum of lines 1-2)	134, 845, 640	0	134, 845, 640	1. 000000	0	3.00
		ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	col s. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0)	15, 533, 459		1. 00
3.00	Total (sum of lines 1-2)	0	0	(15, 533, 459	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
	DART LLL BECONOLILATION OF CARLTAL COOTS	11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		440.000			47.004.000	
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 346, 774	· ·	1	0		1.00
3.00	Total (sum of lines 1-2)	1, 346, 774	140, 990	1 (0	17, 021, 223	3.00

Provider CCN: 15-0059

				To	om 01/01/2018 12/31/2018		
				Expense Classification on		5/28/2019 1: 2	3 pm
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2. 00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -5, 964, 136		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-416, 670			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0	l l	0. 00	0	13. 00
14. 00 15. 00	Rental of quarters to employee	В	-536, 030 0	CAFETERI A	11. 00 0. 00	0	
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients		0		0. 00	0	17. 00
18. 00			0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0. 00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00				FIXT *** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	1 ' 2		0	*** Cost Center Deleted ***	19. 00		28.00
29. 00 30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

Provider CCN: 15-0059 Peri od: Worksheet A-8 From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

					0 12/31/2018	Date/IIMe Pre 5/28/2019 1:2	
				Expense Classification on	Worksheet A	072072017 1.2	J PIII
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	•	(2)				Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	HAF EXPENSE	A	-7, 326, 990	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	PHYSICIAN RECRUITMENT OFFSET	A	-3, 100	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	OTHER REV MEDICAL REPORT	В	-1, 703	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 02
33. 03	OTHER REVENUES ->PURCHASE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
	DI SCOUNTS						
33.04	NON-OP EXPENSE INVESTMENT FEES	В	208, 449	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33.05	RADI OLOGY- OTHER REVENUE-CDS	В	-2, 650	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 05
	FOR LEG						
33.06	AMBULANCE ->OTHER REVENUE	В	-3, 290	AMBULANCE SERVICES	95. 00	0	33.06
33. 07	LABORATORY -> OTHER REVENUE	В	-108, 611	LABORATORY	60.00	0	33. 07
33.08	MATERNITY CENTER ->OTHER	В	-1, 000	ADULTS & PEDIATRICS	30.00	0	33. 08
	REVENUE						
33.09	ENGINEERING- ENERGY REBATES	В	-1, 997	OPERATION OF PLANT	7. 00	0	33. 09
33. 10	WOUND CARE-OTHER REVENUE	В	-19, 963	OUTPATI ENT	90. 01	0	33. 10
33. 11	INFORMATION SYSTEMS-OTHER	В	-7, 500	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
	REVENUE						
33. 12	ADMINISTRATION-> LEAN TEAM	В	-496	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	WOUND CARE-OTHER REVENUE-WTA	В	-2, 100	OUTPATI ENT	90. 01	0	33. 13
	COURSE						
33. 14	EDUCATION -> OTHER REVENUE	В	-3, 285	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	SHO/UNCLAIMED REFUNDS	В	1, 013	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	OP PHARMACY REVENUE	В	-5, 524, 682	PHARMACY	15. 00	0	33. 16
33. 17	DIETARY -> SALES PR DEDUCT	В	-222, 936	CAFETERI A	11. 00	0	33. 17
33. 18	WELLNESS SERVICES -	В	-61, 410	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 18
	EXTERNAL->-OTHER						
33. 19	OTHER REV PREMIER PROGRAM	В		CENTRAL SERVICES & SUPPLY	14. 00	0	33. 19
33. 20	NON-OP REV -> MI SCELLANEOUS	В	-42, 331	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 20
	INTEREST			FLXT			
33. 21	COMMUNITY RELATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 22	COMMUNITY RELATIONS BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 22
33. 23	CRNA	A		OPERATING ROOM	50. 00	0	
33. 24	I HA LOBBYING EXPENSE	A	-4, 396	ADMINISTRATIVE & GENERAL	5. 00	0	00.2.
50.00	TOTAL (sum of lines 1 thru 49)		-23, 008, 845				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

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

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

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

6. 00	В	RMSA	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:

Worksheet A-8, column 2,

line 12.

- 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.
- 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems			RI VERVI EW HOSPI TAL					In Lieu of Form CMS-2552-10			
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZAT	IONS AND HOME	Provi der	CCN:	15-0059	Peri od:	Worksheet A-	8-1
OFFICE COSTS									From 01/01/2018	D-+- /T: D	
									To 12/31/2018	Date/Time Pro 5/28/2019 1::	
	Net	Wkst. A-7 Ref.								072072017 1	Lo piii
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTM	MENTS RE	QUI RED AS	A RESULT OF T	RANSACTI ONS	S WIT	H RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:										
1. 00	-416, 670	0									1.00
2. 00	0	0									2.00
3. 00	0	0									3.00
4. 00	0	0									4. 00
5. 00	-416, 670										5.00
									rksheet A, columr		
appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which											
has not			col umns	1 and/or 2	2, the amount	allowable	shoul	d be indi	cated in column 4	of this part	
	Related Organization(s)										
	and/or Home Office										
	T 6.5 1										
	Type of Business										
	4	00									
			TED ODGA	NI ZATI ON (S) VND/OD HOWE	OEEI CE:					
	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.

6.00		6.00
7. 00 8. 00 9. 00 10. 00		7.00
8. 00		8.00
9. 00		9.00
10. 00	10	10.00
100.00	100	00.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 15-0059

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 1: 23 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Provider Component	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	100	100	0	0	0	1.00
2.00		ADMINISTRATIVE & GENERAL	695, 960		0		_	
3. 00		OPERATING ROOM	2, 951	2, 951	0	0	1	
4. 00		OPERATING ROOM	388, 696		0	0	0	
5. 00		OPERATING ROOM OPERATING ROOM	-3, 808		0		0	5. 00
6. 00 7. 00		CLINIC	102, 860 4, 847	102, 860 4, 847	0	0	0	6. 00 7. 00
8. 00		CLINIC	61	61	0		Ö	
9. 00		OPERATING ROOM	-5, 953		0	Ö	Ö	
10.00	50. 00	OPERATING ROOM	493, 943	493, 943	0	0	0	10.00
11. 00		OPERATING ROOM	5, 609		0	0	0	
12.00		EMERGENCY	1, 100, 000		0	0	0	
13. 00 14. 00		ADMINISTRATIVE & GENERAL	243, 163	243, 163	0	0	0	13.00
15. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	130, 640	130, 640	0	0	0	14. 00 15. 00
16. 00		ADMINISTRATIVE & GENERAL	93, 396		0		Ö	16. 00
17. 00		ADMINISTRATIVE & GENERAL	629	629	0	Ö	Ö	ı
18. 00		OPERATING ROOM	1, 598, 456	1, 598, 456	0	0	0	1
19. 00		CARDIAC CATHETERIZATION	735, 000	735, 000	0	0	0	19. 00
20.00		ELECTROCARDI OLOGY	67, 586	67, 586	0	0	0	20.00
21. 00		ELECTROCARDI OLOGY	210 000	210 000	0	0	0	21.00
22. 00 200. 00	65.00	RESPIRATORY THERAPY	310, 000 5, 964, 136		0	0	0	22. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2. 00	8. 00	9. 00	Education 12.00	12 13. 00	14. 00	
1. 00		ADMI NI STRATI VE & GENERAL	0.00	7.00	0			1.00
2. 00		ADMINISTRATIVE & GENERAL	0	0	0	l e		
3.00	50. 00	OPERATING ROOM	0	0	0	0	0	3. 00
4.00		OPERATING ROOM	0	0	0	0	0	
5. 00		OPERATING ROOM	0	0	0	0	0	
6. 00		OPERATING ROOM CLINIC	0	0	0	0	0	
7. 00 8. 00		CLI NI C		0	0		0	7. 00 8. 00
9. 00		OPERATING ROOM		0	0	ĺ	Ö	9. 00
10.00		OPERATING ROOM	0	0	0	O	0	i
11.00	50. 00	OPERATING ROOM	0	0	0	0	0	11.00
12.00		EMERGENCY	0	0	0	0	0	
13.00		ADMINISTRATIVE & GENERAL	0	0	0	0	0	
14. 00 15. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	0	0	0	0	0	
16. 00		ADMINISTRATIVE & GENERAL		0	0		0	16. 00
17. 00		ADMINISTRATIVE & GENERAL	l	ő	0	ا	Ö	1
18. 00		OPERATING ROOM	0	0	0	O	0	18.00
19.00		CARDIAC CATHETERIZATION	0	0	0	0	0	19. 00
20.00		ELECTROCARDI OLOGY	0	0	0	0	0	20.00
21. 00		ELECTROCARDI OLOGY	0	0	0		0	
22. 00 200. 00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	22. 00 200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0	0	0			1. 00
2.00		ADMINISTRATIVE & GENERAL	0	0	0	695, 960		2.00
3.00		OPERATING ROOM	0	0	0	2, 951	1	3. 00
4.00		OPERATING ROOM	0	0	0	388, 696	1	4. 00
5. 00		OPERATING ROOM	0	0	0	-3, 808	1	5.00
6. 00 7. 00		OPERATING ROOM CLINIC	0	0	0	102, 860 4, 847	1	6. 00 7. 00
8. 00		CLINIC		0	0	61	1	8. 00
9. 00		OPERATING ROOM	0	ő	Ö	-5, 953		9. 00
10.00		OPERATING ROOM	0	0	0	493, 943	1	10. 00
11. 00		OPERATING ROOM	0	0	0	5, 609		11. 00
12.00		EMERGENCY	0	0	0	1, 100, 000	1	12.00
13.00		ADMINISTRATIVE & GENERAL	0	0	0	243, 163	1	13.00
14.00		ADMINISTRATIVE & GENERAL		0	0	120 640		14.00
15. 00 16. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL		0	0	130, 640 93, 396		15. 00 16. 00
17. 00		ADMINISTRATIVE & GENERAL				1		17. 00
		•		1	•	,		· · · · · · · · · · · · · · · · · · ·

Heal th	Financial Syste	ems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
PROVI DE	ER BASED PHYSIC	IAN ADJUSTMENT		Provi der (CCN: 15-0059	Peri od:	Worksheet A-	8-2	
						From 01/01/2018			
						To 12/31/2018	Date/Time Pr 5/28/2019 1:	epared: 23 pm	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0, 20, 20, 7		
		l denti fi er	Component	Limit	Di sal I owance				
			Share of col.						
			14						
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00			
18.00	50.00	OPERATING ROOM	0	0		0 1, 598, 456		18. 00	
19.00	59. 00	CARDIAC CATHETERIZATION	0	0		0 735, 000		19.00	
20.00	69. 00	ELECTROCARDI OLOGY	0			0 67, 586		20.00	
21.00	69. 00	ELECTROCARDI OLOGY	0	0		0 0		21.00	
22.00	65. 00	RESPIRATORY THERAPY	0	0		0 310, 000		22. 00	
200.00			0	0		0 5, 964, 136		200.00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0059

Cost Center Description						Ť	o 12/31/2018	Date/Time Pre 5/28/2019 1:2	
CAST Centred Description					CAPI TAL			372072019 1.2	3 piii
PRINCIPLE PRIN									
BEREAL SERVICE COST CENTERS			Cost Center Description				Subtotal		
					FIXI			E & GENERAL	
DEBERAL SERVICE DOST CENTERS 11,00 4,00 44 5,00 44 5,00 4 4									
EXERCIL SENVICE COST CENTERS 1. 00 0000 GENELOYEE ESERT TS DEPARMENT 2. 610 040 1 92, 406 6, 712, 455 2. 00 0000 GENELOYEE ESERT TS DEPARMENT 2. 610 040 1 92, 406 6, 712, 455 2. 00 0000 GENELOYEE ESERT TS DEPARMENT 2. 640 990 6, 397, 597, 150 1, 505, 508 2. 52, 22, 406 25, 524, 605 2. 00 0000 GENELOYEE ESERT TS DEPARMENT 2. 640 990 6, 397, 597, 150 1, 505, 508 2. 00 0000 GENELOYEE ESERT TS DEPARMENT 4. 42, 600 477, 437 6, 320 6. 00 0000 GENELOYEE ESERT TS DEPARMENT 1. 73, 204 83, 373 123, 109 18, 446, 802 2. 71, 100 0000 GENELOYEE THE SERVICE 4. 42, 600 477, 437 6, 320 6. 100 0000 GENELOYEE THE SERVICE 4. 42, 600 477, 437 6, 320 6. 100 0000 GENELOYEE THE SERVICE GOST CENTERS 3. 00 0000 GENELOYEE THE SERVICE SERVICE GOST CENTERS 3. 00 0000 GENELOYEE THE SERVICE SERVICE SERVICE GOST CENTERS 3. 00 00000 GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE GOST CENTERS 3. 00 00000 FRAMMENT GENELOYEE THE SERVICE					1.00	1.00			
1.00 DISTOD INTO CAP PER LORSTS-BLDG & FIXT 17,021,222 17,021,225 1,364,318 1,035,500 22,227,80 4,00 5,00		CENED	AL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
4.00 GOODG PARATHON OF PLANT SEPARATINEN 6,619,049 93,406 6,772,485 7,782,406 25,792,406 5,000 7,000	1. 00			17, 021, 223	17, 021, 223				1.00
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0.00 0.0000 AUJUNDAY & LINEN SERVICE 432,606 47,437 6,320 486,363 76,104 8.00 10.00 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000									
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11.00 01100 CAFETERIA 1.201, 447 0 95, 867 1,357, 314 212, 386 11.00 11.30 01300 MURSING AMM NISTRATION 580, 354 17,193 60, 604 65, 951 102, 171 13.00 10300 MURSING AMM NISTRATION 580, 354 17,93 60, 604 65, 951 102, 171 13.00 10300 MURSING AMM NISTRATION 16,535,367 139,050 81,529 16,755,946 2,743,320 17,750 10,750									•
13.00 (31300) MURSHEG ADMINISTRATION									1
14.00 01400 CFNITMA SERVICES & SUPPLY 16, 535, 597 139, 050 81, 597 16, 755, 268 2, 671, 887 14.00 16.00 01400 MEDICAL RECORDS & LIBRARRY 1, 509, 239 100, 644 104, 691 1, 714, 574 268, 288 16.00 17.00 17000 07100 05010 0514 SERVICE COST CENTERS 1787, 590 53, 566 77, 798 77, 799 77, 798									1
15.00 0 1500 PIAMAMACY 16.970.400 221,371 340,371 17,522,081 2,743,332 15.00 10.00 0 100 0100									1
17. 00 01700 SOCIAL SERVICE 787, 590 53, 564 77, 938 919, 094 143, 815 17, 00 230 02300 PARALET EN PROGUE PLASMACY 119, 246 5, 053 14, 145 138, 444 21, 163, 230 230 230 200		01500	PHARMACY						1
0.00									ł
INPATILENT ROUTINE SERVICE COST CENTERS 3, 266, 088 2, 510, 003 901, 871 11, 757, 962 1, 839, 827 30. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0							·		•
30.00	23.00			117, 240	5,053	14, 143	130, 444	21,003	23.00
41.00 04100 MURSERY 0 0 0 0 0 0 0 0 0	30.00	03000	ADULTS & PEDIATRICS	8, 286, 088	2, 510, 003	961, 871	11, 757, 962	1, 839, 827	30. 00
43.00 04300 NURSERY 0									
0.4400 SKILLED NURSING FACILITY 2,056,889 301,736 0 2,358,725 369,081 44,00 NOLLEY PERVICE COST CENTERS				2, 380, 898					
ANCILLARY SERVICE COST CENTERS 5.0.00 05000 DEPRATING ROM 4,655,958 1,215,944 324,862 6,196,764 969,639 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 4,655,958 1,215,944 324,662 6,196,764 969,639 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 2,495,794 231,608 216,338 2,943,740 466,622 54.00 55.00 05500 RADIOLOCY-THERAPEUTI C 1,063,123 231,511 53,229 1,347,863 210,907 55.00 57.01 03630 ULTRA SOUND 211,121 10,563 25,050 246,734 38,608 57.01 58.00 05500 MAGNETI C. RESONANCE IMAGING (MRI) 278,815 61,455 32,462 372,753 58,327 58.00 59.00 05900 CARDIAC CATHETERIZATION 869,227 93,863 95,591 1,058,681 165,657 59.00 05900 CARDIAC CATHETERIZATION 6,417,464 419,529 363,278 7,200,753 1,126,738 60.00 0600 BLOOD LABORATORY 6,417,464 419,529 363,278 7,200,753 1,126,738 60.00 0600 BLOOD LABORATORY 6,417,464 419,529 363,278 7,200,753 1,126,738 60.00 0600 BLOOD LABORATORY 7,377,47 8,563 147,379 1,611,689 252,189 65.00 0600 OSCORD CENSPI RATIORY 1,395,747 8,563 147,379 1,611,689 252,189 65.00 0600 OCCUPATIONAL THERAPY 7,337,136 97,319 588,066 8,022,521 1,255,524 66.00 0600 OCCUPATIONAL THERAPY 7,337,136 97,319 588,066 8,022,521 1,255,524 66.00 0600 OSCORD CUEPATIONAL THERAPY 90,536,240 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				2, 056, 989					1
52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		ANCI L	LARY SERVICE COST CENTERS	, ,	,		, ,	, , , , , , , , , , , , , , , , , , , ,	
54. 00 05400 RADIOLOGY-DI AGNOSTIC 2, 495, 794 231, 608 210, 338 2, 943, 740 400, 622 54, 00 57. 00 05700 CT SCAN 360, 259 49, 523 34, 288 444, 070 69, 486 57. 01 03630 UITAR SOUND 211, 121 10, 563 25, 505 244, 734 38, 608 57. 01 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 278, 815 61, 456 52, 482 372, 753 58, 327 58. 00 60. 00 06000 CARDIAC CATHETER IZATION 869, 227 93, 863 95, 591 1, 686, 681 166, 567 59. 00 6000 CARDIAC CATHETER IZATION 869, 227 93, 863 95, 591 1, 686, 681 166, 567 59. 00 6000 ABDRATORY 0		1	l .	4, 655, 958			6, 196, 764		1
55.00 05500 RADIOLOGY-THERAPEUTIC 1, 063, 123 231, 151 55, 229 1, 347, 863 210, 977 55, 00 57, 00 5700 07500 CT SCAM 360, 259 49, 523 342, 886 444, 070 69, 486 57, 00 5700 07500 CT SCAM 38, 608 57, 00 57, 00 07500 CARDIATORY CT SCAM 211, 121 10, 563 25, 605 246, 734 38, 608 57, 00 59, 00 05900 CARDIATORY CT SCAM 589, 227 793, 863 95, 991 1, 058, 681 165, 657 59, 00 00, 00 0, 00				2 495 794	_	1	0 2 943 740		•
57. 01 03630 ULTRA SOUND 211, 121 10, 563 25, 060 246, 734 38, 608 57, 015 59, 00 05900 CARDITAC RESONANCE INAGING (WRI) 278, 815 61, 456									•
58. 00 05800 MAGNETIC RESONANCE I MAGI NC (MRI) 278, 815 61, 456 32, 482 372, 753 58, 327 59, 00 600, 00 06000 CARDI ACC ATHETERI ZATI ON 869, 227 93, 863 328 7, 200, 753 1, 126, 738 60, 00 60, 01 06001 BLODO LABORATORY 0 0 0 0 0 0 0 0 0		05700	CT SCAN						1
59,00 CARDID AC CATHETERIZATION 869,227 93,863 95,591 1,058,881 165,687 89,00									•
60.00 06000 LABORATORY 6, 417, 946 419, 529 363, 278 7, 200, 753 1, 126, 738 60.00									•
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 554,029 63,640 0 617,669 96,650 63.00									•
64 00 06400 INTRAVENOUS THERAPY 1,395,747 68,563 147,379 1,611,689 252,189 65.00 06500 0				0	_	1	0	_	1
65.00 0.50				554, 029			617, 669		1
66.00 06600 PHYSI CAL THERAPY 7, 337, 136 97, 319 588, 066 8, 022, 521 1, 255, 324 66.00		1	l .	1, 395, 747	_	1	1, 611, 689		1
68.00		06600	PHYSI CAL THERAPY						
69-00 06900 ELECTROCARDIO LOCY 935, 226 349, 206 89, 900 1, 374, 332 215, 049 69, 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 908, 585 142, 171 72. 00 73. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0	0		1
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 908,585 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 324,682 30,288 0 354,970 55,544 74,00 76.00 03020 OTHER ANCI LLARY 0 0 0 0 0 0 0 76.01 03140 CARDI AC REHAB 1,722,116 51,577 98,285 1,871,978 292,918 76.01 76.02 03030 0300 0300 0300 0300 0				935 226	349 206	89 900	1 374 332		
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74. 00 07400 RENAL DI ALYSIS 324,682 30,288 0 354,970 55,544 74.00 76.00 03020 OTHER ANCILLARY 0 0 0 0 0 0 0 0 0									•
76. 00 03020 OTHER ANCI LLARY 0 0 0 0 76. 0		1		-					
76. 01 03140 CARDI AC REHAB 1,722,116 51,577 98,285 1,871,978 292,918 76. 01 76. 02 76. 03									
76. 03 03330 ENDOSCOPY 0 0 0 0 0 0 0 76. 03		03140	CARDI AC REHAB	1, 722, 116					
OUTPATI ENT SERVI CE COST CENTERS									
90. 00 09000 CLINIC 437, 240 78, 605 44, 810 560, 655 87, 728 90. 00 90. 01 09001 0UTPATIENT 1, 072, 767 114, 467 75, 729 1, 262, 963 197, 622 90. 01 90. 02 09002 NEUROPSYCHOLOGY 109, 792 132, 660 12, 118 254, 570 39, 834 90. 02 91. 00 09100 EMERGENCY 4, 083, 367 510, 034 295, 229 4, 888, 630 764, 948 91. 00 91. 01 99101 SHORT STAY 0 0 0 0 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 144, 942, 652 16, 379, 443 6, 213, 914 143, 802, 331 18, 550, 103 18, 702 190. 00 190	76. 03			0	0	0	0	0	76.03
90. 02 09002 NEUROPSYCHOLOGY 109, 792 132, 660 12, 118 254, 570 39, 834 90. 02 91. 00 09100 EMERGENCY 4, 083, 367 510, 034 295, 229 4, 888, 630 764, 948 91. 00 91. 01 09101 SHORT STAY 0 0 0 0 0 0 92. 00 095ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 07 07 07 07 07 07 07	90. 00			437, 240	78, 605	44, 810	560, 655	87, 728	90.00
91. 00									1
91. 01 09101 SHORT STAY 0 0 0 0 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 91. 01 92. 00 OTHER REI MBURSABLE COST CENTERS 095.00 AMBULANCE SERVI CES 100, 922 11, 215 7, 386 119, 523 18, 702 95. 00 SPECI AL PURPOSE COST CENTERS 0 SUBTOTALS (SUM OF LINES 1 through 117) 144, 942, 652 16, 379, 443 6, 213, 914 143, 802, 331 18, 550, 103 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 335, 740 199, 364 22, 527 557, 631 87, 255 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 36, 361, 564 442, 416 0 36, 803, 980 5, 758, 832 192. 00 192.01 19201 FOUNDATI ON 179, 638 0 21, 511 201, 149 31, 475 192. 01 192. 02 19202 CLI NI CS 1, 515, 563 0 161, 913 1, 677, 476 262, 483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 1, 489 0 0 1, 489 233 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 206, 716 0 138, 604 1, 345, 320 210, 509 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 708 192. 05 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08 192. 08 192.05 192.05 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08 192. 08 192.05									1
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 100, 922 11, 215 7, 386 119, 523 18, 702 95. 00 SPECI AL PURPOSE COST CENTERS 18. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 144, 942, 652 16, 379, 443 6, 213, 914 143, 802, 331 18, 550, 103 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 335, 740 199, 364 22, 527 557, 631 87, 255 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 36, 361, 564 442, 416 0 36, 803, 980 5, 758, 832 192. 00 192. 01 19201 FOUNDATI ON 179, 638 0 21, 511 201, 149 31, 475 192. 01 192. 02 19202 CLI NI CS 1, 515, 563 0 161, 913 1, 677, 476 262, 483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 1, 489 0 0 1, 489 233 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 206, 716 0 138, 604 1, 345, 320 210, 509 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 788 192. 05 192. 08 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08 192. 08 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08 192. 08 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08							4, 888, 630 0		
95. 00 09500 AMBULANCE SERVI CES 100, 922 11, 215 7, 386 119, 523 18, 702 95. 00 SPECI AL PURPOSE COST CENTERS 144, 942, 652 16, 379, 443 6, 213, 914 143, 802, 331 18, 550, 103 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 335, 740 199, 364 22, 527 557, 631 87, 255 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 36, 361, 564 442, 416 0 36, 803, 980 5, 758, 832 192. 00 192. 01 19201 FOUNDATI ON 179, 638 0 21, 511 201, 149 31, 475 192. 01 192. 02 19202 CLI NI CS 1, 515, 563 0 161, 913 1, 677, 476 262, 483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 1, 489 0 0 1, 489 233 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 206, 716 0 138, 604 1, 345, 320 210, 509 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 788 192. 05 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08 192. 08 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08 192. 08 192. 08 192. 08 19205 RI VERVI EW MEDI CAL ARTS 130, 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 08 100. 00 137, 098 21, 452 192. 0				J	9		0	Ü	
SPECIAL PURPOSE COST CENTERS 144, 942, 652 16, 379, 443 6, 213, 914 143, 802, 331 18, 550, 103 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 144, 942, 652 16, 379, 443 6, 213, 914 143, 802, 331 18, 550, 103 118. 00 NONREI MBURSABLE COST CENTERS 335, 740 199, 364 22, 527 557, 631 87, 255 190. 00 190. 00 19000 PHYSI CI ANS' PRI VATE OFFICES 36, 361, 564 442, 416 0 36, 803, 980 5, 758, 832 192. 00 192. 01 19201 FOUNDATI ON 179, 638 0 21, 511 201, 149 31, 475 192. 01 192. 02 19202 CLI NI CS 1, 515, 563 0 161, 913 1, 677, 476 262, 483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 1, 489 0 0 1, 489 233 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 206, 716 0 138, 604 1, 345, 320 210, 509 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 788 192. 05 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08 192.									
18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 144, 942, 652 16, 379, 443 6, 213, 914 143, 802, 331 18, 550, 103 118. 00	95. 00			100, 922	11, 215	7, 386	119, 523	18, 702	95.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 335,740 199,364 22,527 557,631 87,255 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 36,361,564 442,416 0 36,803,980 5,758,832 192. 00 192. 01 19201 FOUNDATI ON 179,638 0 21,511 201,149 31,475 192. 01 192. 02 19202 CLI NI CS 1,515,563 0 161,913 1,677,476 262,483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 1,489 0 0 1,489 233 192. 02 192. 04 19207 WESTFI ELD SCHOOLS 1,206,716 0 138,604 1,345,320 210,509 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 779,958 0 62,270 842,228 131,788 192. 05 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137,098 0 0 137,098 21,452 192. 08 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137,098 0 0 137,098 21,452 192. 08 192. 08 192. 08 19205 19208 19208 19	118.00			144, 942, 652	16, 379, 443	6, 213, 914	143, 802, 331	18, 550, 103	1 118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 36, 361, 564 442, 416 0 21, 511 201, 149 31, 475 192. 01 192. 01 19201 FOUNDATI ON 179, 638 0 21, 511 201, 149 31, 475 192. 01 192. 02 19202 CLI NI CS 1, 515, 563 0 161, 913 1, 677, 476 262, 483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 1, 489 0 0 1, 489 233 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 206, 716 0 138, 604 1, 345, 320 210, 509 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 788 192. 05 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08		NONRE	IMBURSABLE COST CENTERS						
192. 01 19201 FOUNDATION 179, 638 0 21, 511 201, 149 31, 475 192. 01 192. 02 19202 CLI NI CS 1, 515, 563 0 161, 913 1, 677, 476 262, 483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P 1, 489 0 0 1, 489 233 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 206, 716 0 138, 604 1, 345, 320 210, 509 192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 788 192. 05 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08									1
192. 02 19202 CLINICS 1, 515, 563 0 161, 913 1, 677, 476 262, 483 192. 02 192. 03 19206 HOME HEALTH PARTNERSHIP 1, 489 0 0 1, 489 233 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 206, 716 0 138, 604 1, 345, 320 210, 509 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 788 192. 05 192. 06 19204 MOB - NOBLESVI LLE SQUARE -18, 110 0 0 137, 098 192. 06 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08									1
192. 03 19206 HOME HEALTH PARTNERSHIP					0				
192. 05 19203 PRACTI CE MANAGEMENT 779, 958 0 62, 270 842, 228 131, 788 192. 05 192. 06 19204 MOB - NOBLESVI LLE SQUARE -18, 110 0 -18, 110 0 -18, 110 0 192. 06 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08	192. 03	19206	HOME HEALTH PARTNERSHIP	1, 489	0	0	1, 489	233	192. 03
192. 06 19204 MOB - NOBLESVI LLE SQUARE -18, 110 0 0 -18, 110 0 192. 06 192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08					0				1
192. 08 19205 RI VERVI EW MEDI CAL ARTS 137, 098 0 0 137, 098 21, 452 192. 08					0				
193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00	192. 08	19205	RIVERVIEW MEDICAL ARTS	137, 098		0	137, 098	21, 452	192. 08
	193.00	19300	NONPALD WORKERS	0	0	0	0	0	193. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2018 Fo 12/31/2018	Date/Time Pre	pared:
					5/28/2019 1: 2	3 pm
		CAPI TAL				
Cook Cooker December	Not Function	RELATED COSTS	-	C	ADMINI CTDATIV	
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost	FLXT	BENEFITS		E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1.00	4. 00	4A	5. 00	
194. 00 07950 WORKMED	940, 144	0	80, 73	1, 020, 878	159, 742	194.00
194.01 07951 MEALS ON WHEELS	235, 276	0	10, 98	2 246, 258	38, 533	194. 01
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0)	0	0	201.00
202.00 TOTAL (sum lines 118 throug	h 201) 186, 617, 728	17, 021, 223	6, 712, 45	186, 617, 728	25, 252, 405	202. 00

Provi der CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm

			''	0 12/31/2010	5/28/2019 1: 2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10. 00	11. 00	
GENERAL SERVICE COST CENTERS			1			
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	15, 367, 668					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	79, 546	642, 013				8. 00
9. 00 00900 HOUSEKEEPI NG	64, 348	0	2, 186, 258			9.00
10. 00 01000 DI ETARY	587, 222	0	8, 924	2, 024, 839		10.00
11. 00 01100 CAFETERI A	o	0	62, 465	o	1, 632, 165	11.00
13.00 01300 NURSING ADMINISTRATION	20, 447	0	0	o	13, 216	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	233, 172	4, 826	2, 231	o	47, 335	•
15. 00 01500 PHARMACY	371, 217	., ===	55, 772	0	99, 855	1
16. 00 01600 MEDICAL RECORDS & LIBRARY	168, 770	0		0	44, 651	16.00
17. 00 01700 SOCI AL SERVI CE	89, 825	0	0	0	21, 728	17.00
23. 00 02300 PARAMED ED PRGM PHARMACY	8, 474	0	0	0	2, 023	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0, 474		0	<u> </u>	2,023	23.00
30. 00 03000 ADULTS & PEDIATRICS	4, 209, 021	201, 236	762, 957	1, 009, 557	325, 957	30.00
						1
31. 00 03100 NTENSI VE CARE UNI T	773, 651	46, 913		130, 337	75, 988	31.00
41. 00 04100 SUBPROVI DER - RF	539, 112	50, 160			68, 212	41.00
43. 00 04300 NURSERY	0	0	·	0	0	43.00
44. 00 04400 SKILLED NURSING FACILITY	505, 981	46, 562	136, 083	434, 140	0	44.00
ANCILLARY SERVICE COST CENTERS	0.000.014	(0.011			110 117	
50. 00 05000 OPERATING ROOM	2, 039, 014	62, 311	238, 704	0	148, 167	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	_	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	388, 384	37, 596	35, 694	0	77, 765	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	388, 220	5, 194	22, 309	0	13, 492	55.00
57. 00 05700 CT SCAN	83, 045	0	0	0	11, 812	57.00
57. 01 03630 ULTRA SOUND	17, 713	0	0	0	805	57. 01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	103, 055	0	2, 231	0	11, 192	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	157, 398	16, 565	0	0	25, 064	59.00
60. 00 06000 LABORATORY	703, 508	0	78, 081	o	148, 809	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	106, 718	0	j o	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	100, 710	0	j ,	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	114, 973	0	6, 693	0	46, 488	65.00
66. 00 06600 PHYSI CAL THERAPY	163, 193	5, 413		0	205, 315	1
1	103, 143	5,415		0	205, 315	1
	U	0		0	-	67.00
68. 00 06800 SPEECH PATHOLOGY	505 500	0	14 /10	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	585, 582	5, 510	44, 618	0	33, 341	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	50, 789	0	0	0	0	74.00
76. 00 03020 0THER ANCI LLARY	0	0	0	0	0	76.00
76. 01 03140 CARDI AC REHAB	86, 490	474	60, 234	0	31, 465	76. 01
76. 02 03070 WOMEN' S CENTER	232, 298	3, 202	44, 618	0	21, 110	76. 02
76. 03 03330 ENDOSCOPY	0	0	0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	131, 812	869	0	0	18, 076	90.00
90. 01 09001 OUTPATI ENT	191, 950	17, 442		0	24, 273	90. 01
90. 02 09002 NEUROPSYCHOLOGY	222, 457	. 0	. 0	0	2, 715	1
91. 00 09100 EMERGENCY	855, 275	86, 659	189, 624	0	84, 699	
91. 01 09101 SHORT STAY	0	00,007	107, 021	0	0 1, 0 , 7	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	ı .	Ü	Ĭ	Ŭ	O	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	18, 807	0	0	o	2, 886	95.00
SPECIAL PURPOSE COST CENTERS	10, 007	0	0	U _I	2,000	95.00
	14 201 4/7	F00, 022	2 050 000	2 024 020	1 (0(120	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 291, 467	590, 932	2, 059, 098	2, 024, 839	1, 606, 439	1118.00
NONREI MBURSABLE COST CENTERS	201.011				10.500	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	334, 314	0	2, 231	0	12, 538	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	741, 887	50, 642		0		192. 00
192. 01 19201 FOUNDATI ON	0	0	0	0		192. 01
192. 02 19202 CLI NI CS	0	228	124, 929	0		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	0	0	0	0	192. 03
192.04 19207 WESTFI ELD SCHOOLS	l ol	0	0	O	0	192. 04
192. 05 19203 PRACTI CE MANAGEMENT	ol	211	0	o	0	192. 05
192.06 19204 MOB - NOBLESVILLE SQUARE	ol	0	0	o		192.06
192.08 19205 RI VERVI EW MEDICAL ARTS	n	0	n	n		192. 08
193. 00 19300 NONPALD WORKERS	اً ما	n	n	n		193.00
194. 00 07950 WORKMED	اً م	0	l ŏ	l o		194.00
194.01 07951 MEALS ON WHEELS	ا م	0		0		194.00
200.00 Cross Foot Adjustments		0		٥		200.00
201.00 Negative Cost Centers	٨	0	_	0		201.00
202.00 TOTAL (sum lines 118 through 201)	15, 367, 668	642, 013	2, 186, 258	2, 024, 839		
	. 5, 557, 556	5 72, 013	2, 100, 200	2, 024, 037	1, 002, 100	

Provi der CCN: 15-0059

			10	12/31/2018	Date/lime Pre 5/28/2019 1:2	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMINISTRATIO N	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
	13. 00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 O1300 NURSING ADMINISTRATION	788, 785					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	19, 665, 397				14.00
15. 00 01500 PHARMACY	0	0	20, 802, 257	0 007 407		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0	0	2, 207, 437 0	1, 174, 462	16. 00 17. 00
23. 00 02300 PARAMED ED PRGM PHARMACY	0	0	0	0	1, 174, 402	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	<u> </u>	0	<u> </u>		23.00
30. 00 03000 ADULTS & PEDIATRICS	463, 382	0	0	504, 402	936, 730	30. 00
31.00 03100 INTENSIVE CARE UNIT	108, 024	0	0	146, 439	63, 897	31.00
41. 00 04100 SUBPROVI DER - I RF	96, 971	0	0	0	102, 408	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44. 00 04400 SKILLED NURSING FACILITY	0	0	0	0	71, 427	44.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	O	ol	0	862, 366	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	o	0	002, 300	0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	l ol	o	0	16, 271	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	o	0	59, 660	0	55.00
57.00 05700 CT SCAN	o	0	0	0	0	57.00
57. 01 03630 ULTRA SOUND	0	0	0	0	0	57. 01
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	42 200	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	0	0	43, 389	0	60. 00 60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	l ol	Ö	0	Ö	0	64.00
65. 00 06500 RESPIRATORY THERAPY	o	o	0	Ō	0	65.00
66. 00 06600 PHYSI CAL THERAPY	O	0	0	390, 505	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	10 //5 207	0	59, 660	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	19, 665, 397	0	O O	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS		0	20, 802, 257	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	l ol	Ö	0	Ö	0	74.00
76. 00 03020 OTHER ANCI LLARY	o	o	0	o	0	76.00
76. 01 03140 CARDI AC REHAB	o	0	0	0	0	76. 01
76. 02 03070 WOMEN' S CENTER	0	0	0	0	0	76. 02
76. 03 03330 ENDOSCOPY	0	0	0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS		O	0	ما	0	90.00
90. 00 09000 CLI NI C 90. 01 09001 OUTPATI ENT	0	0	0	0	0	90.00
90. 02 09002 NEUROPSYCHOLOGY		0	0	0	0	90.01
91. 00 09100 EMERGENCY	120, 408	o	0	108, 474	0	91.00
91. 01 09101 SHORT STAY	o	0	0	0	0	91. 01
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS			-			
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	788, 785	19, 665, 397	20, 802, 257	2, 191, 166	1, 174, 462	110 00
NONREI MBURSABLE COST CENTERS	700, 700	19, 000, 397	20, 602, 237	2, 191, 100	1, 174, 402	110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o	o	0	o		192.00
192. 01 19201 FOUNDATI ON	O	0	0	0	0	192. 01
192. 02 19202 CLINICS	0	0	0	16, 271		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192. 03
192. 04 19207 WESTFI ELD SCHOOLS	0	0	0	0		192.04
192. 05 19203 PRACTI CE MANAGEMENT	0	0	0	0		192.05
192.06 19204 MOB - NOBLESVILLE SQUARE 192.08 19205 RIVERVIEW MEDICAL ARTS		O	0	0		192. 06 192. 08
193. 00 19300 NONPALD WORKERS		O O	0	0		192.00
194. 00 07950 WORKMED	l ől	ő	0	ő		194. 00
194. 01 07951 MEALS ON WHEELS	o	o	0	ō		194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	RI VERVI EW F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-0059	Peri od:	Worksheet B	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	
					5/28/2019 1: 2	3 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15. 00	16.00	17.00	
202.00 TOTAL (sum lines 118 through 201)	788, 785	19, 665, 397	20, 802, 25	7 2, 207, 437	1, 174, 462	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0059

					lo 12/31/2018	Date/lime Prepared: 5/28/2019 1:23 pm
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	, c, 20, 201, 1120 p
		PRGM PHARMACY		Resi dents		
				Cost & Post		
				Stepdown Adjustments		
		23. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5. 00 7. 00
8. 00	00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00	01700 SOCI AL SERVI CE					17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY	170, 604				23.00
30. 00	O3000 ADULTS & PEDIATRICS	O	22, 011, 031	I	22, 011, 031	30.00
31.00	1 1	0	5, 340, 647		5, 340, 647	
41. 00	04100 SUBPROVI DER – I RF	o	4, 769, 362		4, 769, 362	
43.00	04300 NURSERY	o	0		0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	3, 921, 999		3, 921, 999	44.00
E0 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	10 514 045		10, 516, 965	50.00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	10, 516, 965 0		10, 516, 965 0 0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	3, 960, 072	1	3, 960, 072	
55.00	05500 RADI OLOGY-THERAPEUTI C	O	2, 047, 645		2, 047, 645	
57.00	05700 CT SCAN	0	608, 413	1	608, 413	
57. 01	03630 ULTRA SOUND	0	303, 860		303, 860	
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	547, 558 1, 423, 365	1	547, 558 1, 423, 365	
60. 00	06000 LABORATORY		9, 301, 278		9, 301, 278	
60. 01	06001 BLOOD LABORATORY	O	0		0	l
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	821, 037		821, 037	63.00
64.00	06400 NTRAVENOUS THERAPY	0	0	•	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	2, 032, 032 10, 042, 271		2, 032, 032 10, 042, 271	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		10, 042, 271		0 10,042,271	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0	1	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	2, 318, 092		2, 318, 092	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 665, 397		19, 665, 397	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	170, 604	1, 050, 756 20, 972, 861	1	1, 050, 756 20, 972, 861	72. 00 73. 00
74.00	07400 RENAL DI ALYSI S	170, 804	461, 303		461, 303	74.00
	03020 OTHER ANCI LLARY	ő	0		0	
	03140 CARDI AC REHAB	O	2, 343, 559		2, 343, 559	76. 01
	03070 WOMEN'S CENTER	0	1, 056, 870		1, 056, 870	
76. 03	03330 ENDOSCOPY	0	0		0	76. 03
90 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	nl	799, 140		799, 140	90.00
	09001 OUTPATI ENT	o o	1, 709, 866	•	1, 709, 866	
90. 02	09002 NEUROPSYCHOLOGY	o	519, 576		519, 576	
	09100 EMERGENCY	0	7, 098, 717	1	7, 098, 717	
91. 01 92. 00	09101 SHORT STAY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	91. 01 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>	92.00
95. 00	09500 AMBULANCE SERVICES	0	159, 918		159, 918	95. 00
	SPECIAL PURPOSE COST CENTERS					
118.00		170, 604	135, 803, 590	(135, 803, 590	118. 00
100.00	NONREI MBURSABLE COST CENTERS		002.040	1	002.040	100.00
) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	993, 969 43, 355, 341		993, 969 43, 355, 341	190. 00 192. 00
	19201 FOUNDATION		238, 818		238, 818	
	19202 CLI NI CS	0	2, 081, 387		2, 081, 387	192. 02
	19206 HOME HEALTH PARTNERSHIP	0	1, 722		1, 722	
	19207 WESTFI ELD SCHOOLS	0	1, 555, 829		1, 555, 829	
	19203 PRACTI CE MANAGEMENT	0	974, 227		974, 227	
	19204 MOB - NOBLESVILLE SQUARE 19205 RIVERVIEW MEDICAL ARTS		-18, 110 158, 550		-18, 110 158, 550	
	19300 NONPALD WORKERS		0		0 130, 330	
194.00	07950 WORKMED	o	1, 180, 620		1, 180, 620	194. 00
194. 01	07951 MEALS ON WHEELS	0	291, 785		291, 785	194. 01

Heal th Fina	ncial Systems	RI VERVI EW H	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pr	epared:
						5/28/2019 1:	23 pm
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
		PRGM PHARMACY		Resi dents			
				Cost & Post			
				Stepdown			
				Adjustments			
		23. 00	24. 00	25. 00	26. 00		
200.00	Cross Foot Adjustments	0	0		0 0		200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202. 00	TOTAL (sum lines 118 through 201)	170, 604	186, 617, 728		0 186, 617, 728		202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0059

					12/31/2018	5/28/2019 1: 2	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	
		0	1.00	2A	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS	T	Г	1			
1. 00 4. 00 5. 00 7. 00 8. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0 0	93, 406 1, 364, 318 6, 399, 159 47, 437	1, 364, 318 6, 399, 159	93, 406 14, 388 3, 427 88	1, 378, 706 113, 523	1. 00 4. 00 5. 00 7. 00 8. 00
9. 00 10. 00 11. 00 13. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0 0 0	38, 373 350, 184 0 12, 193	38, 373 350, 184 0	1, 714 561 1, 334 841		9. 00 10. 00 11. 00 13. 00
14. 00 15. 00 16. 00 17. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0 0 0 0	139, 050 221, 371 100, 644 53, 566	139, 050 221, 371 100, 644	1, 135 4, 737 1, 457 1, 085	143, 146 149, 777 14, 648	14. 00 15. 00 16. 00 17. 00
23. 00		0	5, 053	1	197	1, 183	23. 00
20.00	I NPATIENT ROUTI NE SERVI CE COST CENTERS	0	0 540 000	0 540 000	12 200	100 110	
30. 00 31. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	0 0	2, 510, 003 461, 358 321, 493 0	461, 358 321, 493	13, 388 4, 196 2, 358 0	28, 476 24, 534	30. 00 31. 00 41. 00 43. 00
44. 00		0	301, 736	301, 736	0	20, 151	44. 00
50. 00 52. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	1, 215, 944		4, 522 0	52, 939 0	50. 00 52. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	231, 608 231, 511	231, 511	3, 011 741	25, 148 11, 515	54. 00 55. 00
57. 00 57. 01	05700 CT SCAN 03630 ULTRA SOUND	0	49, 523 10, 563		477 349	3, 794 2, 108	57. 00 57. 01
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	61, 456		452	•	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	93, 863		1, 331	9, 044	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	419, 529	419, 529 0	5, 056 0	61, 516 0	60. 00 60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63, 640		0	5, 277	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0	68, 563		2, 051	13, 769	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	97, 319 0		8, 185 0	68, 536 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	O	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	349, 206		1, 251	11, 741	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 7, 762	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	Ö	0	0	73.00
74.00		0	30, 288	1	0	3, 033	
76. 00 76. 01	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	0	0 51, 577	,	0 1, 368		
76. 02	03070 WOMEN' S CENTER	0	1		707	5, 582	76. 02
76. 03		0	0	0	0	0	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	78, 605	78, 605	624	4, 790	90.00
90. 01	09001 OUTPATI ENT	0	114, 467	114, 467	1, 054	10, 789	90. 01
90. 02 91. 00		0	132, 660 510, 034		169 4, 109	•	90. 02 91. 00
91.00	09101 SHORT STAY	0	0 0 0 0 0	1	4, 109		91.00
92. 00				0			92.00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0	11, 215	11, 215	103	1, 021	95. 00
93.00	SPECIAL PURPOSE COST CENTERS	0	11, 213	11, 215	103	1,021	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	16, 379, 443	16, 379, 443	86, 466	1, 012, 775	118. 00
100.00	NONREI MBURSABLE COST CENTERS		100 244	100.274	214	4 7/4	100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	0	199, 364 442, 416		314 0		190. 00 192. 00
192. 01	1 19201 FOUNDATI ON	0	0	0	299	1, 718	192. 01
	2 19202 CLINICS 3 19206 HOME HEALTH PARTNERSHIP	0	0	0	2, 254 0		192. 02 192. 03
	4 19207 WESTFIELD SCHOOLS	0	0	0	1, 929		
192. 05	5 19203 PRACTICE MANAGEMENT	0	0	0	867	7, 195	192.05
	6 19204 MOB - NOBLESVILLE SQUARE B 19205 RIVERVIEW MEDICAL ARTS	0	0	0	0		192. 06 192. 08
193.00	19300 NONPALD WORKERS	0	0		0	0	193. 00
194.00	07950 WORKMED	0	0	0	1, 124	8, 721	194. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0059	Peri od:	Worksheet B		
				From 01/01/2018 To 12/31/2018		narod:	
				10 12/31/2010	5/28/2019 1: 2	3 pm	
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V		
	Assigned New	FLXT		BENEFI TS	E & GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs						
	0	1.00	2A	4. 00	5. 00		
194.01 07951 MEALS ON WHEELS	0	0		0 153	2, 104	194. 01	
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	0	17, 021, 223	17, 021, 22	93, 406	1, 378, 706	202. 00	

Provi der CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm

				12/31/2010	5/28/2019 1: 2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10. 00	11. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	, 54, 400					5.00
7. 00 00700 OPERATION OF PLANT	6, 516, 109	05 400				7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	33, 729	85, 409				8.00
9. 00 00900 HOUSEKEEPI NG	27, 284	0	,	(10 (20		9.00
10. 00 01000 DI ETARY	248, 991	0	339	610, 629	15 202	10.00
11. 00 01100 CAFETERI A	0 (70	0	2, 373	0	15, 303	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	8, 670	(42	0	0	124	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	98, 868	642	85	0	444	14.00
15. 00 01500 PHARMACY	157, 401	0	2, 119	0	936	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	71, 561	0	424	O O	419	16.00
17. 00 01700 SOCIAL SERVICE	38, 087	0	0	0	204 19	17.00
23. 00 02300 PARAMED ED PRGM PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 593	U	U U	U	19	23. 00
30. 00 03000 ADULTS & PEDIATRICS	1 701 405	24 772	28, 980	304, 451	3, 055	30.00
	1, 784, 685	26, 773			· ·	
31.00 03100 I NTENSI VE CARE UNI T 41.00 04100 SUBPROVI DER - I RF	328, 039	6, 241	5, 339	39, 306	712	31.00
	228, 591 0	6, 673 0	5, 339	135, 949	640	41.00
	-1	•	I -	120 022	0	43.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	214, 543	6, 194	5, 169	130, 923	U	44. 00
50. 00 05000 OPERATING ROOM	864, 571	8, 289	9, 067	O	1, 389	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	004, 371	0, 209	9,007	0	1, 369	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	164, 680	5, 001		0	729	54.00
	· · ·		1, 356	0		
	164, 611	691	847	0	126	55.00
57. 00 05700 CT SCAN	35, 212	0	0	0	111	57.00
57. 01 03630 ULTRA SOUND	7, 511	0	0	0	8	57. 01
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	43, 697	0	85	0	105	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	66, 739	2, 204	0	0	235	59. 00
60. 00 06000 LABORATORY	298, 297	0	2, 966	0	1, 395	60.00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	45, 250	0	0	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	48, 750	0	254	0	436	65.00
66. 00 06600 PHYSI CAL THERAPY	69, 196	720	0	0	1, 925	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	248, 295	733	1, 695	0	313	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DI ALYSI S	21, 535	0	0	0	0	74.00
76. 00 03020 OTHER ANCI LLARY	o	0	0	0	0	76. 00
76. 01 03140 CARDI AC REHAB	36, 673	63	2, 288	0	295	76. 01
76. 02 03070 WOMEN' S CENTER	98, 497	426	1, 695	o	198	76. 02
76. 03 03330 ENDOSCOPY	o	0	0	o	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	55, 890	116	0	0	169	90.00
90. 01 09001 0UTPATI ENT	81, 390	2, 320	593	0	228	90. 01
90. 02 09002 NEUROPSYCHOLOGY	94, 325	0	0	0	25	90. 02
91. 00 09100 EMERGENCY	362, 649	11, 528	7, 203	0	794	91.00
91. 01 09101 SHORT STAY	O	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	7, 974	0	0	0	27	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 059, 784	78, 614	78, 216	610, 629	15, 061	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	141, 754	0	85	0	118	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	314, 571	6, 737	0	0	0	192.00
192. 01 19201 FOUNDATI ON	0	0	0	0	58	192. 01
192. 02 19202 CLI NI CS	o	30	4, 745	0	0	192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	o	0		ol	0	192. 03
192. 04 19207 WESTFI ELD SCHOOLS	o	0	0	o		192.04
192. 05 19203 PRACTI CE MANAGEMENT	o	28	o	o		192.05
192.06 19204 MOB - NOBLESVILLE SQUARE	o	0		o		192.06
192. 08 19205 RI VERVI EW MEDICAL ARTS	ol	0	n	ol		192. 08
193. 00 19300 NONPAI D WORKERS	ol	0	n	ol		193. 00
194. 00 07950 WORKMED	o	0	ا	o o		194. 00
194. 01 07951 MEALS ON WHEELS	ا	0	ا	n		194. 01
200.00 Cross Foot Adjustments		· ·		٦	00	200.00
201.00 Negative Cost Centers	o	0	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 516, 109	85, 409	83, 046	610, 629	15, 303	
	,,, .	,,		::	-, - 30	

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm

					12/31/2018	5/28/2019 1: 2	pareu: 3 pm
	Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SOCI AL SERVI CE	
		N N	SUPPLY		LI BRARY	SERVICE	
		13. 00	14. 00	15. 00	16.00	17. 00	
	RAL SERVICE COST CENTERS ON NEW CAP REL COSTS-BLDG & FIXT						1.00
	00 EMPLOYEE BENEFITS DEPARTMENT						4.00
	OO ADMINISTRATIVE & GENERAL						5. 00
	OO OPERATION OF PLANT						7. 00
8.00 0080	OO LAUNDRY & LINEN SERVICE						8. 00
	OO HOUSEKEEPI NG						9. 00
	DO DI ETARY						10.00
	OO CAFETERI A	27 40/					11.00
	DO NURSING ADMINISTRATION DO CENTRAL SERVICES & SUPPLY	27, 406 0	383, 370				13. 00 14. 00
	OO PHARMACY		303, 370	536, 341			15.00
	00 MEDICAL RECORDS & LIBRARY	o	o	0	189, 153		16.00
	OO SOCIAL SERVICE	0	О	0	0	100, 794	17.00
23. 00 0230	OO PARAMED ED PRGM PHARMACY	0	o	0	0	0	23. 00
	TIENT ROUTINE SERVICE COST CENTERS						
	OO ADULTS & PEDIATRICS	16, 100	0	0	43, 222	80, 391	30.00
	DO INTENSIVE CARE UNIT DO SUBPROVIDER - IRF	3, 753 3, 369	0	0	12, 548	5, 484	31. 00 41. 00
	OO NURSERY	3, 369	0	0	0	8, 789 0	41.00
	OO SKILLED NURSING FACILITY	0	0	0	0	6, 130	44. 00
	LLARY SERVICE COST CENTERS	-1	-1	-1	-1		
50.00 0500	OO OPERATING ROOM	0	0	0	73, 896	0	50.00
	DO DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
1	00 RADI OLOGY-DI AGNOSTI C	0	0	0	1, 394	0	54.00
	00 RADI OLOGY-THERAPEUTI C	0	0	0	5, 112	0	55.00
	00 CT SCAN 80 ULTRA SOUND	0	0	0	O O	0	57. 00 57. 01
	00 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	58.00
	O CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
	OO LABORATORY	o	o	0	3, 718	0	60.00
60. 01 0600	01 BLOOD LABORATORY	0	О	0	0	0	60. 01
63.00 0630	DO BLOOD STORING, PROCESSING & TRANS.	0	O	0	0	0	63.00
	OO INTRAVENOUS THERAPY	0	0	0	0	0	64.00
	00 RESPI RATORY THERAPY	0	0	0	0	0	65.00
	OO PHYSI CAL THERAPY	0	0	0	33, 462	0	66.00
	00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY	0	0	0	O O	0	67. 00 68. 00
	00 ELECTROCARDI OLOGY	0	0	0	5, 112	0	69.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		383, 370	0	3, 112	0	71.00
	OO IMPL. DEV. CHARGED TO PATIENT	o	0	0	o	0	72.00
	DO DRUGS CHARGED TO PATIENTS	0	o	536, 341	0	0	73.00
	00 RENAL DIALYSIS	0	0	0	0	0	74.00
	O OTHER ANCI LLARY	0	0	0	0	0	76. 00
	O CARDI AC REHAB	0	0	0	0	0	76. 01
	70 WOMEN'S CENTER BO ENDOSCOPY	0	0	0	0	0	76. 02 76. 03
	PATIENT SERVICE COST CENTERS	J O	U _I	U _I	υį	0	70.03
	OO CLI NI C	0	0	0	0	0	90.00
	01 OUTPATI ENT	0	О	0	0	0	90. 01
	NEUROPSYCHOLOGY	0	0	0	0	0	90. 02
	OO EMERGENCY	4, 184	0	0	9, 295	0	91.00
	OT SHORT STAY	0	0	0	0	0	91.01
	OO OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS						92.00
	OO AMBULANCE SERVICES	0	0	0	0	0	95. 00
	TI AL PURPOSE COST CENTERS	<u> </u>	<u> </u>	٥١	<u> </u>		75.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	27, 406	383, 370	536, 341	187, 759	100, 794	118. 00
	REIMBURSABLE COST CENTERS						
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	OO PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	01 FOUNDATION	0	0	0	0		192. 01
192. 02 1920	02 CLINICS 06 HOME HEALTH PARTNERSHIP	0	0	0	1, 394		192. 02 192. 03
	70 HOME HEALTH PARTNERSHIP 07 WESTFIELD SCHOOLS		0	0	0		192. 03
	03 PRACTICE MANAGEMENT		0	0	0		192. 04
	04 MOB - NOBLESVILLE SQUARE		o n	0	ol O		192.06
	05 RIVERVIEW MEDICAL ARTS		ő	Ö	ol		192. 08
193. 00 1930	NONPALD WORKERS	0	o	0	O	0	193. 00
194. 00 0795		0	o	0	О		194. 00
	MEALS ON WHEELS	0	0	0	0		194. 01
200.00	Cross Foot Adjustments						200. 00 201. 00
201. 00	Negative Cost Centers	0	0	0	υĮ	0	<u> </u> ∠∪1. UU

Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B		
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 1:2		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	3 pili	
	ADMI NI STRATI O	SERVICES &	THANNAOT	RECORDS &	SERVI CE		
	N	SUPPLY		LI BRARY			
	13. 00	14. 00	15. 00	16.00	17. 00		
202.00 TOTAL (sum lines 118 through 201)	27, 406	383, 370	536, 34	1 189, 153	100, 794	202. 00	

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0059 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/28/2019 1:23 pm Cost Center Description PARAMED ED Subtotal Intern & Total PRGM PHARMACY Resi dents Cost & Post Stepdown Adjustments 23. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17 00 23.00 02300 PARAMED ED PRGM PHARMACY 10,045 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4. 911. 496 0 0 4, 911, 496 30.00 31.00 03100 INTENSIVE CARE UNIT 895, 452 895, 452 31.00 04100 SUBPROVI DER - I RF 0 41.00 737, 735 737, 735 41.00 04300 NURSERY 0 43.00 43.00 04400 SKILLED NURSING FACILITY 44.00 684, 846 0 684, 846 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 2, 230, 617 0 2, 230, 617 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 432, 927 432, 927 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 415, 154 415, 154 55.00 0 57.00 05700 CT SCAN 89, 117 89, 117 57.00 0 03630 ULTRA SOUND 57 01 20, 539 20 539 57 01 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 108, 979 108, 979 58.00 59.00 05900 CARDIAC CATHETERIZATION 173, 416 0 173, 416 59.00 60.00 06000 LABORATORY 792, 477 0 792, 477 60.00 06001 BLOOD LABORATORY 60.01 0 60 01 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 114, 167 114, 167 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 133, 823 0 133, 823 65.00 06600 PHYSI CAL THERAPY 279, 343 0 279, 343 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 68 00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 0 618, 346 618, 346 69.00 69.00 οĺ 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 383, 370 383, 370 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 7, 762 0 7, 762 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 536, 341 536.341 73.00 0 74.00 07400 RENAL DIALYSIS 54,856 54, 856 74 00 0 76.00 03020 OTHER ANCI LLARY 76.00 76. 01 03140 CARDI AC REHAB 108, 256 0 108, 256 76.01 03070 WOMEN'S CENTER 0 245, 633 76.02 245, 633 76.02 03330 ENDOSCOPY 0 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 140, 194 140, 194 90.00 09001 OUTPATIENT 0 0 90.01 210, 841 210.841 90.01 90.02 09002 NEUROPSYCHOLOGY 229, 354 229, 354 90.02 91.00 09100 EMERGENCY 951, 560 0 951, 560 91.00 91.01 09101 SHORT STAY 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 20, 340 20, 340 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 15, 526, 941 15, 526, 941 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 346, 399 0 346, 399 190.00 1,078,145 0 1, 078, 145 192 00 0 192. 01 19201 FOUNDATI ON 2,075 2, 075 192.01 192. 02 19202 CLI NI CS 22, 754 0 22, 754 192.02 192. 03 19206 HOME HEALTH PARTNERSHIP 13 0 13 192.03 192. 04 19207 WESTFIELD SCHOOLS 0 192.04 13, 422 13 422 192. 05 19203 PRACTI CE MANAGEMENT 8,090 0 8,090 192.05 192.06 19204 MOB - NOBLESVILLE SQUARE 0 0 192.06 192. 08 19205 RI VERVI EW MEDICAL ARTS 0 1, 171 192. 08 1, 171 0 193.00 19300 NONPALD WORKERS 193.00 0 194. 00 07950 WORKMED 9,845 9, 845 194.00 194.01 07951 MEALS ON WHEELS 2, 323 0 2, 323 194.01

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Peri od:	Worksheet B	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pr	epared:
					5/28/2019 1:	23 pm
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM PHARMACY		Resi dents			
			Cost & Post			
			Stepdown			
			Adjustments			
	23. 00	24. 00	25.00	26.00		
200.00 Cross Foot Adjustments	10, 045	10, 045		0 10, 045		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	10, 045	17, 021, 223		0 17, 021, 223		202.00

	Financial Systems	RI VERVI EW 1		CN: 15 0050 D		u of Form CMS-: Worksheet B-1	
COST	ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0059 P	eriod: rom 01/01/2018 o 12/31/2018	worksneet B-1	
				Т	o 12/31/2018	Date/Time Pre 5/28/2019 1:2	
		CAPI TAL				3/20/2019 1.2	J Pill
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		FLXT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS	1.00	4.00] JA	3.00	7.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	522, 083					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 865	52, 166, 462				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	41, 847	8, 047, 607				5. 00
7. 00	00700 OPERATION OF PLANT	196, 278	1, 913, 458	1			
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 455	49, 115	l .	,	1, 455	1
9.00	00900 HOUSEKEEPI NG	1, 177	957, 216	1	1, 834, 808		
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	10, 741	313, 251 745, 037	l .	.,,	10, 741 0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	374	469, 438	l .		374	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	4, 265	633, 609			4, 265	1
15. 00	01500 PHARMACY	6, 790	2, 644, 743	l .		6, 790	1
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 087	813, 617	l .		3, 087	•
17.00	01700 SOCIAL SERVICE	1, 643	605, 705	l c	919, 094	1, 643	17. 00
23.00	02300 PARAMED ED PRGM PHARMACY	155	109, 929	C	138, 444	155	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	7, 000	7 175 050	1	11 757 0/0	7, 000	
30.00	03000 ADULTS & PEDIATRICS	76, 988	7, 475, 258	1		76, 988	1
31. 00 41. 00	03100 I NTENSI VE CARE UNI T	14, 151	2, 342, 821	1			1
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	9, 861	1, 316, 469 0			9, 861 0	1
44. 00	1 1	9, 255	0		-		1
00	ANCILLARY SERVICE COST CENTERS	7,200			2,000,720	7,200	1
50.00	05000 OPERATI NG ROOM	37, 296	2, 524, 687	C	6, 196, 764	37, 296	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	o c	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 104	1, 681, 285	1			1
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 101	413, 677	1		7, 101	
57.00	05700 CT SCAN	1, 519	266, 475	1	444, 070		
57. 01	03630 ULTRA SOUND	324	194, 675	1		324	1
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	1, 885 2, 879	252, 433 742, 891	1		1, 885 2, 879	1
60.00	06000 LABORATORY	12, 868	2, 823, 247			12, 868	1
60. 01	06001 BLOOD LABORATORY	12,000	2,023,247		7, 200, 733	12,000	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 952	0	o o	617, 669	1, 952	1
64.00	06400 I NTRAVENOUS THERAPY	0	0	o c	0	0	1
65.00	06500 RESPI RATORY THERAPY	2, 103	1, 145, 369	o c	1, 611, 689	2, 103	65.00
66.00	06600 PHYSI CAL THERAPY	2, 985	4, 570, 200	0	8, 022, 521	2, 985	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68.00	06800 SPEECH PATHOLOGY	10 711	(00,770		1 274 222	0	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	10, 711	698, 668	0	,		69. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		908, 585	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		700, 303	0	•
	07400 RENAL DIALYSIS	929	0		354, 970	929	•
76.00	03020 OTHER ANCI LLARY	o	0	d		0	1
76. 01	03140 CARDI AC REHAB	1, 582	763, 829	C	1, 871, 978	1, 582	76. 01
76. 02	03070 WOMEN' S CENTER	4, 249	394, 551	1	·	4, 249	1
76. 03	03330 ENDOSCOPY	0	0	0	0	0	76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 411	348, 245		560, 655	2, 411	90.00
90.00	09000 CETNIC 09001 OUTPATI ENT	3, 511	588, 537		1, 262, 963		1
90. 01	09002 NEUROPSYCHOLOGY	4, 069	94, 173	1	254, 570		
91.00	09100 EMERGENCY	15, 644	2, 294, 395	1			1
91. 01	09101 SHORT STAY	0	0	o c		0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				1		
95. 00	09500 AMBULANCE SERVICES	344	57, 403	0	119, 523	344	95.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	502, 398	48, 292, 013	-25, 252, 405	118, 549, 926	261, 408	110 00
110.00	NONREI MBURSABLE COST CENTERS	302, 340	40, 272, 013	-25, 252, 405	110, 347, 720	201, 400	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 115	175, 072	C	557, 631	6, 115	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	13, 570	0	Ö			192.00
	19201 FOUNDATI ON	0	167, 172	o c			192. 01
	19202 CLI NI CS	0	1, 258, 316	0	1, 677, 476		192. 02
	19206 HOME HEALTH PARTNERSHIP	0	0) o	1, 489		192. 03
	19207 WESTFI ELD SCHOOLS	0	1, 077, 175		1, 345, 320		192.04
	19203 PRACTICE MANAGEMENT	0	483, 936		842, 228		192. 05 192. 06
	19204 MOB - NOBLESVILLE SQUARE 19205 RIVERVIEW MEDICAL ARTS		0	18, 110			192.08
	19205 RIVERVIEW MEDICAL ARTS		0	1			193. 00
	11	<u> </u>			<u> </u>	<u> </u>	1

201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 32.602523 0.128674 203.00 Unit cost multiplier (Wkst. B, Part I) 32.602523 0.128674 0.156475 54.671116 203.00 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001791 0.008543 23.181328 205.00 206.00 NAHE adjustment amount to be allocated 206.00 206.	Health F	nancial Systems	RI VERVI EW I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CAPITAL RELATED COSTS NEW BLDG & EMPLOYEE SOUNT FEET SALARI ES) SALARI ES) SALARI ES SOUNT SALARI ES SALARI ES SOUNT SALARI ES SALARI ES SOUNT SALARI ES SAL	COST ALL	OCATION - STATISTICAL BASIS		Provi der C				
CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET) SALARIES New BLDG & FIXT (ACCUM. (COST) FEET) SALARIES New BLDG & FEET) SALARIES New BLDG & FEET) New BLDG & FEET New BLDG & N							Date/Time Pre	
NEW BLDG & FIXT (SQUARE FEET) BENEFITS DEPARTMENT (GROSS SALARIES) DEPARTMENT (GROSS SALARIES) DEPARTMENT (GROSS SALARIES) DEPARTMENT (ACCUM. COST) FEET)			CAPI TAL	<u> </u>				
FIXT (SQUARE FEET) BENEFITS DEPARTMENT (GROSS SALARIES) SALARIES) SALARIES S			RELATED COSTS					
(SQUARE FEET) DEPARTMENT (GROSS SALARIES) (GROSS SALARIES		Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
FEET) GROSS SALARIES SALA			FI XT	BENEFITS	n	E & GENERAL	PLANT	
SALARIES 1.00 4.00 5A 5.00 7.00 194.00 07950 WORKMED 0 627,432 0 1,020,878 0 194.01 194.01 07951 MEALS ON WHEELS 0 85,346 0 246,258 0 194.01			(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
1.00 4.00 5A 5.00 7.00			FEET)			COST)	FEET)	
194. 00 07950 WORKMED								
194. 01 07951 MEALS ON WHEELS 200. 00 201. 00 202. 00 203. 00 2046, 258 0 194. 0 200. 00 201. 00 202. 00 203. 00 2046, 258 0 194. 0 200. 00 201. 00 202. 00 203. 00 2046, 258 0 194. 0 200. 00 201. 00 201. 00 201. 00 203. 00 204. 05 205. 00 206. 00 207. 00 208. 00 208. 00 209. 00			1. 00					
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustments 200.00 201.00 205.00 NAHE adjustments 200.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00 203.00 205.00 206.00 206.00 206.00 206.00			0	627, 432		1, 020, 878		
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 32.602523 0.128674 203.00 Unit cost multiplier (Wkst. B, Part I) 32.602523 0.128674 0.156475 54.671116 203.00 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001791 0.008543 23.181328 205.00 206.00 NAHE adjustment amount to be allocated 206.00 206.			0	85, 346	(246, 258	0	
202.00 Cost to be allocated (per Wkst. B, Part I) 17,021,223 6,712,455 25,252,405 15,367,668 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 32.602523 0.128674 0.156475 54.671116 203.00 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001791 0.008543 23.181328 205.00 206.00 NAHE adjustment amount to be allocated 206.00								200. 00
203.00 Part I) 32.602523 0.128674 0.156475 54.671116 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001791 0.008543 23.181328 205.00 206.00 NAHE adjustment amount to be allocated 206.00 206.								201.00
203.00 Unit cost multiplier (Wkst. B, Part I) 32.602523 0.128674 0.156475 54.671116 203.00 (204.00 Cost to be allocated (per Wkst. B, Part II) 0.001791 0.008543 23.181328 205.00 Unit cost multiplier (Wkst. B, Part II) 0.008543 23.181328 205.00 NAHE adjustment amount to be allocated 206.00	202. 00		17, 021, 223	6, 712, 455		25, 252, 405	15, 367, 668	202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 93,406 1,378,706 6,516,109 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001791 0.008543 23.181328 205.00 206.00 NAHE adjustment amount to be allocated 206.00 206.0		Part I)						
Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 0.001791 0.008543 23.181328 205.00			32. 602523	0. 128674		0. 156475		
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 0.001791 0.008543 23.181328 205.00	204.00			93, 406	4	1, 378, 706	6, 516, 109	204. 00
206.00 NAHE adjustment amount to be allocated 206.00								
206.00 NAHE adjustment amount to be allocated 206.00	205. 00			0. 001791		0. 008543	23. 181328	205. 00
		1 /						
(206. 00							206. 00
		(per Wkst. B-2)						
	207. 00							207. 00
Parts III and IV)		Parts III and IV)			[

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0059

				To	12/31/2018	Date/Time Pre 5/28/2019 1:2	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI O N	5 piii
		LAUNDRY)				(DIRECT NRSING HRS)	
	GENERAL SERVICE COST CENTERS	8. 00	9. 00	10.00	11. 00	13. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 5. 00 7. 00 8. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	73, 174	000				4. 00 5. 00 7. 00 8. 00
9. 00 10. 00 11. 00 13. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 0	980 4 28 0	83, 472 0	1, 171, 764 9, 488		9. 00 10. 00 11. 00 13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	550 0	1 25		33, 983 71, 688		14. 00 15. 00
16. 00 17. 00	O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE	0	5 0		32, 056 15, 599	0	16. 00 17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	1, 452	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	22, 936	342	41, 618	234, 012	234, 012	30.00
31. 00 41. 00	03100 INTENSIVE CARE UNIT 04100 SUBPROVI DER - I RF	5, 347 5, 717	63 63		54, 553 48, 971	54, 553 48, 971	31. 00 41. 00
43. 00	04300 NURSERY	0	0		40, 771		43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	5, 307	61	17, 897	0	0	44.00
50. 00	05000 OPERATING ROOM	7, 102	107		106, 372	0	50.00
52. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 4, 285	0 16	_	0 55, 829	0	52.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	592	10	0	9, 686	0	55. 00
57. 00 57. 01	05700 CT SCAN	0	0		8, 480 578	0	57. 00 57. 01
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1	0	8, 035	0	58.00
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY	1, 888 0	0 35	-	17, 994 106, 833		59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	o	0		0	0	60.01
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0	0	63. 00 64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 617	3	0	33, 375 147, 400		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0 0	0	0	0	ő	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 628	0 20		0 23, 936	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00 73.00
74.00	07400 RENAL DIALYSIS	O	0	0	0	0	74. 00
76. 00 76. 01	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	0 54	0 27	_	0 22, 589		76. 00 76. 01
76. 02	03070 WOMEN' S CENTER	365	20	0	15, 155	0	76. 02
76. 03	03330 ENDOSCOPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 03
90. 00 90. 01	09000 CLI NI C 09001 OUTPATI ENT	99 1, 988	0 7		12, 977 17, 426		90. 00 90. 01
90. 02	09002 NEUROPSYCHOLOGY	0	0	0	1, 949		90. 02
91. 00 91. 01	09100 EMERGENCY 09101 SHORT STAY	9, 877 0	85 0		60, 807 0	60, 807 0	91. 00 91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	ı .		J			92.00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	ol	0	0	2, 072	0	95. 00
	SPECIAL PURPOSE COST CENTERS	(7.252					110.00
118.00	NONREI MBURSABLE COST CENTERS	67, 352	923		1, 153, 295		
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 5, 772	1 0		9, 001 0		190. 00 192. 00
	19201	0 26	0 56		4, 447 0		192. 01 192. 02
	19202 CETNICS 19206 HOME HEALTH PARTNERSHIP	0	0		0		192. 02
	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT	0 24	0	0	0		192. 04 192. 05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192. 06
	3 19205 RIVERVIEW MEDICAL ARTS 3 19300 NONPAID WORKERS	0	0	0	0		192. 08 193. 00
194.00	07950 WORKMED		0	0	0	0	194.00
194. 01	07951 MEALS ON WHEELS	0	0	0	5, 021	0	194. 01

Heal th F	inancial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018		
					Γο 12/31/2018	Date/Time Pre 5/28/2019 1:2	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	.5 pili
	cost center bescription	LI NEN SERVI CE		(MEALS		ADMI NI STRATI O	
		(POUNDS OF	SERVICE)	SERVED)	HOURS)	N N	
		LAUNDRY)	JERVI CE)	JERVED)	11001(3)	(DI RECT	
		LAGINDICT)				NRSI NG HRS)	
		8. 00	9, 00	10.00	11. 00	13.00	
200.00	Cross Foot Adjustments	0.00					200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	642, 013	2, 186, 258	2, 024, 839	1, 632, 165		
	Part I)		_,,	_, -,,	1, 222, 123		
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 773786	2, 230. 875510	24, 257703	1, 392913	1. 980165	203.00
204.00	Cost to be allocated (per Wkst. B,	85, 409			15, 303	27, 406	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1. 167204	84. 740816	7. 31537	0. 013060	0. 068800	205.00
	11)						
201 00	haire all administrations of the first state of the state	1	i				201 00

206.00

207. 00

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

206.00

207.00

Hearth Financial Systems	RIVERVIEW F				u or Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCI AL SERVI CE (TI ME SPENT)	5/28/2019 1: 2 PARAMED ED PRGM PHARMACY (ASSI GNED TI ME)	3 piii
	14. 00	15. 00	16.00	17. 00	23. 00	
GENERAL SERVICE COST CENTERS 1. 00	100 0 0 0 0	100 0 0 0	407 C	5, 459	l	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS	0	0	93	4, 354	0	30.00
31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0 0	0 0 0 0	1	297 476 0	0 0	31.00 41.00 43.00
ANCILLARY SERVICE COST CENTERS 50. 00	TS 100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	155 0 3 111 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 52. 00 54. 00 55. 00 57. 01 58. 00 59. 00 60. 01 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 02 76. 03
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0	C	0	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	117) 100	100	404	5, 459	100	118. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 192. 01 19201 FOUNDATION 192. 02 19202 CLI NI CS 192. 03 19206 HOME HEALTH PARTNERSHI P 192. 04 19207 WESTFI ELD SCHOOLS 192. 05 19203 PRACTI CE MANAGEMENT 192. 06 19204 MOB - NOBLESVI LLE SQUARE 192. 08 19205 RI VERVI EW MEDI CAL ARTS 193. 00 19300 NONPAI D WORKERS 194. 00 07950 WORKMED 194. 01 07951 MEALS ON WHEELS	N O O O O O O O O O O O O O O O O O O O	0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 192. 06 192. 08 193. 00 194. 00 194. 01

Heal th Fina	ncial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2018 To 12/31/2018		pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCI AL SERVI CE (TI ME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
		14. 00	15. 00	16.00	17. 00	23. 00	
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	19, 665, 397	20, 802, 257	2, 207, 43	7 1, 174, 462	170, 604	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	196, 653. 97000 0	208, 022. 57000 0	5, 423. 67813	3 215. 142334	1, 706. 040000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	383, 370	536, 341	189, 15	100, 794	10, 045	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	3, 833. 700000	5, 363. 410000	464. 74938	18. 463821	100. 450000	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	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0059	Peri od: Worksheet C

From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: 5/28/2019 1:23 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 22, 011, 031 22, 011, 031 22, 011, 031 30.00 03100 INTENSIVE CARE UNIT 5, 340, 647 0 5, 340, 647 31.00 5, 340, 647 31.00 41.00 04100 SUBPROVI DER - I RF 4, 769, 362 4, 769, 362 0 4, 769, 362 41.00 04300 NURSERY 0 43.00 0 43 00 44.00 04400 SKILLED NURSING FACILITY 3, 921, 999 3, 921, 999 3, 921, 999 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 10, 516, 965 10, 516, 965 10, 516, 965 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 960, 072 3, 960, 072 0 3, 960, 072 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 047, 645 2,047,645 0 2, 047, 645 55.00 0 608, 413 05700 CT SCAN 57.00 608, 413 608, 413 57.00 0 57.01 03630 ULTRA SOUND 303, 860 303, 860 303, 860 57.01 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 547, 558 547, 558 0 547, 558 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 423, 365 1, 423, 365 0 0 1, 423, 365 59.00 06000 LABORATORY 60 00 9, 301, 278 9, 301, 278 9, 301, 278 60 00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 821, 037 821, 037 0 0 821, 037 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 0 2, 032, 032 2, 032, 032 65.00 06500 RESPIRATORY THERAPY 2, 032, 032 65.00 66.00 0 06600 PHYSI CAL THERAPY 10, 042, 271 10, 042, 271 10, 042, 271 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 68 00 0 0 2, 318, 092 69.00 06900 ELECTROCARDI OLOGY 2, 318, 092 2, 318, 092 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 19, 665, 397 19, 665, 397 19, 665, 397 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 050, 756 1, 050, 756 0 0 1, 050, 756 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20, 972, 861 20, 972, 861 20, 972, 861 73.00 74.00 07400 RENAL DIALYSIS 461, 303 461, 303 461, 303 74.00 03020 OTHER ANCILLARY 0 76.00 0 0 76.00 0 76 01 03140 CARDI AC REHAB 2.343.559 2, 343, 559 2, 343, 559 76 01 03070 WOMEN'S CENTER 76.02 1,056,870 1,056,870 1, 056, 870 76.02 03330 ENDOSCOPY 76.03 76.03 0 OUTPATIENT SERVICE COST CENTERS 90 00 799, 140 799, 140 799, 140 0 90 00 09000 CLI NI C 0 90.01 09001 OUTPATI ENT 1, 709, 866 1, 709, 866 1, 709, 866 90.01 09002 NEUROPSYCHOLOGY 519, 576 519, 576 0 519, 576 90.02 90.02 91.00 09100 EMERGENCY 7, 098, 717 7, 098, 717 0 7, 098, 717 91.00 91 01 09101 SHORT STAY 0 91 01 0 Ω 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 427, 295 2, 427, 295 2, 427, 295 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 159, 918 159, 918 95. 00 159, 918 200.00 Subtotal (see instructions) 138, 230, 885 Ω 138, 230, 885 0 138, 230, 885 200. 00 201.00 Less Observation Beds 2, 427, 295 2, 427, 295 2, 427, 295 201. 00 202.00 Total (see instructions) 135, 803, 590 135, 803, 590 135, 803, 590 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 1:23 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 29, 145, 877 30.00 03000 ADULTS & PEDIATRICS 29, 145, 877 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 748, 707 7, 748, 707 31.00 04100 SUBPROVI DER - I RF 41.00 6, 253, 039 6, 253, 039 41.00 43.00 04300 NURSERY 43.00 0 04400 SKILLED NURSING FACILITY 44.00 2, 643, 269 2, 643, 269 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 30, 070, 110 49, 913, 360 79, 983, 470 0 131489 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 52.00 10, 540, 847 05400 RADI OLOGY-DI AGNOSTI C 1, 878, 402 12, 419, 249 0. 318866 0.000000 54.00 54 00 82, 189 55.00 05500 RADI OLOGY-THERAPEUTI C 7, 688, 035 7, 770, 224 0.263525 0.000000 55.00 57.00 05700 CT SCAN 3, 051, 823 13, 015, 623 16, 067, 446 0.037866 0.000000 57.00 57.01 03630 ULTRA SOUND 1, 119, 101 4, 031, 302 5, 150, 403 0.058997 0.000000 57.01 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 624, 182 4, 198, 072 4, 822, 254 0.113548 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 20, 377, 328 0.069850 59 00 7, 619, 752 12, 757, 576 0.000000 59.00 13, 909, 986 06000 LABORATORY 0. 199574 0.000000 60.00 32, 695, 645 46, 605, 631 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0.000000 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 1,074,548 589, 924 0.493272 0.000000 63.00 1, 664, 472 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 6, 108, 735 4, 688, 099 65.00 1, 420, 636 0.332644 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 12, 675, 311 16, 158, 098 28, 833, 409 0. 348286 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 68.00 8, 401, 386 06900 ELECTROCARDI OLOGY 0. 225844 69.00 1, 862, 740 10, 264, 126 0.000000 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 898, 950 18, 395, 204 37, 294, 154 0.527305 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 7, 390, 000 15, 806, 460 72.00 8, 416, 460 0.066476 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 15, 003, 490 37. 988. 252 52, 991, 742 0.395776 0.000000 73.00 73.00 07400 RENAL DIALYSIS 74.00 714, 622 3, 712 718, 334 0.642185 0.000000 74.00 76.00 03020 OTHER ANCI LLARY 0.000000 0.000000 76.00 03140 CARDI AC REHAB 76.01 593, 858 10, 235, 686 10, 829, 544 0. 216404 0.000000 76.01 76 02 03070 WOMEN'S CENTER 7, 999 6, 753, 275 6, 761, 274 0 156312 0.000000 76 02 03330 ENDOSCOPY 76.03 0.000000 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5, 967 5, 608, 484 5, 614, 451 0.142336 0.000000 90.00 90 01 09001 OUTPATI ENT 245, 594 0.000000 90 01 4, 556, 726 4, 802, 320 0.356050 90.02 09002 NEUROPSYCHOLOGY 612, 641 612, 641 0.848092 0.000000 90.02 09100 EMERGENCY 4, 749, 859 0. 238306 0.000000 91.00 25, 038, 386 29, 788, 245 91.00 91 01 09101 SHORT STAY 0.000000 0.000000 91.01 0

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09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

09500 AMBULANCE SERVICES

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0059	From 01/01/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 1:23 pm

			10 12/31/2018	5/28/2019 1:23 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient	THE WALL	110001 tu	
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>			
50. 00 05000 OPERATING ROOM	0. 131489			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 318866			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 263525			55.00
57. 00 05700 CT SCAN	0. 037866			57.00
57. 01 03630 ULTRA SOUND	0. 058997			57. 01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 113548			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 069850			59.00
60. 00 06000 LABORATORY	0. 199574			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 493272			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 332644			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 348286			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 225844			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 527305			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 066476			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 395776			73.00
74. 00 07400 RENAL DIALYSIS	0. 642185			74.00
76. 00 03020 OTHER ANCI LLARY	0. 000000			76.00
76. 01 03140 CARDI AC REHAB	0. 216404			76. 01
76. 02 03070 WOMEN' S CENTER	0. 156312			76. 02
76. 03 03330 ENDOSCOPY	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
90. 00 09000 CLI NI C	0. 142336			90.00
90. 01 09001 OUTPATI ENT	0. 356050			90. 01
90. 02 09002 NEUROPSYCHOLOGY	0. 848092			90. 02
91. 00 09100 EMERGENCY	0. 238306			91.00
91. 01 09101 SHORT STAY	0. 000000			91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 646001			92.00
OTHER REIMBURSABLE COST CENTERS	·			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	. '			•

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0059	Peri od:	Worksheet C

From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: 5/28/2019 1:23 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 22, 011, 031 22, 011, 031 22, 011, 031 30.00 03100 INTENSIVE CARE UNIT 5, 340, 647 0 5, 340, 647 31.00 5, 340, 647 31.00 41.00 04100 SUBPROVI DER - I RF 4, 769, 362 4, 769, 362 0 4, 769, 362 41.00 04300 NURSERY 0 43.00 0 43 00 44.00 04400 SKILLED NURSING FACILITY 3, 921, 999 3, 921, 999 3, 921, 999 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 10, 516, 965 10, 516, 965 10, 516, 965 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 960, 072 3, 960, 072 0 3, 960, 072 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 047, 645 2,047,645 0 2, 047, 645 55.00 0 608, 413 05700 CT SCAN 57.00 608, 413 608, 413 57.00 0 57.01 03630 ULTRA SOUND 303, 860 303, 860 303, 860 57.01 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 547, 558 547, 558 0 547, 558 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 423, 365 1, 423, 365 0 0 1, 423, 365 59.00 06000 LABORATORY 60 00 9, 301, 278 9, 301, 278 9, 301, 278 60 00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 821, 037 821, 037 0 0 821, 037 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 0 2, 032, 032 2, 032, 032 65.00 06500 RESPIRATORY THERAPY 2, 032, 032 65.00 66.00 0 06600 PHYSI CAL THERAPY 10, 042, 271 10, 042, 271 10, 042, 271 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 68 00 0 0 2, 318, 092 69.00 06900 ELECTROCARDI OLOGY 2, 318, 092 2, 318, 092 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 19, 665, 397 19, 665, 397 19, 665, 397 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 050, 756 1, 050, 756 0 0 1, 050, 756 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20, 972, 861 20, 972, 861 20, 972, 861 73.00 74.00 07400 RENAL DIALYSIS 461, 303 461, 303 461, 303 74.00 03020 OTHER ANCILLARY 0 76.00 0 0 76.00 0 76 01 03140 CARDI AC REHAB 2.343.559 2, 343, 559 2.343.559 76 01 03070 WOMEN'S CENTER 76.02 1,056,870 1,056,870 1, 056, 870 76.02 03330 ENDOSCOPY 76.03 76.03 0 OUTPATIENT SERVICE COST CENTERS 90 00 799, 140 799, 140 799, 140 0 90 00 09000 CLI NI C 0 90.01 09001 OUTPATI ENT 1, 709, 866 1, 709, 866 1, 709, 866 90.01 09002 NEUROPSYCHOLOGY 519, 576 519, 576 0 519, 576 90.02 90.02 91.00 09100 EMERGENCY 7, 098, 717 7, 098, 717 0 7, 098, 717 91.00 91 01 09101 SHORT STAY 0 91 01 0 0 Ω 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 427, 295 2, 427, 295 2, 427, 295 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 159, 918 159, 918 95. 00 159, 918 200.00 Subtotal (see instructions) 138, 230, 885 Ω 138, 230, 885 0 138, 230, 885 200. 00 201.00 Less Observation Beds 2, 427, 295 2, 427, 295 2, 427, 295 201. 00

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202.00

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 1:23 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 29, 145, 877 30.00 03000 ADULTS & PEDIATRICS 29, 145, 877 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 748, 707 7, 748, 707 31.00 04100 SUBPROVI DER - I RF 41.00 6, 253, 039 6, 253, 039 41.00 43.00 04300 NURSERY 43.00 0 04400 SKILLED NURSING FACILITY 44.00 2, 643, 269 2, 643, 269 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 30, 070, 110 49, 913, 360 79, 983, 470 0 131489 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 52.00 10, 540, 847 05400 RADI OLOGY-DI AGNOSTI C 1, 878, 402 0. 318866 0.000000 54.00 12, 419, 249 54 00 82, 189 55.00 05500 RADI OLOGY-THERAPEUTI C 7, 688, 035 7, 770, 224 0.263525 0.000000 55.00 57.00 05700 CT SCAN 3, 051, 823 13, 015, 623 16, 067, 446 0.037866 0.000000 57.00 57.01 03630 ULTRA SOUND 1, 119, 101 4, 031, 302 5, 150, 403 0.058997 0.000000 57.01 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 624, 182 4, 198, 072 4, 822, 254 0.113548 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 20, 377, 328 0.069850 59 00 7, 619, 752 12, 757, 576 0.000000 59.00 13, 909, 986 06000 LABORATORY 0. 199574 0.000000 60.00 32, 695, 645 46, 605, 631 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0.000000 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 1,074,548 589, 924 0.493272 0.000000 63.00 1, 664, 472 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 6, 108, 735 4, 688, 099 65.00 1, 420, 636 0.332644 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 12, 675, 311 16, 158, 098 28, 833, 409 0. 348286 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 68.00 8, 401, 386 06900 ELECTROCARDI OLOGY 0. 225844 69.00 1, 862, 740 10, 264, 126 0.000000 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 898, 950 18, 395, 204 37, 294, 154 0.527305 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 7, 390, 000 15, 806, 460 72.00 8, 416, 460 0.066476 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 15, 003, 490 37. 988. 252 52, 991, 742 0.395776 0.000000 73.00 73.00 07400 RENAL DIALYSIS 74.00 714, 622 3, 712 718, 334 0.642185 0.000000 74.00 76.00 03020 OTHER ANCI LLARY 0.000000 0.000000 76.00 03140 CARDI AC REHAB 76.01 593, 858 10, 235, 686 10, 829, 544 0. 216404 0.000000 76.01 76 02 03070 WOMEN'S CENTER 7, 999 6, 753, 275 6, 761, 274 0 156312 0.000000 76 02 03330 ENDOSCOPY 76.03 0.000000 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5, 967 5, 608, 484 5, 614, 451 0.142336 0.000000 90.00 90 01 09001 OUTPATI ENT 245, 594 0.000000 90 01 4, 556, 726 4, 802, 320 0.356050 90.02 09002 NEUROPSYCHOLOGY 612, 641 612, 641 0.848092 0.000000 90.02

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09100 EMERGENCY

09101 SHORT STAY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

09500 AMBULANCE SERVICES

91.00

91 01

92.00

95.00

200.00

201.00

202.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0059	Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

			10 12/31/2016	5/28/2019 1: 23 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	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 SUBPROVI DER - I RF				41.0
13. 00 04300 NURSERY				43.0
4.00 04400 SKILLED NURSING FACILITY				44.0
ANCILLARY SERVICE COST CENTERS				
0.00 05000 OPERATING ROOM	0. 000000			50.0
2.00 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
7. 00 05700 CT SCAN	0. 000000			57. (
7.01 03630 ULTRA SOUND	0. 000000			57. (
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.
0. 00 06000 LABORATORY	0. 000000			60.
0. 01 06001 BLOOD LABORATORY	0. 000000			60.
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.
4. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.
5. 00 06500 RESPIRATORY THERAPY	0. 000000			65.
6. 00 06600 PHYSI CAL THERAPY	0. 000000			66.
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.
8.00 06800 SPEECH PATHOLOGY	0. 000000			68.
9. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
4.00 07400 RENAL DIALYSIS	0. 000000			74.
6. 00 03020 OTHER ANCI LLARY	0. 000000			76.
6. 01 03140 CARDI AC REHAB	0. 000000			76.
6. 02 03070 WOMEN' S CENTER	0. 000000			76.
6. 03 03330 ENDOSCOPY	0. 000000			76.
OUTPATIENT SERVICE COST CENTERS				
0. 00 09000 CLINIC	0. 000000			90.
0. 01 09001 0UTPATI ENT	0. 000000			90.0
0. 02 09002 NEUROPSYCHOLOGY	0. 000000			90.
1. 00 09100 EMERGENCY	0. 000000			91.
1. 01 09101 SHORT STAY	0. 000000			91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
OTHER REIMBURSABLE COST CENTERS	0. 000000			72.
5. 00 09500 AMBULANCE SERVICES	0. 000000			95.
00.00 Subtotal (see instructions)	5. 000000			200.0
01.00 Less Observation Beds				201. (
202.00 Total (see instructions)				202. (
oz. oo Total (see Histi detions)	1			1202.1

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2018 Fo 12/31/2018		pared: 3 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4, 911, 496	0	4, 911, 49			30.00
31.00 INTENSIVE CARE UNIT	895, 452		895, 45		320. 72	31.00
41. 00 SUBPROVI DER - I RF	737, 735	0	737, 73	5, 314	138. 83	41.00
43. 00 NURSERY	0			0	0.00	
44.00 SKILLED NURSING FACILITY	684, 846		684, 84	4, 574	149. 73	44.00
200.00 Total (lines 30 through 199)	7, 229, 529		7, 229, 529	27, 715		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5, 102					30.00
31.00 INTENSIVE CARE UNIT	1, 165		•			31.00
41. 00 SUBPROVI DER - I RF	3, 471		•			41.00
43. 00 NURSERY	0					43.00
44.00 SKILLED NURSING FACILITY	3, 105		•			44. 00
200.00 Total (lines 30 through 199)	12, 843	2, 987, 100				200. 00

Health Financial Systems	RI VERVI EW HO	RI VERVI EW HOSPI TAL		
ADDODEL ONMENT OF INDATIONS A	NOLLI ADVI CEDVI CE CADITAL COCTO	D	Davet and	Wasalsalaa D

	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2018 To 12/31/2018	5/28/2019 1: 2	epared: !3 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col . 26)			4 00		
	ANOLLI ADV. CEDVI OF COCT. CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000 (47	70.000.470	0.0070	40 500 000	040.707	
50.00	05000 OPERATING ROOM	2, 230, 617	1				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1				
54.00	05400 RADI OLOGY-DI AGNOSTI C	432, 927					1
55. 00	05500 RADI OLOGY-THERAPEUTI C	415, 154					1
57.00	05700 CT SCAN	89, 117					1
57. 01	03630 ULTRA SOUND	20, 539				1	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	108, 979	1 ' '				1
59. 00	05900 CARDI AC CATHETERI ZATI ON	173, 416		1			
60.00	06000 LABORATORY	792, 477	46, 605, 631				
60. 01	06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	114, 167	1, 664, 472				1
64.00	06400 NTRAVENOUS THERAPY	100 000	(100 705	0.00000		0	
65. 00	06500 RESPI RATORY THERAPY	133, 823					1
66.00	06600 PHYSI CAL THERAPY	279, 343					1
67.00	06700 OCCUPATI ONAL THERAPY	0	0			_	
68. 00	06800 SPEECH PATHOLOGY	0	0	0.00000		0	
69. 00	06900 ELECTROCARDI OLOGY	618, 346				72, 112	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	383, 370	1				
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	7, 762					
73. 00	07300 DRUGS CHARGED TO PATIENTS	536, 341	1				1
74.00	07400 RENAL DIALYSIS	54, 856	1				
76. 00	03020 OTHER ANCI LLARY	0	1				
76. 01	03140 CARDI AC REHAB	108, 256					1
76. 02	03070 WOMEN' S CENTER	245, 633					
76. 03	03330 ENDOSCOPY	0	0	0. 00000	00 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	110.101	T = /44 /54			100	
90.00	09000 CLINIC	140, 194					
90. 01	09001 OUTPATI ENT	210, 841					
90. 02	09002 NEUROPSYCHOLOGY	229, 354				1	
91.00	09100 EMERGENCY	951, 560	1			72, 276	
91. 01	09101 SHORT STAY	544 (00	0 757 444	0.0000			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	541, 622	3, 757, 414	0. 14414	18 0	0	92.00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES		1	I			05.00
95.00		0 010 404	400 042 224		4E 202 014	074 102	95.00
200.00	Total (lines 50 through 199)	8, 818, 694	409, 043, 326	1	45, 383, 914	876, 193	₁ 200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2018 To 12/31/2018		epared: 23 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0 0 0	0 0		0 0 0 0	0 0	31. 00 41. 00
44. 00 04400 SKILLED NURSING FACILITY				0 0	0	44.00
200.00 Total (lines 30 through 199)		0			0	200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.00
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00	0	0	15, 03 2, 79 5, 31	0. 00	1, 165	31.00
43. 00 04300 NURSERY	0	0	5, 5	0.00		
44. 00 O4400 SKILLED NURSING FACILITY		0	4, 57			
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		,			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	0 0 0 0					30.00 31.00 41.00 43.00
44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0					44. 00 200. 00

Health Financial Systems	Systems RI VERVI EW HOSPI TAL			
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0059	Period: Worksheet D		

From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared: THROUGH COSTS 5/28/2019 1: 23 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st School Post-Stepdown School Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 0 0 50 00 0 000000000000000000000000000 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0 55.00 05700 CT SCAN 0 57.00 57.00 0 0 03630 ULTRA SOUND 57.01 0 0 57.01 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 0 0 06000 LABORATORY 0 60.00 60.00 0 0 60.01 06001 BLOOD LABORATORY 0 0 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 170, 604 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 03020 OTHER ANCILLARY 0 76.00 76.00 0 0 0 0 03140 CARDI AC REHAB 0 76. 01 0 0 76.01 03070 WOMEN'S CENTER 0 0 76.02 0 76.02 76.03 03330 ENDOSCOPY 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 C 0 09001 OUTPATI ENT 0 90.01 0 0 90.01 0 09002 NEUROPSYCHOLOGY 0 0 90.02 90.02 0 0 0 0 91 00 09100 EMERGENCY 0 0 91.00 09101 SHORT STAY 0 91.01 91.01 C 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS

0

0

95.00

170, 604 200. 00

0

0

95. 00 09500 AMBULANCE SERVI CES

Total (lines 50 through 199)

200.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0059	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2018 Part IV

From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) 4. 00 5.00 7. 00 8. 00 6.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 79, 983, 470 0.000000 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 0000000000000000000000000 05400 RADI OLOGY-DI AGNOSTI C 0 0 12, 419, 249 54.00 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 7, 770, 224 0.000000 0 55.00 0 55.00 0 57.00 05700 CT SCAN 0 16, 067, 446 0.000000 57.00 57.01 03630 ULTRA SOUND 5, 150, 403 0.000000 57.01 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 4, 822, 254 0.000000 58.00 59 00 05900 CARDI AC CATHETERI ZATI ON 0 0 20, 377, 328 0.000000 59 00 60.00 06000 LABORATORY C 46, 605, 631 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0 1, 664, 472 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 0 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 6, 108, 735 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0 28, 833, 409 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0 C 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 10, 264, 126 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 37, 294, 154 0.000000 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 15, 806, 460 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 170, 604 170, 604 52, 991, 742 0.003219 73.00 07400 RENAL DIALYSIS 74.00 718, 334 0.000000 74.00 76 00 03020 OTHER ANCI LLARY 0 0.000000 76 00 Ω 03140 CARDI AC REHAB 0 10, 829, 544 76.01 C 0.000000 76.01 76.02 03070 WOMEN'S CENTER 0 6, 761, 274 0.000000 76.02 03330 ENDOSCOPY 76.03 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 5, 614, 451 0.000000 90.00 0 90.01 09001 OUTPATI ENT 0 0 4, 802, 320 0.000000 90.01 0 09002 NEUROPSYCHOLOGY 90.02 0 0 612, 641 0.000000 90.02 0 09100 EMERGENCY 91.00 Ω 29, 788, 245 0.000000 91.00

0

0

0

C

170, 604

0

170, 604

3, 757, 414

409, 043, 326

0.000000

0.000000

91.01

92.00

95.00

200.00

91.01

92.00

200.00

09101 SHORT STAY

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN	NCILLARY SERVICE OTHER PASS Provider CCN: 15-0059	Peri od: Worksheet D
		E 04 (04 (0040 D I IV

From 01/01/2018 | Part IV To 12/31/2018 | Date/Time Prepared: THROUGH COSTS 5/28/2019 1: 23 pm Title XVIII Hospi tal PPS I npati ent Outpati ent Cost Center Description Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 12) 13.00 x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50.00 12, 503, 822 10, 660, 125 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 841, 508 0 1, 904, 122 54.00 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 3, 052, 147 55.00 55.00 20, 874 0 05700 CT SCAN 0 57.00 0.000000 1, 162, 747 3, 492, 601 0 57.00 57.01 03630 ULTRA SOUND 0.000000 0 22,865 0 57.01 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 205, 947 1,088,804 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59 00 0.000000 2, 036, 810 0 5, 531, 100 0 0 60.00 06000 LABORATORY 0.000000 5, 494, 495 3, 482, 978 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 301, 393 132, 836 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 64.00 0 65.00 06500 RESPIRATORY THERAPY 0.000000 1, 973, 474 619, 445 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 1, 519, 776 93, 895 0 66.00 06700 OCCUPATI ONAL THERAPY 0 0.000000 67.00 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 1, 197, 011 0 3, 357, 392 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 6, 727, 097 0 4, 779, 292 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 2, 019, 023 72.00 0.000000 3, 278, 560 \cap 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.003219 5, 355, 634 17, 240 16, 308, 023 52, 496 73.00 07400 RENAL DIALYSIS 74.00 0.000000 289, 163 0 74.00 76 00 03020 OTHER ANCI LLARY 0.000000 0 Ω 76.00 C 03140 CARDI AC REHAB 0.000000 0 76.01 122, 672 4, 436, 770 0 76.01 0 76.02 03070 WOMEN'S CENTER 0.000000 690, 674 0 76.02 1,043 03330 ENDOSCOPY 76.03 0.000000 0 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.000000 4, 320 0 2, 269, 892 0 90.01 09001 OUTPATI ENT 0.000000 84, 997 0 1, 591, 169 0 90.01 09002 NEUROPSYCHOLOGY 90.02 0.000000 0 224, 453 0 90.02 0 09100 EMERGENCY 91.00 91.00 0.000000 2, 262, 571 3, 910, 319 0 0 91.01 09101 SHORT STAY 0.000000 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 789, 126 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

45, 383, 914

17, 240

70, 457, 051

52, 496 200. 00

200.00

Total (lines 50 through 199)

Health Fin	nancial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONN	MENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provi der C	CN: 15-0059	Peri od:	Worksheet D	
					From 01/01/2018 To 12/31/2018	Part V	
					To 12/31/2018	Date/Time Pre	pared:
			T: +1 -		11: 4-1	5/28/2019 1: 2	:3 pm
			IIIII	XVIII	Hospi tal	PPS	
	Cook Cooker Dooreitsties	0+ +-	DDC	Charges	0+	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Servi ces (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ILLARY SERVICE COST CENTERS			1			
	OO OPERATING ROOM	0. 131489	10, 660, 125		0	1, 401, 689	1
	OO DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0	0	
	00 RADI OLOGY-DI AGNOSTI C	0. 318866	1, 904, 122		0	607, 160	
	00 RADI OLOGY-THERAPEUTI C	0. 263525	3, 052, 147		0	804, 317	55.00
57.00 057	00 CT SCAN	0. 037866	3, 492, 601		0	132, 251	57.00
57. 01 036	30 ULTRA SOUND	0. 058997	22, 865		0	1, 349	57. 01
58. 00 058	OO MAGNETIC RESONANCE IMAGING (MRI)	0. 113548	1, 088, 804		o o	123, 632	58.00
59.00 059	OO CARDI AC CATHETERI ZATI ON	0. 069850	5, 531, 100		o o	386, 347	59.00
60.00 060	OO LABORATORY	0. 199574	3, 482, 978		o o	695, 112	60.00
	01 BLOOD LABORATORY	0. 000000	0	1	o o	0	1
	00 BLOOD STORING, PROCESSING & TRANS.	0. 493272	132, 836	1	0 0	65, 524	1
	OO I NTRAVENOUS THERAPY	0. 000000	0		o o	00,021	
	00 RESPI RATORY THERAPY	0. 332644	619, 445	1	0 0	206, 055	
	00 PHYSI CAL THERAPY	0. 348286	93, 895	1	0 0	32, 702	
	00 OCCUPATI ONAL THERAPY	0. 000000	75,075		0 0	32, 702	1
	00 SPEECH PATHOLOGY	0. 000000	0	1	0 0	0	
	OO ELECTROCARDI OLOGY	0. 225844	2 257 202	1	0 0		1
		1	3, 357, 392		0 0	758, 247	
•	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 527305	4, 779, 292	1		2, 520, 145	1
	OO I MPL. DEV. CHARGED TO PATIENT	0. 066476	2, 019, 023		0 0	134, 217	
	OO DRUGS CHARGED TO PATIENTS	0. 395776	16, 308, 023		0 18, 439	6, 454, 324	
	00 RENAL DI ALYSI S	0. 642185	0	1	0 0	0	
	20 OTHER ANCI LLARY	0. 000000	0	1	0	0	
	40 CARDI AC REHAB	0. 216404	4, 436, 770		0	960, 135	
	70 WOMEN'S CENTER	0. 156312	690, 674		0	107, 961	
	30 ENDOSCOPY	0. 000000	0		0 0	0	76. 03
	PATIENT SERVICE COST CENTERS						1
	OO CLI NI C	0. 142336	2, 269, 892	1	0	323, 087	
	01 OUTPATI ENT	0. 356050	1, 591, 169	1	0	566, 536	
90. 02 090	02 NEUROPSYCHOLOGY	0. 848092	224, 453		0	190, 357	90.02
91.00 091	OO EMERGENCY	0. 238306	3, 910, 319	1	0 0	931, 852	91.00
91. 01 091	01 SHORT STAY	0. 000000	0)	0	0	91.01
92.00 092	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 646001	789, 126	.l	o o	509, 776	92.00
OTH	ER REIMBURSABLE COST CENTERS						1
	00 AMBULANCE SERVICES	0. 000000			0		95.00
200. 00	Subtotal (see instructions)		70, 457, 051		0 18, 439	17, 912, 775	200.00
201. 00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		70, 457, 051		0 18, 439	17, 912, 775	202.00
		•	•	•			•

Health Financial Systems RIVERVIEW APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0059

| Peri od: | Worksheet D | From 01/01/2018 | Part V | To | 12/31/2018 | Date/Time | Prepared:

					10 12/31/2018	Date/IIMe Pre 5/28/2019 1:2	
			Title	XVIII	Hospi tal	PPS	.5 piii
		Cos		,,,,,,	, noopi tui		
	Cost Center Description	Cost	Cost				
	5551 551161 B5551 Ft. 511	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS	•		·			
50.00	05000 OPERATING ROOM	0	0				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00		0	0				54.00
55.00		0	0				55.00
57.00		0	0				57.00
57. 01	03630 ULTRA SOUND	0	0				57. 01
58. 00		0	0				58.00
59. 00		0	0				59.00
60.00	l i	0	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60.01
63. 00	l i	0	0				63.00
64. 00		0	0				64.00
65. 00	l i	0	0				65.00
66. 00		0	0				66.00
67. 00		0	0				67.00
68. 00		0	0				68.00
69.00		0	0				69.00
71. 00		0	0				71.00
72.00		0	0				72.00
73. 00		0	7, 298				73.00
74.00		0	0	1			74.00
76. 00		0	0				76.00
76. 01		0	0				76. 01
76. 02		0	0				76. 02
76. 03		0	0				76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0				90.00
90. 01	09001 OUTPATI ENT	0	0				90. 01
90. 02		0	0				90.02
91. 00		0	0				91.00
91. 01		0	0				91.01
92. 00	l i	0	Ö	•			92.00
50	OTHER REIMBURSABLE COST CENTERS	<u> </u>		·			1
95.00		0					95. 00
200.00		0	7, 298				200.00
201.00		0	., 2,0				201.00
	Only Charges						
202.00		0	7, 298				202.00
		•	-	•			

	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Component	CN: 15-0059 CCN: 15-T059	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/28/2019 1:2	pared:
			Title	· XVIII	Subprovi der -	5/28/2019 1: 2 PPS	:3 pm
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	·	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 230, 617	79, 983, 470			3, 759	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000	00	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	432, 927	12, 419, 249	0. 03485	49, 014	1, 709	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	415, 154	7, 770, 224	0. 05342	29 0	0	55.00
57.00	05700 CT SCAN	89, 117	16, 067, 446	0. 00554	16 56, 963	316	57.00
57. 01	03630 ULTRA SOUND	20, 539	5, 150, 403	0. 00398	38 0	0	57. 01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	108, 979	4, 822, 254	0. 02259	99 19, 327	437	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	173, 416	20, 377, 328	0.00851	19, 513	166	59.00
60.00	06000 LABORATORY	792, 477	46, 605, 631	0. 01700	728, 606	12, 389	60.00
60.01	06001 BLOOD LABORATORY	0	0	0. 00000	00	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	114, 167	1, 664, 472	0. 06859	91 9, 916	680	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0. 00000	00	0	64.00
65.00	06500 RESPI RATORY THERAPY	133, 823	6, 108, 735	0. 02190	312, 976	6, 856	65.00
66.00	06600 PHYSI CAL THERAPY	279, 343	28, 833, 409	0. 00968	3, 778, 290	36, 604	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	00	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0. 00000	00	0	68.00
69.00	06900 ELECTROCARDI OLOGY	618, 346	10, 264, 126	0. 06024	13 38, 332	2, 309	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	383, 370			· ·	6, 372	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	7, 762		l .		4	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	536, 341			· ·	9, 415	
74.00	07400 RENAL DIALYSIS	54, 856				10, 834	74.00
76.00	03020 OTHER ANCI LLARY	0		1		0	76.00
76. 01	03140 CARDI AC REHAB	108, 256	10, 829, 544	l .		49	76. 01
76. 02	03070 WOMEN'S CENTER	245, 633				0	76. 02
76. 03	03330 ENDOSCOPY	0		1	00	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	140, 194	5, 614, 451	0. 02497	70 1, 290	32	90.00
90. 01	09001 OUTPATI ENT	210, 841	4, 802, 320	0. 04390	34, 500	1, 515	90. 01
90. 02	09002 NEUROPSYCHOLOGY	229, 354			· ·	0	1
91.00	09100 EMERGENCY	951, 560				1, 494	
91. 01	09101 SHORT STAY	0				0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		•		0	1
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	8, 277, 072	409, 043, 326		6, 934, 963	94, 940	200. 00

Health Financial Systems	RI VERVI EW					u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0059		i od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T059	To	om 01/01/2018 12/31/2018	Part IV Date/Time Pre	nared:
		Component	0014: 10 1007			5/28/2019 1: 2	3 pm
		Title	XVIII	Su	ıbprovi der -	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		I RF	Allied Health	
cost center bescription	Anesthetist	School	School		ost-Stepdown	Allieu neal tii	
	Cost	Post-Stepdown	3011001		Adjustments		
	0031	Adjustments		'	raj astilicitis		
	1. 00	2A	2. 00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00		2.00			0.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	o	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	o	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	o	0	55.00
57. 00 05700 CT SCAN	0	0		0	ol	0	57.00
57. 01 03630 ULTRA SOUND	0	0		0	o	0	57. 01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	o	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	o	0	59.00
60. 00 06000 LABORATORY	o	0		0	o	0	60.00
60. 01 06001 BL00D LABORATORY	0	0		0	o	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	O	0		0	o	0	63.00
64.00 06400 INTRAVENOUS THERAPY	O	0		0	o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	O	0		0	o	0	65.00
66. 00 06600 PHYSI CAL THERAPY	o	0		0	o	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	170, 604	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76. 00 03020 0THER ANCI LLARY	0	0		0	0	0	76.00
76. 01 03140 CARDI AC REHAB	0	0		0	0	0	76. 01
76. 02 03070 WOMEN' S CENTER	0	0		0	0	0	76. 02
76. 03 03330 ENDOSCOPY	0	0		0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0		0	0	0	90.00
90. 01 09001 0UTPATI ENT	0	0		0	0	0	90.01
90. 02 09002 NEUROPSYCHOLOGY	0	0		0	0	0	90.02
91. 00 09100 EMERGENCY	0	0		0	0	0	91.00
91. 01 09101 SHORT STAY	0	0		0	0	0	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
OTHER REIMBURSABLE COST CENTERS					1		05 00
95.00 09500 AMBULANCE SERVICES		^				170 404	95.00
200.00 Total (lines 50 through 199)	0	0	I	0	0	170, 604	1200. UU

Health Financial Systems	RI VERVI EW H		N 15 0050		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	S Provider C		Peri od: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2018	Date/Time Pre 5/28/2019 1:2	
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
'	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
	4. 00	5. 00	and 4) 6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM	O	0		0 79, 983, 470	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 77,700,170	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 419, 249	0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 7, 770, 224	0. 000000	
57. 00 05700 CT SCAN	o	0		0 16, 067, 446	0. 000000	
57. 01 03630 ULTRA SOUND	o	0		0 5, 150, 403	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0		0 4, 822, 254	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 20, 377, 328	0.000000	
60. 00 06000 LABORATORY	0	0		0 46, 605, 631	0.000000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 664, 472	0.000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		o o	0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 6, 108, 735	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 28, 833, 409	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		o o	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 10, 264, 126	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	s o	0		0 37, 294, 154	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 15, 806, 460	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	170, 604	170, 60	52, 991, 742	0. 003219	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 718, 334	0.000000	74.00
76. 00 03020 OTHER ANCI LLARY	0	0		0 0	0.000000	76.00
76. 01 03140 CARDI AC REHAB	0	0		0 10, 829, 544	0.000000	76.01
76. 02 03070 WOMEN' S CENTER	0	0		0 6, 761, 274	0.000000	76.02
76. 03 03330 ENDOSCOPY	0	0		0 0	0. 000000	76. 03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 5, 614, 451	0.000000	
90. 01 09001 OUTPATI ENT	0	0		0 4, 802, 320	0.000000	
90. 02 09002 NEUROPSYCHOLOGY	0	0		0 612, 641	0.000000	
91. 00 09100 EMERGENCY	0	0		0 29, 788, 245	0. 000000	
91. 01 09101 SHORT STAY	0	0		0 0	0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0	0		0 3, 757, 414	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	170, 604	170, 60)4 409, 043, 326		200.00

Health Financial Systems		RI VERVI EW F	IOSPI TAI		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OU	TPATIENT ANCILLARY SE		_	CN: 15-0059	Peri od:	Worksheet D	2002 10
THROUGH COSTS			Component		From 01/01/2018 To 12/31/2018		epared:
			Title	XVIII	Subprovi der -	PPS	.о рш
Cost Center Descr	iption	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13.00	
ANCILLARY SERVICE COST	CENTERS						
50.00 05000 OPERATI NG ROOM		0. 000000	134, 793	(0	0	50.00
52.00 05200 DELIVERY ROOM & L		0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOS		0. 000000	49, 014	(0	0	54.00
55. 00 05500 RADI OLOGY-THERAPE	UTIC	0. 000000	0	(0	0	55.00
57.00 05700 CT SCAN		0. 000000	56, 963	(0	0	57.00
57.01 03630 ULTRA SOUND		0. 000000	0	(0	0	
58.00 05800 MAGNETIC RESONANC		0. 000000	19, 327	(0	0	
59. 00 05900 CARDI AC CATHETERI	ZATI ON	0. 000000	19, 513	(0	0	59.00
60. 00 06000 LABORATORY		0. 000000	728, 606	(0	0	60.00
60. 01 06001 BLOOD LABORATORY		0. 000000	0		0	0	
63.00 06300 BLOOD STORING, PR		0. 000000	9, 916		0	0	
64.00 06400 I NTRAVENOUS THERA		0. 000000	0		0	0	
65. 00 06500 RESPIRATORY THERA	ιPY	0. 000000	312, 976		0	0	
66. 00 06600 PHYSI CAL THERAPY		0. 000000	3, 778, 290		0	0	
67. 00 06700 OCCUPATI ONAL THER	RAPY	0. 000000	0		0	0	
68.00 06800 SPEECH PATHOLOGY		0. 000000	0		0	0	
69. 00 06900 ELECTROCARDI OLOGY		0. 000000	38, 332		0	0	
71.00 07100 MEDICAL SUPPLIES		0. 000000	619, 842		0	0	
72. 00 07200 I MPL. DEV. CHARGE		0. 000000	7, 802		0	0	
73. 00 07300 DRUGS CHARGED TO	PATI ENTS	0. 003219	930, 277	2, 99		0	
74.00 07400 RENAL DIALYSIS		0. 000000	141, 872		0	0	
76. 00 03020 OTHER ANCI LLARY		0. 000000	0		0	0	
76. 01 03140 CARDI AC REHAB		0. 000000	4, 890		0	0	
76. 02 03070 WOMEN' S CENTER		0. 000000	0		0	0	
76. 03 03330 ENDOSCOPY	- OFWITEDO	0. 000000	0	(0 0	0	76. 03
OUTPATIENT SERVICE COST	I CENTERS	0.000000	4 000				00.00
90. 00 09000 CLI NI C		0.000000	1, 290		0	0	
90. 01 09001 0UTPATI ENT 90. 02 09002 NEUROPSYCHOLOGY		0. 000000 0. 000000	34, 500		0 0	0	
			0		0 0	0	
91. 00 09100 EMERGENCY		0.000000	46, 760		-	0	
91. 01 09101 SHORT STAY	(NON DISTINCT DART)	0. 000000 0. 000000	0		0 0	0	
92. 00 09200 OBSERVATION BEDS OTHER REIMBURSABLE COST		0.000000	0		υ	0	92.00
95. 00 09500 AMBULANCE SERVICE		T					95.00
200.00 Total (lines 50 t			6, 934, 963	2, 99	5 0	0	200.00
200.00 10tal (111es 50 t	111 Gugii 177)	ı l	0, 734, 703	[Z, 99	ار ا ا	0	₁ 200.00

	Financial Systems	RI VERVI EW				u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	RVICE OTHER PAS		CN: 15-0059 CCN: 15-5669	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre 5/28/2019 1:2	pared: 3 pm
			Title	XVIII	Skilled Nursing Facility		
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health	
	T	1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50.00	05000 OPERATING ROOM	0	0		0 0	1	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	1	52.00
54. 00 55. 00	05400 RADI OLOGY THERAPEUTI C	0	0		0 0	0	54. 00 55. 00
57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	0		0 0		57.00
57.00	03630 ULTRA SOUND	0	0		0 0		57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	Ö	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	Ö	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	Ō	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	170, 604	73.00
74. 00	07400 RENAL DIALYSIS	0	0		0	0	74.00
76. 00	03020 OTHER ANCI LLARY	0	0		0 0	0	76.00
76. 01	03140 CARDI AC REHAB	0	0		0 0	0	76. 01
76. 02	03070 WOMEN' S CENTER	0	0		0 0	0	76.02
76. 03	03330 ENDOSCOPY	0	0		0 0	0	76. 03
90.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		0 0	0	90.00
90.00	09000 CLINIC 09001 OUTPATIENT		0		0 0		90.00
90.01	09001 OUTPATTENT		0		0 0	0	90.01
90.02	09100 EMERGENCY		0		0 0		90.02
91.00	09101 SHORT STAY		0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	0	92.00
00	OTHER DELMINISTRALE COST CENTERS						1 33

92.00 95.00 170, 604 200. 00

92. 00 | O9200 | OBSERVATION BEDS (NON-DISTINCT PART) |
OTHER REIMBURSABLE COST CENTERS |
95. 00 | O9500 | AMBULANCE SERVICES |
200. 00 | Total (lines 50 through 199)

	Financial Systems	RI VERVI EW				u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre 5/28/2019 1:2	epared:
			Title	XVIII	Skilled Nursing	PPS	.о рііі
					Facility		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		4. 00	5. 00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0	0		0 79, 983, 470	0.000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	·		0 0		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 419, 249		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ö	•	0 7, 770, 224	0. 000000	1
57.00	05700 CT SCAN	0	0		0 16, 067, 446	0. 000000	57.00
57. 01	03630 ULTRA SOUND	0	0		0 5, 150, 403		57. 01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 4, 822, 254	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 20, 377, 328	0.000000	59.00
60.00	06000 LABORATORY	0	0		0 46, 605, 631	0.000000	60.00
60.01	06001 BLOOD LABORATORY	0	0		0	0.000000	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 664, 472	0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 6, 108, 735		
66.00	06600 PHYSI CAL THERAPY	0	0		0 28, 833, 409		
	06700 OCCUPATI ONAL THERAPY	0	0		0	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	0		0	0. 000000	1
	06900 ELECTROCARDI OLOGY	0	0		0 10, 264, 126		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 37, 294, 154		
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 15, 806, 460		
	07300 DRUGS CHARGED TO PATIENTS	0	170, 604		1 '		
	07400 RENAL DIALYSIS	0	0	ŀ	0 718, 334		
	03020 OTHER ANCI LLARY	0	0	1	0 0	0. 000000	
	03140 CARDI AC REHAB	0	0		0 10, 829, 544		
	03070 WOMEN' S CENTER	0	0		0 6, 761, 274		
76. 03	03330 ENDOSCOPY	0	0		0 0	0. 000000	76. 03
00 00	OUTPATIENT SERVICE COST CENTERS				0 5 (14 451	0.000000	00 00
	09000 CLI NI C 09001 OUTPATI ENT	0	0	l	0 5, 614, 451		
	09001 OUTPATTENT 09002 NEUROPSYCHOLOGY				0 4, 802, 320 0 612, 641	0. 000000	
	09100 EMERGENCY				0 29, 788, 245		
	09100 EMERGENCT				0 29, 700, 243		

0

170, 604

170, 604

3, 757, 414

409, 043, 326

0.000000

0.000000

91.01

92.00 95.00

200.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

91. 01 | 09101 | SHORT STAY

200.00

Health Financial Systems	RI VERVI EW HO				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der C		Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2018		nared.
		· ·			5/28/2019 1: 2	3 pm
		Title	: XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col . 12)	
ANOLILIABLY OFFICE ORDER OFFITEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000					F0 00
50. 00 05000 OPERATING ROOM	0. 000000	0		0 0	-	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	30, 900		0 0	0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	30, 890		-	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000 0. 000000	0	1	0 0	0	55. 00 57. 00
57. 00 05700 CT SCAN		0				
57. 01 03630 ULTRA SOUND	0. 000000	0			0	57. 01 58. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0. 000000	•			0	59.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0. 000000 0. 000000	13, 951		0 0	0	60.00
60. 01 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0. 000000	1, 047, 422 0			0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0			0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0			0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	229, 106			0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 408, 450			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 400, 430			0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		o o	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	375		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	288, 438			0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	200, 430		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 003219	1, 907, 506			Ö	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 707, 500		o o	Ö	74.00
76. 00 03020 OTHER ANCI LLARY	0. 000000	0		o o	0	76.00
76. 01 03140 CARDI AC REHAB	0. 000000	1, 815		o o	0	76.01
76. 02 03070 WOMEN' S CENTER	0. 000000	.,		0	Ö	76. 02
76. 03 03330 ENDOSCOPY	0. 000000	0	1	ol ol	Ö	76. 03
OUTPATIENT SERVICE COST CENTERS	2. 2.2.2.2.2	-	I.	-1	-	
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01 09001 OUTPATI ENT	0. 000000	0		o o	0	90. 01
90. 02 09002 NEUROPSYCHOLOGY	0. 000000	0		o o	Ō	90. 02
91. 00 09100 EMERGENCY	0. 000000	0		o o	0	91.00
91. 01 09101 SHORT STAY	0. 000000	0		o o	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		o o	0	92.00
OTHER REIMBURSABLE COST CENTERS	·]
OTHER RETIREDITORISEE COOT CENTERO						
95. 00 09500 AMBULANCE SERVI CES						95.00

Health Fir	nancial Systems	RI VERVI EW HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATIO	ON OF INPATIENT OPERATING COST		Provider CCN: 15-0059	Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
PAR	T I - ALL PROVIDER COMPONENTS					
I NP	ATIENT DAYS					
1.00 Ing	patient days (including private room days a	and swing-bed day	s, excluding newborn)		15, 035	1.00

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		15, 035	1.00
2.00	Inpatient days (including private room days, excluding swing-			15, 035	2.00
3.00	Private room days (excluding swing-bed and observation bed days	ys). If you have only pr	ivate room days,	0	3.00
4 00	do not complete this line.	and days)		10 077	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation between Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	13, 377 0	4. 00 5. 00
3. 00	reporting period	om days) trii ough beecimbe	or or the cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roc	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roc	m days) after December 3	11 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember s	or the cost	O	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	5, 102	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		nom days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		dom days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	alli (excruding swing-bed	uays)	0	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0. 00	17. 00
10.00	reporting period	on often December 21 of	+bc coc+	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period	3			
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0. 00	20.00
21 00	reporting period			22, 011, 031	21. 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line		1
22.00	5 x line 17)	ci or or the cost report	ing period (ind	· ·	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 🛭	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through Decembe $ 7 \times $ Line 19)	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	X Time 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrou (Trie o	O	25.00
26.00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		22, 011, 031	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	dd		0	20.00
28.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	and observation bed cr	narges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	1
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)	·		0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	1
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	22, 011, 031	36.00
37.00	27 minus line 36)	and private room cost ur	(IIII	22,011,031	37.30
	PART II - HOSPITAL AND SUBPROVIDERS ONLY]
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 463. 99	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			7, 469, 277 0	1
41. 00	, , , , , , , , , , , , , , , , , , , ,			7, 469, 277	
	1 3 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,			

30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	22, 011, 031	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 463. 99	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	7, 469, 277	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	7, 469, 277	41.00

Heal th	h Financial Systems RIVERVIEW HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ITATION OF INPATIENT OPERATING COST Provider (CCN: 15-0059	Peri od: From 01/01/2018	Worksheet D-1	
			To 12/31/2018		
	Ti †I	e XVIII	Hospi tal	5/28/2019 1: 2: PPS	3 pm
	Cost Center Description Total Total	Average Per	Program Days	Program Cost	
	Inpati ent Inpati ent	Diem (col. 1		(col. 3 x	
	Cost Days 1. 00 2. 00	÷ col. 2)	4. 00	col. 4) 5.00	
42. 00		0.0			42.00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 5,340,647 2,79	2 1 012 0	1 1/5	2 220 450	42.00
43. 00 44. 00		2 1, 912. 8	1, 165	2, 228, 459	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00					46.00
47.00	O OTHER SPECIAL CARE (SPECIFY) Cost Center Description				47.00
				1. 00	
48.00) Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructi	ione)		11, 496, 252 21, 193, 988	48. 00 49. 00
47.00	PASS THROUGH COST ADJUSTMENTS	1 0113)		21, 173, 700	47.00
50.00		om Wkst. D, su	m of Parts I and	2, 040, 309	50. 00
51. 00		from Wkst D	sum of Parts II	893, 433	51. 00
01.00	and IV)	Trom more. b,	34m 01 141 t3 11	070, 100	01.00
52.00	, ,		h-4:-4	2, 933, 742	
53. 00	Total Program inpatient operating cost excluding capital related, non-pl medical education costs (line 49 minus line 52)	nysician anest	netist, and	18, 260, 246	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54. 00 55. 00	Program discharges Target amount per discharge			0 0. 00	
56. 00				0.00	56.00
57. 00		(line 56 minus	line 53)	0	57.00
58. 00 59. 00	,	undated and c	omnounded by the	0.00	58. 00 59. 00
37.00	market basket	upuateu anu c	ompounded by the	0.00	37.00
60.00				0.00	
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the less which operating costs (line 53) are less than expected costs (lines 54)			0	61. 00
	amount (line 56), otherwise enter zero (see instructions)		9		
62. 00 63. 00				0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST			0	03.00
64. 00		ne cost report	ing period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the	cost reportin	a period (See	o	65. 00
	instructions)(title XVIII only)	·			
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line CAH (see instructions)	65)(title XVI	II only). For	0	66. 00
67.00		of the cost r	eporting period	0	67.00
40.00	(line 12 x line 19)	F +b2 222+ 222	anting paried		40.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of (line 13 x line 20)	r the cost rep	orting period	U	68. 00
69. 00	, i			0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/III Skilled nursing facility/other nursing facility/ICF/IID routine service)		70. 00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line	•	,		71. 00
72.00	, ,	1: 25)			72.00
73. 00 74. 00					73. 00 74. 00
75. 00		,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)				76. 00
77.00	· · · · · · · · · · · · · · · · · · ·				77.00
78. 00					78. 00
79. 00 80. 00	55 5		nus line 79)	-	79. 00 80. 00
81.00	· · · · · · · · · · · · · · · · · · ·	(81. 00
82.00					82.00
83. 00 84. 00					83. 00 84. 00
85.00	Utilization review - physician compensation (see instructions)				85.00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				86. 00
87. 00				1, 658	87. 00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			1, 463. 99	
89.00	Observation bed cost (line 87 x line 88) (see instructions)			2, 427, 295	89.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 911, 496	22, 011, 031	0. 22313	2, 427, 295	541, 622	90.00
91.00 Nursing School cost	0	22, 011, 031	0.00000	0 2, 427, 295	0	91.00
92.00 Allied health cost	0	22, 011, 031	0.00000	0 2, 427, 295	0	92.00
93.00 All other Medical Education	0	22, 011, 031	0. 00000	2, 427, 295	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od:	Worksheet D-1
		From 01/01/2018	
	Component CCN: 15-T059	To 12/31/2018	Date/Time Prepared:
	·		5/28/2019 1:23 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

		I constitution of the cons	RF		
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day			5, 314	•
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		room daye	5, 314 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only private i	ooiii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		5, 314	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through December 31 of	the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December 31 of t	he cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December 31 of	the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 31 of th	e cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding swing-	hed and	3, 471	9. 00
7. 00	newborn days)			3, 171	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		s)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (íncluding private room day	s) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		days)	0	12. 00
12.00	through December 31 of the cost reporting period	,			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y		days)	0	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14. 00
15.00	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 of the c	ost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of the cos	t	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the co	st	0. 00	19. 00
20.00	reporting period	<u> </u>		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period				20.00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ind (line	4, 769, 362 0	
22.00	5 x line 17)	or or the cost reporting per	100 (11110	o .	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting perio	d (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporting peri	od (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting period	(line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 769, 362	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed charges)		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	,		0	•
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	•
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	•
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nue lina 33)(sae instructions)		0. 00 0. 00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	•
36.00	Private room cost differential adjustment (line 3 x line 35)		ł	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost different	ial (line	4, 769, 362	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			897. 51	38. 00
39.00	Program general inpatient routine service cost (line 9 x line	•		3, 115, 257	
40.00	Medically necessary private room cost applicable to the Progr	,		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		3, 115, 257	41.00

Heal th	Financial Systems	RI VERVI EW H	HOSPI TAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0059	Peri od: From 01/01/2018		
				CCN: 15-T059	To 12/31/2018	5/28/2019 1: 2	
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	·					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk. Total Program inpatient costs (sum of lines			ons)		2, 429, 386 5, 544, 643	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpulli)	atient routine	services (fro	m Wkst. D, sı	um of Parts I and	481, 879	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	97, 935	
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non-ph	veician anget	thatist and	579, 814 4, 964, 829	
55.00	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		rateu, non-pri	ysi ci aii ailesi	metrst, and	4, 704, 027	33.00
54. 00	Program di scharges					0	54.00
55. 00 56. 00						0.00	1
57.00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	s line 53)	0	1
58.00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '					0.00	
59. 00	DO Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59. 00
60.00	00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 00	which operating costs (line 53) are less than					0	61.00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)			-	0	62.00
	00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	porting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				7)		70.00
71.00	Adjusted general inpatient routine service co	•		•	()		71.00
72.00			. (lino 14 v l	ino 3E)			72.00
73. 00 74. 00	Medically necessary private room cost applications and Program general inpatient routine serv		•	,			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
	Inpatient routine service cost (line 74 minus						78.00
79.00	99 9	, ,		•	nuc Line 70)		79.00
81.00	Total Program routine service costs for compartient routine service cost per diem limi		ost rimitatio	ווו סו שווון וו	nus IIIE /7)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (ine 9 x line 81	* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		15)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.00
87.00	Total observation bed days (see instructions))	line 2)			0	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•				l	88. 00 89. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 1:2	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	737, 735	4, 769, 362	0. 15468	32 0	0	90.00
91.00 Nursing School cost	0	4, 769, 362	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 769, 362	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 769, 362	0. 00000	00 0	0	93.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059		Worksheet D-1
		From 01/01/2018	
	Component CCN: 15-5669	To 12/31/2018	Date/Time Prepared:
	·		5/28/2019 1: 23 pm
	Title XVIII	Skilled Nursing	PPS
		Facility	

		Facility		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	I NPATI ENT DAYS			
1. 00	Inpatient days (including private room days and swing-bed day		4, 574	•
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		4, 574 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only private room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)	4, 574	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through December 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) area becomber or or the east	· ·	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	in days) arter becomber 51 or the cost	O	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding swing-bed and	3, 105	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		O	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		0	12. 00
12.00	through December 31 of the cost reporting period	A only (frict during private room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI		0	13. 00
14.00	after December 31 of the cost reporting period (if calendar y		0	14.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed days)	0	
16. 00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 of the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of the cost	0. 00	18. 00
10.00	reporting period	- thursual December 21 of the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	c)	3, 921, 999	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb			
	5 x line 17)			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporting period (line	0	24.00
05.00	7 x line 19)	24 - 6 - 11 1	0	05.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	3) of the cost reporting period (line 8)	0	25. 00
26. 00	Total swing-bed cost (see instructions)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	3, 921, 999	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		0	•
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)	0. 000000	•
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	•
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	0. 00 0. 00	
35.00	Average per diem private room cost differential (line 34 x li		0.00	•
36.00	Private room cost differential adjustment (line 3 x line 35)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differential (line		•
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see			38. 00
39.00	Program general inpatient routine service cost (line 9 x line	<i>'</i>		39. 00
40.00	Medically necessary private room cost applicable to the Progr	,		40.00
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		41.00

	Financial Systems	RI VERVI EW			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	FING COST Provider CCN: 15-0059 Period: From 01/01/2018		Worksheet D-1			
		Component CCN: 15-5669 To 12/31/2018			Date/Time Pre 5/28/2019 1:2	pared: 3 pm	
			Title	XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2)	1	(col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00	2.00	3. 00	4. 00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					1.00	48. 00
49. 00	Total Program inpatient costs (sum of lines : PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)			49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, s	um of Parts I and		50. 00
51. 00	<pre> Pass through costs applicable to Program inp</pre>	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II		51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital r	elated, non-ph	ysician anes	thetist, and		53.00
	medical education costs (line 49 minus line 1 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00 55. 00	Program di scharges Target amount per di scharge						54. 00 55. 00
56.00	Target amount (line 54 x line 55)						56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and t	arget amount (line 56 minus	s line 53)		57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and	compounded by the		59. 00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, u	pdated by the	market baske	t		60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that						61.00
	amount (line 56), otherwise enter zero (see		(11100 01 %	00), 01 1.0	or the target		
62. 00 63. 00							62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost renor	ting period (See		64.00
	instructions)(title XVIII only)	G		·			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decem	ber 31 of the	cost reporti	ng period (See		65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(title XV	III only). For		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs throug	h December 31	of the cost	reporting period		67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after	December 31 of	the cost re	porting period		68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 ± lin	e 68)			69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILIT	Y, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				7)	3, 921, 999 857. 45	1
72.00	Program routine service cost (line 9 x line	71)				2, 662, 382	72.00
73. 00 74. 00	Medically necessary private room cost applications. Total Program general inpatient routine serv		•			0 2, 662, 382	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine servic	e costs (from	Worksheet B,	Part II, column	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus					0	
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp		•	,	inus Lino 70)	0	79. 00 80. 00
81.00	Inpatient routine service cost per diem limit	tati on		ii (iiiie 70 iii	Thus Title 17)	0. 00	81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•			0 2, 662, 382	82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)	ŕ			1, 694, 134	84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum					0 4, 356, 516	85. 00 86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27				0. 00	88. 00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)			0	89. 00

Health Financial Systems RIVERVIEW HOSPITAL				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018		nared·
		Component	3014. 10 0007	10 12/01/2010	5/28/2019 1: 2	
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0. 00000	00	0	90.00
91.00 Nursing School cost	0	0	0. 00000	00	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od: From 01/01/2018	Worksheet D-1			
		To 12/31/2018	Date/Time Prep 5/28/2019 1:23			
	Ti tle XIX	Hospi tal	Cost			
Cost Center Description						
			1. 00			
PART I - ALL PROVIDER COMPONENTS						
INPATIENT DAYS						
1.00 Inpatient days (including private room days	Inpatient days (including private room days and swing-bed days, excluding newborn)					
2.00 Inpatient days (including private room days	On Inpatient days (including private room days, excluding swing-bed and newborn days)					
3.00 Private room days (excluding swing-bed and						

	Cost Center Description	1 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15, 035	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15, 035	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13, 377	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	310	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12 00
13. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U)	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	
	SWI NG BED ADJUSTMENT	- J	
17. 00		0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	22, 011, 031	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
22.00	5 x line 17)	١	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)	-	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22, 011, 031	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
30.00	Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	22, 011, 031	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 463. 99	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	453, 837	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 452 027	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	453, 837	41.00

	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	310	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12 00	through December 31 of the cost reporting period	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	
10.00	SWING BED ADJUSTMENT	U	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	22, 011, 031	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)	0	22 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	Ty x line 19)	U	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22, 011, 031	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		35. 00 36. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 22, 011, 031	
37.00	27 minus line 36)	22,011,031	37.00
	27 III III STITIE 30) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 463. 99	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	453, 837	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	453, 837	
	, , , , , , , , , , , , , , , , , , , ,		

7.00	report in g peri od	٠	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ĭ	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	310	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	22, 011, 031	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		
22.00	5 x line 17)	٥	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
20.00	In line 18)	ĭ	20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	ol	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	o	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	22, 011, 031	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	22, 011, 031	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 463. 99	38. 00
39.00	Program general inpatient routine service cost (line 9 x line 38)	453, 837	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	455, 657	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	453, 837	
41.00	Total Trogram general impatient routine service cost (The 37 + Time 40)	400,007	41.00

Heal th	Financial Systems RIVERVIEW HOSPITAL In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0059 Period: From 01/01/2018	Worksheet D-1	
	To 12/31/2018	B Date/Time Pre	
	Title XIX Hospital	5/28/2019 1: 2 Cost	3 pm
	Cost Center Description Total Total Average Per Program Days	Program Cost	
	Inpatient Inpatient Diem (col. 1 Cost Days + col. 2)	(col. 3 x col. 4)	
	1.00 2.00 3.00 4.00	5. 00	
42. 00	NURSERY (title V & XIX only) 0 0 0.00 (Intensive Care Type Inpatient Hospital Units	0	42.00
43.00	INTENSIVE CARE UNIT 5, 340, 647 2, 792 1, 912. 84 (0	43.00
44.00	CORONARY CARE UNIT		44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT		46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47.00
	Cost Center Description	1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	190, 215	•
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	644, 052	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I an	d 0	50.00
51. 00	III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51.00
51.00	and IV)		31.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53. 00
F.4.00	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program di scharges Target amount per di scharge	0.00	
56.00	Target amount (line 54 x line 55)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	57. 00 58. 00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	1	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00		0.00	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62.00	Relief payment (see instructions)	0	62.00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00
64. 00		0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
65.00	instructions)(title XVIII only)		05.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00		0	67. 00
49.00	(line 12 x line 19)		68. 00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82.00	Inpatient routine service cost per drein finitation [line 9 x line 81]		82.00
83.00	Reasonable inpatient routine services (see instructions)		83.00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	1, 658	87. 00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 463. 99	88. 00
89. UU	Observation bed cost (line 87 x line 88) (see instructions)	2, 427, 295	δ9. UU

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 911, 496	22, 011, 031	0. 22313	2, 427, 295	541, 622	90.00
91.00 Nursing School cost	0	22, 011, 031	0.00000	0 2, 427, 295	0	91.00
92.00 Allied health cost	0	22, 011, 031	0.00000	0 2, 427, 295	0	92.00
93.00 All other Medical Education	0	22, 011, 031	0. 00000	2, 427, 295	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od:	Worksheet D-1
		From 01/01/2018	
	Component CCN: 15-T059	10 12/31/2018	
			5/28/2019 1: 23 pm
	Title XIX	Subprovi der -	Cost
		I RF	

		I RF		
	Cost Center Description	_	4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, exclu	udi na newborn)	5, 314	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and		5, 314	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If		0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5, 314	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days)) through December 31 of the cost	0	5. 00
4 00	reporting period) ofter December 21 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) reporting period (if calendar year, enter 0 on this line)) after beceiliber 31 of the cost	U	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days)	through December 31 of the cost	0	7. 00
7.00	reporting period	till dagi. Bedelinger er er tille dest	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private room days)	after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Pr	rogram (excluding swing-bed and	0	9. 00
10. 00	<pre>newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (inc</pre>	cluding private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	cruding private room days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (inc	cluding private room davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 of	on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only ((including private room days)	0	12.00
	through December 31 of the cost reporting period			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (0	13. 00
14. 00	after December 31 of the cost reporting period (if callendar year, ent		0	14. 00
15. 00	Medically necessary private room days applicable to the Program (excl Total nursery days (title V or XIX only)	ruding swing-bed days)	0	15.00
16. 00	Nursery days (title V or XIX only)		0	
10.00	SWI NG BED ADJUSTMENT			10.00
17.00	Medicare rate for swing-bed SNF services applicable to services through	ugh December 31 of the cost	0.00	17.00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after	r December 31 of the cost	0. 00	18. 00
19. 00	reporting period	gh Docombor 21 of the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services through reporting period	gri becember 31 of the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after	December 31 of the cost	0. 00	20. 00
	reporting period			
21. 00	Total general inpatient routine service cost (see instructions)		4, 769, 362	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of	f the cost reporting period (line	0	22. 00
22 00	5 x line 17)	+h++iii (li (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of 1 x line 18)	the cost reporting period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of	the cost reporting period (line	0	24. 00
2 00	7 x line 19)	the east raper tring parties (trina	· ·	21100
25.00	Swing-bed cost applicable to NF type services after December 31 of the	he cost reporting period (line 8	0	25.00
	x line 20)			
26. 00	Total swing-bed cost (see instructions)	1 -1 - 11 - 27	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	I minus iine 26)	4, 769, 362	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and ob-	hservation hed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	oser vatron bed charges)	0	
30.00	Semi -private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 2	28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34.00	Average per diem private room charge differential (line 32 minus line	e 33)(see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	vato room cost differential (line	0 4 760 262	36.00
37.00	General inpatient routine service cost net of swing-bed cost and prival 27 minus line 36)	vate room cost differential (IIMe	4, 769, 362	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	S		
38. 00	Adjusted general inpatient routine service cost per diem (see instruc		897. 51	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		0	39. 00
40.00	Medically necessary private room cost applicable to the Program (line	,	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line	40)	0	41. 00

Heal th	Financial Systems	RI VERVI EW H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 15-0059 CCN: 15-T059	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 5/28/2019 1:2	pared:
			Ti t	le XIX	Subprovi der -	Cost	. <u>5 piii </u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0.	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	0		0 0.	00 0	0	43.00
44. 00 45. 00 46. 00 47. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						44. 00 45. 00 46. 00 47. 00
	Cost Center Description			•			
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00	48. 00
	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		0	
50.00	Pass through costs applicable to Program inpa	atient routine :	servi ces (fr	om Wkst. D, si	um of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	y services (from Wkst. D,	sum of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud	ding capital rel	lated, non-pl	nysician anes	thetist, and	0 0	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	,	ing cost and ta	rget amount	(line 56 minus	s line 53)	0	1
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period (endi ng 1996,	updated and	compounded by the	0.00	59.00
market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target					0. 00 0	1	
42.00	amount (line 56), otherwise enter zero (see i	instructions)					62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	1
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost			ne cost renor	ting period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	Ü		•		0	
	instructions)(title XVIII only)			·			
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	•	•	, ,	3,	0	66.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing					0	
	(line 13 x line 20)			·	oor tring porrou	0	
07.00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	37.00
70.00	Skilled nursing facility/other nursing facili				7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line	,	ine /o ÷ iine	= 2)			71.00
73. 00	Medically necessary private room cost applica	able to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient (26, line 45)				Part II, column		74. 00 75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79.00	Aggregate charges to beneficiaries for excess				inus Lino 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ost mill tall (on (iiie 10 IIII	THUS TITLE 17)		80.00
	Inpatient routine service cost limitation (li	ine 9 x line 81					82.00
83. 00 84. 00	Reasonable inpatient routine service costs (see insurance inpatient ancillary services (see insurance)		S)				83.00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00			rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0. 00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 1:2	
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	737, 735	4, 769, 362	0. 15468	2 0	0	90.00
91.00 Nursing School cost	0	4, 769, 362	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 769, 362	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 769, 362	0. 00000	0 0	0	93.00

Health Financial Systems	RIVERVIEW HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018		
	Titl€	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
				col . 2)	
LADATI FAIT POLITIAIS CERVILOS COCT OFAITERS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			0.007.507	I	
30. 00 03000 ADULTS & PEDIATRICS			8, 906, 526		30.00
31. 00 O3100 INTENSIVE CARE UNIT			3, 022, 311		31.00
41. 00 04100 SUBPROVI DER - RF			231, 010		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 13148	12, 503, 822	1, 644, 115	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 00000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 31886			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 26352			
57. 00 05700 CT SCAN		0. 03786			
57. 01 03630 ULTRA SOUND		0. 05899		0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 11354			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.06985			
60. 00 06000 LABORATORY		0. 19957			
60. 01 06001 BLOOD LABORATORY		0.00000	0		60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 49327	2 301, 393	148, 669	63.00
64. 00 06400 INTRAVENOUS THERAPY		0.00000	00	0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 33264	1, 973, 474	656, 464	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 34828	1, 519, 776	529, 317	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 22584	1, 197, 011	270, 338	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 52730	· · · · · ·		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 06647			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 39577			
74. 00 07400 RENAL DIALYSIS		0. 64218		185, 696	
76. 00 03020 OTHER ANCI LLARY		0.00000			
76. 01 03140 CARDI AC REHAB		0. 21640			
7/ 02 02070 WOMENUC CENTED		0 45/04	1 0 4 2	1/2	7/ 00

76.02

76.03

90.00

90.01

90.02

91.00

201.00

202.00

163

615

0

0 91.01

0 92.00 95.00

11, 496, 252 200. 00

30, 263

539, 184

0

0. 156312

0.000000

0. 142336

0.356050

0.848092

0. 238306

0.000000

0.646001

1,043

4, 320

84, 997

2, 262, 571

45, 383, 914

45, 383, 914

76.02

76.03

90.00

90.01

90.02

91.00

91.01

92.00

200.00

201.00

202.00

03070 WOMEN'S CENTER

09002 NEUROPSYCHOLOGY

OUTPATIENT SERVICE COST CENTERS

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

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

03330 ENDOSCOPY

09001 OUTPATI ENT

09100 EMERGENCY

09101 SHORT STAY

95. 00 09500 AMBULANCE SERVICES

09000 CLI NI C

ealth Financial Systems RIVERVIEW NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	HOSPITAL Provider C	CN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-3	
		CCN: 15-T059	From 01/01/2018 To 12/31/2018		
	'			5/28/2019 1: 2	23 pm
	Title	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
D. 00 03000 ADULTS & PEDIATRICS 1. 00 03100 INTENSIVE CARE UNIT			0		30.
1. 00 04100 SUBPROVI DER			4, 005, 779		41.
3. 00 04300 NURSERY			4,003,777		43.
ANCILLARY SERVICE COST CENTERS					1
D. 00 05000 OPERATING ROOM		0. 1314	134, 793	17, 724	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3188	·	15, 629	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2635		0	1
7.00 05700 CT SCAN 7.01 03630 ULTRA SOUND		0. 0378 0. 0589		2, 157 0	1
B. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0. 0369		2, 195	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0698!		1, 363	
D. 00 06000 LABORATORY		0. 1995		145, 411	
D. 01 06001 BLOOD LABORATORY		0.0000	00	0	60
3.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4932	72 9, 916	4, 891	63
4.00 06400 I NTRAVENOUS THERAPY		0.00000		0	
5. 00 06500 RESPI RATORY THERAPY		0. 3326		104, 110	
6. 00 06600 PHYSI CAL THERAPY		0. 34828	· · ·	1, 315, 926	
7. 00 06700 0CCUPATIONAL THERAPY 3. 00 06800 SPEECH PATHOLOGY		0.0000		0	
9. 00 06900 ELECTROCARDI OLOGY		0. 2258		8, 657	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 52730		326, 846	
2.00 07200 MPL. DEV. CHARGED TO PATIENT		0.0664		519	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 3957	76 930, 277	368, 181	73.
4. 00 07400 RENAL DI ALYSI S		0. 64218		91, 108	
6. 00 03020 OTHER ANCI LLARY		0.0000		0	
6. 01 03140 CARDI AC REHAB		0. 21640	·	1, 058	
6. 02 03070 WOMEN' S CENTER 6. 03 03330 ENDOSCOPY		0. 1563		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	0	0	76.
0. 00 09000 CLINIC		0. 1423	36 1, 290	184	90.
D. 01 09001 0UTPATI ENT		0. 3560	·	12, 284	
D. 02 09002 NEUROPSYCHOLOGY		0.8480	·	0	
1. 00 09100 EMERGENCY		0. 23830	06 46, 760	11, 143	
1.01 09101 SHORT STAY		0.00000		0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 64600	0 0	0	92
OTHER REIMBURSABLE COST CENTERS					- 0-
5.00 09500 AMBULANCE SERVICES Total (sum of Lines E0 through 04 and 06 through 09)			4 024 042	2 420 204	95
DO.00 Total (sum of lines 50 through 94 and 96 through 98) D1.00 Less PBP Clinic Laboratory Services-Program only cha			6, 934, 963	2, 429, 386	200
D2.00 Net charges (line 200 minus line 201)	inges (Title 01)		6, 934, 963		201

Heal th Financial Systems RIVERVIEW H				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CCN: 15-0059	Peri od:	Worksheet D-3	
	Component	CCN: 15-5669	From 01/01/2018 To 12/31/2018		
	Title	e XVIII	Skilled Nursing Facility		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
INDATIENT DOUTING CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1	0		30.00
31. 00 03100 NTENSI VE CARE UNI T			0	l	31.00
41. 00 04100 SUBPROVI DER - I RF			0	l	41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 13148	39 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		o o	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 31886			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 26352		0	1
57. 00 05700 CT SCAN		0. 03786		0	
57. 01 03630 ULTRA SOUND		0.05899	07	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 11354	18	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.06985	13, 951	974	59.00
60. 00 06000 LABORATORY		0. 19957	1, 047, 422	209, 038	60.00
60. 01 06001 BLOOD LABORATORY		0.00000	00	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 49327		0	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 33264	· ·		
66. 00 06600 PHYSI CAL THERAPY		0. 34828			
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 22584		85	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 52730		152, 095 0	1
72. 00 07200 MPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 06647 0. 39577		1	
74. 00 07400 RENAL DI ALYSI S		0. 64218		754, 745	1
74. 00 07400 RENAL DI ALISTS 76. 00 03020 OTHER ANCI LLARY		0.00000		0	
76. 01 03140 CARDI AC REHAB		0. 21640		ľ	1 , 0, 00
76. 02 03070 WOMEN' S CENTER		0. 15631		l	76.02
76. 03 03330 ENDOSCOPY		0. 00000			
OUTPATIENT SERVICE COST CENTERS		0.0000	,0 0		70.00
90. 00 09000 CLI NI C		0. 14233	36 0	0	90.00
90. 01 09001 0UTPATI ENT		0. 35605		Ō	
90. 02 09002 NEUROPSYCHOLOGY		0.84809		0	1
91. 00 09100 EMERGENCY		0. 23830		0	91.00
91. 01 09101 SHORT STAY		0.00000	00	0	91.01
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 64600	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.00
200 00 Total (sum of lines 50 through 94 and 96 through 98)		1	4, 927, 953	1, 694, 134	1200 00

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

4, 927, 953 0 4, 927, 953

1, 694, 134 200. 00 201. 00 202. 00

200. 00 201. 00 202. 00

Health Financial Systems	RI VERVI EW HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der (Period: From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/28/2019 1:2	pared: 3 pm
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs	
				Charges	(col . 1 x col . 2)	
			1.00	2.00	3. 00	
INDATIENT POLITINE SERVICE COST CENTERS						

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS		870, 073		30.00
	03100 INTENSIVE CARE UNIT		75, 401		31.00
41.00	04100 SUBPROVI DER - I RF		273		41.00
43.00	04300 NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 131489	198, 906	26, 154	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 318866	18, 420	5, 874	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 263525	0	0	55.00
57.00	05700 CT SCAN	0. 037866	19, 497	738	57.00
57. 01	03630 ULTRA SOUND	0. 058997	0	0	57. 01
58.00	O5800 MAGNETIC RESONANCE I MAGING (MRI)	0. 113548	8, 105		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 069850	174, 390	12, 181	59.00
60.00	06000 LABORATORY	0. 199574	162, 836	32, 498	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 493272	17, 669	8, 716	63.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 332644	27, 740		65.00
66.00	06600 PHYSI CAL THERAPY	0. 348286	18, 395	6, 407	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 225844	30, 886	6, 975	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 527305	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 066476	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 395776	141, 393	55, 960	73.00
74.00	07400 RENAL DI ALYSI S	0. 642185	10, 675	6, 855	74.00
76.00	03020 OTHER ANCI LLARY	0.000000	0	0	76.00
76. 01	03140 CARDI AC REHAB	0. 216404	9, 615	2, 081	76. 01
76. 02	03070 WOMEN' S CENTER	0. 156312	0	0	76. 02
76.03	03330 ENDOSCOPY	0. 000000	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 142336	0	0	90.00
90. 01	09001 OUTPATI ENT	0. 356050	4, 217	1, 501	90. 01
90. 02	09002 NEUROPSYCHOLOGY	0. 848092	0	0	90. 02
91.00	09100 EMERGENCY	0. 238306	59, 282	14, 127	91.00
91. 01	09101 SHORT STAY	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 646001	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES				95.00
200.00			902, 026		
201.00			0		201. 00
202.00	Net charges (line 200 minus line 201)		902, 026		202. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059		Worksheet E Part A Date/Time Prepared: 5/28/2019 1:23 pm

			10 12/31/2016	5/28/2019 1: 2	
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	0	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	13, 703, 271	1. 02
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI f</pre>	for discharges occurring	prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1.04
2. 00	October 1 (see instructions) Outlier payments for discharges (see instructions)	3		178, 713	2.00
2. 01	Outlier reconciliation amount			0	2.01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
3. 00	Managed Care Simulated Payments	,		0	3.00
4. 00	Bed days available divided by number of days in the cost repo	orting period (see instru	ıcti ons)	101. 07	4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-o	on to the cap for	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7. 00
7. 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. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopa			0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	79(C)(Z)(TV), 04 FR 2034	io (way 12,		
8. 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. 01
8. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir	nes (8, 8,01 and 8,02)	(see	0. 00	9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the curr</pre>	ent year from your reco	-ds	0. 00	10.00
11. 00	FTE count for residents in dental and podiatric programs.			0.00	
12.00	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.		1	0.00	
14. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Sep	tember 30, 1997,	0. 00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16. 00	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital clo	sure			17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4	·).		0.000000	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	1
22. 00	IME payment adjustment (see instructions)			0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42	2 of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resid		`FR 412 105	0.00	23.00
23.00	(f) (1) (i v) (C).	ient cap stots under 42 (JIK 412. 103	0.00	25.00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25. 00	If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or line	e 24 (see	0.00	ł
	instructions)		`		
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28.00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0)1)		0	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	nationt days (see instru	rtions)	1. 54	30.00
31.00	Percentage of Medicaid patient days (see instructions)	acronic days (see institut	0113)	14. 85	
32. 00	Sum of lines 30 and 31			16. 39	
33. 00	Allowable disproportionate share percentage (see instructions	5)		3. 41	
	Disproportionate share adjustment (see instructions)	•		116, 821	
	· · · · · · · · · · · · · · · · · · ·		'		

ALCUI	n Financial Systems RIVERVIEW F LATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
				5/28/2019 1: 2	3 pm
		Title XVIII	Hospi tal	PPS	
			Pri or to 10/1 1.00	2. 00	
	Uncompensated Care Adjustment		1.00	2.00	
5. 00			0	0	35.0
5. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	35.0
5. 02	Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (se	ee 850, 363	1, 096, 252	35. 0
ı - 00	instructions)		(2) 025	27/ 21/	25.0
5. 03 6. 00			636, 025 912, 341	276, 316	35. 0 36. 0
0.00	Additional payment for high percentage of ESRD beneficiary				30.0
0.00	Total Medicare discharges on Worksheet S-3, Part I excludin		0		40.0
	652, 682, 683, 684 and 685 (see instructions)				
1. 00		683, 684 an 685. (see	0		41.00
1 01	instructions)	IC DDCc	,		11 ^
1. 01	Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)	IS-UKGS 652, 682, 683, 684	0		41. 0
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adiustment)	0.00		42. 0
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,				43.00
	instructions)				
4. 00	Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0. 000000		44.0
5. 00	days)	no)	0.00		45. 0
6. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line	•	0.00		46. 0
7. 00	, , ,	11.01)	14, 911, 146		47. 0
8. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 0
	only (see instructions)	·			
				Amount	
9. 00	Total payment for inpatient operating costs (see instruction	nc)		1. 00 14, 911, 146	40.0
60.00	Payment for inpatient program capital (from Wkst. L, Pt. I		1	1, 205, 408	
1.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.0
2.00	Direct graduate medical education payment (from Wkst. E-4,			0	52.0
3.00				32, 150	
4.00	Special add-on payments for new technologies			0	54.0
4. 01	Islet isolation add-on payment	(0)		0	54. 0 55. 0
5. 00 6. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in			0	56. C
7. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	Ö	57. 0
8. 00	Ancillary service other pass through costs from Wkst. D, Pt		, ,	17, 240	58.0
9. 00	Total (sum of amounts on lines 49 through 58)			16, 165, 944	59.0
	Primary payer payments			0	60.0
	1 3 1 3	us line 60)		16, 165, 944	61.0
1. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 584, 980 18, 090	
1. 00 2. 00				25, 541	
1. 00 2. 00 3. 00				16, 602	
1. 00 2. 00 3. 00 4. 00				18, 989	66.0
1. 00 2. 00 3. 00 4. 00 5. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	structions)			67. C
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	structions)		14, 579, 476	07.0
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs (s		0	68.0
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96	r applicable to MS-DRGs (s		0 0	68. C
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	r applicable to MS-DRGs (s).(For SCH see instruction	ns)	0 0 0	68. 0 69. 0 70. 0
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon	r applicable to MS-DRGs (s). (For SCH see instructionstration) adjustment (see	ns)	0 0 0	68. 0 69. 0 70. 0 70. 5
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio	r applicable to MS-DRGs (s). (For SCH see instructionstruction) adjustment (see	ns)	0 0 0	68. 0 69. 0 70. 0 70. 5 70. 8
11. 00 22. 00 33. 00 44. 00 55. 00 66. 00 77. 00 88. 00 99. 00 00. 50 00. 87 00. 88	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see	ns)	0 0 0 0	68. 0 69. 0 70. 0 70. 5 70. 8
11. 00 22. 00 33. 00 44. 00 55. 00 66. 00 77. 00 88. 00 99. 00 00. 50 00. 87 00. 88 00. 89	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	0 0 0 0	68. 0 69. 0 70. 0 70. 8 70. 8 70. 8
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88 0. 89 0. 89 0. 90 0. 90	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	0 0 0 0 0 0	68. 0 69. 0 70. 0 70. 5 70. 8 70. 8 70. 9
55. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 88 70. 88 70. 89 70. 90 70. 91 70. 92	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	0 0 0 0 0 0	68. 0 69. 0 70. 0 70. 8 70. 8 70. 8 70. 9 70. 9
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88 0. 89 0. 89 0. 90 0. 90	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	0 0 0 0 0 0	68. 0 69. 0 70. 0 70. 5 70. 8 70. 8 70. 9

Heal th	Financial Systems RIVERVIEW H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0059	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A	pared:
		Title	e XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1	in column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or			0	0	70. 97
70. 98	Low Volume Payment-3				0	70. 98
	HAC adjustment amount (see instructions)				0	70. 99
	Amount due provider (line 67 minus lines 68 plus/minus line	s 69 & 70)			14, 578, 351	71.00
	Sequestration adjustment (see instructions)				291, 567	1
	Demonstration payment adjustment amount after sequestration				0	
	Interim payments				14, 342, 612	
73.00	Tentative settlement (for contractor use only)	00 70 1			0	
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71 73)				-55, 828	74.00
75. 00	Protested amounts (nonallowable cost report items) in accor CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	dance with			156, 796	75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or su	m of 2 02			0	90.00
70.00	plus 2.04 (see instructions)	IIII 01 2.03			U	70.00
91 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see ins	tructions)			0	
	Capital outlier reconciliation adjustment amount (see instr				0	
	The rate used to calculate the time value of money (see ins				0.00	
	Time value of money for operating expenses (see instruction				0	95.00
96.00	Time value of money for capital related expenses (see instr	uctions)			0	96.00
				Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructi	ons)		0	0	102. 00
400.00	HRR Adjustment for HSP Bonus Payment				0.0000	
	HRR adjustment factor (see instructions)			0.0000	0. 0000	
104.00	HRR adjustment amount for HSP bonus payment (see instruction		uctmont	0	0	104. 00
200 00	Rural Community Hospital Demonstration Project (§410A Demon Is this the first year of the current 5-year demonstration					200. 00
∠00.00	Century Cures Act? Enter "Y" for yes or "N" for no.	per rou under	LIIC ZISL			200.00
	Cost Reimbursement					1
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, I	ine 49)				201. 00
	Medicare discharges (see instructions)	1110 47)				202.00
	Case-mix adjustment factor (see instructions)					203.00
_00.00	The state of the s					1-00.00

Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration

204.00

205.00

206. 00

207.00

208.00

209. 00 210. 00

211. 00

212. 00

213.00

218. 00

peri od)

204.00 Medicare target amount

210.00 Reserved for future use

205.00 Case-mix adjusted target amount (line 203 times line 204)

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

206.00 Medicare inpatient routine cost cap (line 202 times line 205)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Adjustment to Medicare Part A Inpatient Reimbursement

Health Financial Systems RIVERVIEW HO			SPI TAL		In Lie	Lieu of Form CMS-2552-10			
LOW VOLUME CALCULATION EXHIBIT 4				Provi der Co		Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/28/2019 1:2	pared:	
					Title	XVIII	Hospi tal	PPS	-
	W/S E,	Part A	Amounts	(from	Pre/Post	Period Prio	r Peri od	Total (Col 2	

							5/28/2019 1:2	3 pm
		W/C F D 1 A	A		XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	0		0	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	13, 703, 271	0		13, 703, 271	13, 703, 271	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1.04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00	178, 713	0	0	178, 713	178, 713	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Indirect Medical Education Adj Amount from Worksheet E, Part	ustment 21.00	0. 000000	0.000000	0.000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	21.00	0. 000000	0.000000	0.000000	0. 000000	0	6.00
6. 01	instructions) IME payment adjustment for	22. 00	0	0		0	0	6. 00
0.01	managed care (see instructions)		J	0	o o	U	0	0.01
7. 00	Indirect Medical Education Adjustment factor	ustment for the 27.00	0.000000	0.000000		0. 000000		l 7.00
8. 00	(see instructions) IME adjustment (see	28. 00	0. 000000	0. 000000		0. 000000	0	8.00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	
	for managed care (see instructions)			S	S	0	_	
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	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	0	9. 01
	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0341	0. 0341	0. 0341	0. 0341		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	116, 821	0	0	116, 821	116, 821	11. 00
11. 01	Uncompensated care payments Additional payment for high pe	36.00 rcentage of ESI	912,341 RD beneficiary	0 di scharges	636, 025	276, 316	912, 341	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	14, 911, 146 0	0	636, 025 0	14, 275, 121 0	14, 911, 146 0	13.00 14.00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	14, 911, 146	0	636, 025	14, 275, 121	14, 911, 146	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	1, 205, 408	0	О	1, 205, 408	1, 205, 408	16. 00
17. 00	if applicable) Special add-on payments for	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

	Financial Systems LUME CALCULATION EXHIBIT 4		RI VERVI EW	Provi der C	^N: 15 0050	Peri od:	u of Form CMS-: Worksheet E	2002 1
.Ow vo	LOWL CALCULATION LATER 1 4			Frovider C		From 01/01/2018 To 12/31/2018	Part A Exhibi	pared:
				Title	XVIII	Hospi tal	PPS	, p
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
8. 00	Capital outlier reconciliation adjustment amount (see	93. 00	0	0		0 0	0	18.00
9. 00	instructions) SUBTOTAL			0	636, 02	25 15, 480, 529	16, 116, 554	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	1, 115, 915 0			0 1, 115, 915 0 0	1, 115, 915 0	
1. 00	Capital DRG outlier payments	2. 00	51, 775	0		0 51, 775	51, 775	21 00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0			0 0	0	1
2. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22.00
3. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23.00
4. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0338	0. 0338	0. 033	0. 0338		24.00
5. 00	Disproportionate share adjustment (see instructions)	11. 00	37, 718	0		0 37, 718	37, 718	25. 0
6. 00	Total prospective capital payments (see instructions)	12. 00	1, 205, 408	0		0 1, 205, 408	1, 205, 408	26.00
		W/S E, Part A	(Amounts to					
		line 0	E, Part A) 1.00	2.00	3, 00	4.00	5. 00	
7. 00	Low volume adjustment factor	U	1.00	2.00	0.00000		3.00	27.00
	Low volume adjustment (transfer amount to Wkst. E,	70. 96			0.00000	0	0	
9. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	О	29. 00
00. 00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

 Heal th Financial Systems
 RIVERVIEW HOSPITAL

 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5
 Provi
 Provider CCN: 15-0059 Peri od: Worksheet E From 01/01/2018 Part A Exhi bit 5 To 12/31/2018 Date/Time Prepared:

				10) 12/31/2018	5/28/2019 1: 2	
			Title	XVIII	Hospi tal	PPS	
	·	Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)	0.00	0.00		
1 00	DDC	0	1.00	2. 00	3. 00	4. 00	1 00
1.00	DRG amounts other than outlier payments	1.00		0			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	13, 703, 271		13, 703, 271	13, 703, 271	1. 02
1.02	discharges occurring on or after October 1	1.02	13, 703, 271		13, 703, 271	13,703,271	1.02
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1.03
1.00	for Model 4 BPCI occurring prior to October	1.00		Ö			1.00
	1						
1.04	DRG for Federal specific operating payment	1. 04	o		0	0	1.04
	for Model 4 BPCI occurring on or after						
	October 1						
2. 00	Outlier payments for discharges (see	2. 00	178, 713	0	178, 713	178, 713	2.00
	instructions)	0.00					
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01		0	0	0	3.00
4. 00	Operating outlier reconciliation Managed care simulated payments	3. 00	0	0	0	0	4.00
4.00	Indirect Medical Education Adjustment	3.00	0	<u> </u>	<u> </u>	0	4.00
5. 00	Amount from Worksheet E, Part A, Line 21	21. 00	0. 000000	0. 000000	0. 000000		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	o	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for th						
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
0 00	instructions)	20.00		0	0		0.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0	0	0	0	8. 00 8. 01
0.01	care (see instructions)	20.01	0	U	U	U	0.01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9.00
9. 01	Total IME payment for managed care (sum of	29. 01	0	0	0	Ö	9. 01
	lines 6.01 and 8.01)					_	
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33. 00	0. 0341	0. 0341	0. 0341		10.00
	(see instructions)						
11. 00	Disproportionate share adjustment (see	34. 00	116, 821	0	116, 821	116, 821	11.00
11 01	instructions)	24 00	010 241	424 O2E	27/ 21/	010 041	11 01
11. 01	Uncompensated care payments Additional payment for high percentage of ES	36.00	912, 341	636, 025	276, 316	912, 341	11. 01
12. 00	Total ESRD additional payment (see	46. 00	or scriar ges	0	0	0	12.00
.2.00	instructions)	10.00		Ü	J		12.00
13.00	Subtotal (see instructions)	47. 00	14, 911, 146	636, 025	14, 275, 121	14, 911, 146	13.00
14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	14, 911, 146	636, 025	14, 275, 121	14, 911, 146	15. 00
4, 00	(see instructions)	50.00	4 005 400		4 005 400	4 005 400	4, 00
16. 00	Payment for inpatient program capital (from	50. 00	1, 205, 408	0	1, 205, 408	1, 205, 408	16. 00
17. 00	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54. 00		0	0	0	17 00
17.00	Net organ acquisition cost	34.00	ا ۱	U	U		17. 00 17. 01
17. 01	Credits received from manufacturers for	68. 00		0	0	0	17.01
17.02	replaced devices for applicable MS-DRGs	00.00		O	O		''. 52
18. 00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18.00
	amount (see instructions)						
19. 00	SUBTOTAL			636, 025	15, 480, 529	16, 116, 554	19.00
				•			

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		!	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/28/2019 1:2	t 5 pared:
				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, 115, 915	(1, 115, 915	1, 115, 915	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	51, 775	(51, 775	51, 775	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0338	0. 033	0. 0338		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	37, 718	(37, 718	37, 718	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 205, 408	(1, 205, 408	1, 205, 408	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	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	(O	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-1, 125	(-1, 125	-1, 125	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	o	(0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(0	0	31.01
	•					(Amt to	

0 70. 99

1.00

2.00

0

3. 00

(Amt. to Wkst. E, Pt. A) 4. 00

32.00

100.00

0

32.00 HAC Reduction Program adjustment (see

instructions)

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

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-255		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059		Worksheet E Part B Date/Time Prepared: 5/28/2019 1:23 pm	

			10 12/31/2010	5/28/2019 1: 2	
		Title XVIII	Hospi tal	PPS	о рііі
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7, 298	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		17, 860, 279	2.00
3.00	OPPS payments			15, 259, 487	3.00
4.00	Outlier payment (see instructions)			141, 183	
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5.00
6. 00	Line 2 times line 5			0	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8. 00	Transitional corridor payment (see instructions)			0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		52, 496	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 298	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
10.00	Reasonable charges			10, 420	12 00
12.00	Ancillary service charges	inc (0)		18, 439	1
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	The 69)		10 420	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			18, 439	14.00
15. 00	Aggregate amount actually collected from patients liable for	nayment for services on	a chargo basis	0	15.00
16. 00	Amounts that would have been realized from patients liable fo	. 3	•	0	16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(. 3	on a chargebasis	ı	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	6)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			18, 439	
19. 00	Excess of customary charges over reasonable cost (complete on	lvifline 18 exceeds Li	ne 11) (see	11, 141	
	instructions)		110 11) (000	1,	
20.00	Excess of reasonable cost over customary charges (complete on	lv if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)	,	, (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	
21.00	Lesser of cost or charges (see instructions)			7, 298	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			15, 453, 166	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see insti	ructions)	2, 868, 081	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	12, 592, 383	27. 00
	i nstructi ons)			I	
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			12, 592, 383	1
31.00	Primary payer payments			825	
32. 00	Subtotal (line 30 minus line 31)	050)		12, 591, 558	32.00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			00.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			79, 629	
35.00	Adjusted reimbursable bad debts (see instructions)	rusti ana)		51, 759	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		60, 173	
	Subtotal (see instructions)			12, 643, 317 -105	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			- 103	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	e)		ı	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	3)		0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	rtions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see institut	511 0113)	0	39. 99
40.00	Subtotal (see instructions)			12, 643, 422	
40. 01	Sequestration adjustment (see instructions)			252, 868	
40. 02	Demonstration payment adjustment amount after sequestration			0	
41. 00	Interim payments			12, 434, 711	
42. 00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)			-44, 157	
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2.	chapter 1.	0	1
00	§115. 2		ap co. 1,	ı	55
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00
			·		

In Lieu of Form CMS-2552-10

Period: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 1:23 pm Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0059

					5/28/2019 1: 2:	3 pm
		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	
1. 00	Total interim payments paid to provider		14, 253, 172	2	12, 284, 900	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		(0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVI DER	12/31/2018	89, 440	12/31/2018	149, 811	3. 01
3. 02 3. 03 3. 04 3. 05	ABSOSTMENTS TO FROM DER	12/31/2010	()))	0	3. 02 3. 03 3. 04 3. 05
0.00	Provider to Program		`	<u> </u>		0.00
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		(0	3. 50 3. 51
3.52			(0	3. 52
3. 53			(ol	3. 53
3.54			(l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		89, 440)	149, 811	3. 99
4. 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		14, 342, 612	2	12, 434, 711	4. 00
F 00	IU BE COMPLETED BY CONTRACTOR			T		F 00
5. 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. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02			(ol	5. 02
5. 03					l ol	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51	TENTATI VE TO TROGRAM		ì		ا	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines)		5. 99
6. 00	5. 50-5. 98)		(,		6. 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER				0	6. 00
6. 02	SETTLEMENT TO PROGRAM		55, 828	1	44, 157	6. 02
7. 00	Total Medicare program liability (see instructions)		14, 286, 78		12, 390, 554	7.00
7.00	Tiotal medicale program francisty (see firstructions)		14, 200, 784		NPR Date	7.00
				Contractor Number	(Mo/Day/Yr)	
		,)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
8.00	INAME OF CONTRACTOR					8.00

Component CCN: 15-T059

Inpatient Part A			Title	e XVIII	Subprovi der -	PPS	<u> </u>
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatier	nt Part A		t B	
1.00							
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero.			1.00				
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				1			
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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	3. 99				0	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4. 00			5, 864, 84	8	0	4.00
TO BE COMPLÉTED BY CONTRACTOR Solution							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00			1			5 00
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Number (Mo/Day/Yr) 0 1.00 2.00	7.00			5, 864, 45			7.00
0 1.00 2.00							
				0			
	8. 00	Name of Contractor					8.00

Component CCN: 15-5669

Title XVIII Skilled Nursing

Inpatient Part A			litle	XVIII	Killed Nursing Facility	PPS	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			I npati en	t Part A		t B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm/dd/\\\\\\\	Amount	mm/dd/\\\\\\\	Amount	
1.00							
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1. 00	Total interim payments paid to provider					1.00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2.00			0		0	2.00
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Dayment. If none, write "NONE" or enter a zero. (1)							
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Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98)				Ö		l	
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6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00	Determined net settlement amount (balance due) based on					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 1,675,656 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				6, 017			6. 01
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1 475 454			
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Trotal Medicare program francistry (see instructions)		1,6/5,656			7.00
0 1.00 2.00							
			()			
	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems RIVERVIEW HO	SPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0059	Peri od:	Worksheet E-1		
			From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	nared:	
			10 12/31/2010	5/28/2019 1: 2		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4	
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1. 00 2. 00	
2. 00						
3.00						
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					
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 I	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of o	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
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	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)						
			. '		•	

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-T059		Date/Time Prepared: 5/28/2019 1:23 pm
	Title XVIII	Subprovi der -	PPS
		I RF	

	I RF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	5, 946, 430	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0134	2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	101, 684	3. 00
4. 00	Outlier Payments	40, 378	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6. 00	New Teaching program adjustment. (see instructions)	0. 00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. 00
10.00	Average Daily Census (see instructions)	14. 558904	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00		6, 088, 492	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)	0	15.00
16. 00 17. 00		0 6, 088, 492	16. 00 17. 00
18. 00	Subtotal (see instructions) Primary payer payments	23, 668	
19. 00		6, 064, 824	
20. 00	Deducti bl es	65, 588	
21. 00		5, 999, 236	21.00
22. 00		18, 090	
23. 00	Subtotal (line 21 minus line 22)	5, 981, 146	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0, 70.1, 1.10	24.00
25. 00		0	25. 00
26. 00	, , , , , , , , , , , , , , , , , , , ,	0	26. 00
27. 00		5, 981, 146	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	2, 995	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	5, 984, 141	32.00
32. 01	Sequestration adjustment (see instructions)	119, 683	32. 01
32. 02		0	32. 02
33. 00		5, 864, 848	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35. 00 36. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	-390 0	35. 00 36. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	40, 378	
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
	The rate used to calculate the Time Value of Money		52.00
53.00	Time Value of Money (see instructions)	0	53.00

	Financial Systems RIVERVIEW HO: ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od:	wof Form CMS-2 Worksheet E-3	
CALCUL	ATTON OF RETWIDORSEMENT SETTLEMENT	FIOVIDEI CCN. 15-0059	From 01/01/2018		
		Component CCN: 15-5669	To 12/31/2018		pared
		·		5/28/2019 1:2	3 pm
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH	JED HEALTH SEDVICES FOR	TITLE VVIII DADT	1. 00	
	SERVICES	TER HEALTH SERVICES FOR	IIILE AVIII PARI	A PPS SINF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				i
1. 00	Resource Utilization Group Payment (RUGS)			1, 828, 836	1.0
2. 00	Routine service other pass through costs			0	2.0
3. 00	Ancillary service other pass through costs			6, 140	3.0
4. 00	Subtotal (sum of lines 1 through 3)			1, 834, 976	4.0
	COMPUTATION OF NET COST OF COVERED SERVICES				
5. 00	Medical and other services (Do not use this line as vaccine of	costs are included in li	ne 1 of W/S E,		5.0
,	Part B. This line is now shaded.)				
5. 00	Deducti bl e			0	6.0
7. 00 3. 00	Coinsurance			125, 123 0	7.0 8.0
3. 00 9. 00	Allowable bad debts (see instructions) Reimbursable bad debts for dual eligible beneficiaries (see i	netructions)		0	9.0
10.00	Adjusted reimbursable bad debts (see instructions)	ristructions)		0	10.0
11.00	Utilization review			0	11.0
	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 1	10 and 11)(see instruction	ons)	1, 709, 853	
	Inpatient primary payer payments		,	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.0
14. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	14.5
14. 99	Demonstration payment adjustment amount before sequestration			0	14. 9
5.00	Subtotal (see instructions			1, 709, 853	
5. 01	Sequestration adjustment (see instructions)			34, 197	
5. 02	Demonstration payment adjustment amount after sequestration			0	15.0
	Interim payments			1, 669, 639	
	Tentative settlement (for contractor use only)	20 44 47		0	
	Balance due provider/program (line 15 minus lines 15.01, 15.0		0 1 1 1 1 1	6, 017	
19.00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS 19 Pub. 15-	-2, chapter 1,	0	19.0

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Period: Worksheet E-3
		From 01/01/2018 Part VII

			From 01/01/2018 To 12/31/2018		
		Title XIX	Hospi tal	Cost	<u>o p</u>
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		644, 052		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		644, 052	0	4. 00
5. 00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments		,,, ,,,	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		644, 052	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges Routine service charges		045 747		0.00
9. 00	Ancillary service charges		945, 747 902, 026	0	8. 00 9. 00
10. 00	Organ acquisition charges, net of revenue		702, 020	O	10.00
	Incentive from target amount computation				11.00
	Total reasonable charges (sum of lines 8 through 11)		1, 847, 773	0	1
.2.00	CUSTOMARY CHARGES		., 0 ., , , , , ,		12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	Ç			
14.00	Amounts that would have been realized from patients liable for	payment for services or	0	0	14.00
	a charge basis had such payment been made in accordance with 43	2 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
	Total customary charges (see instructions)		1, 847, 773	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	1, 203, 721	0	17. 00
10.00	line 4) (see instructions)	viflima 4 avasada lim		0	10.00
18. 00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	y II IIIne 4 exceeds IIIne	9	0	18. 00
19. 00	Interns and Residents (see instructions)			0	19. 00
	Cost of physicians' services in a teaching hospital (see instri	uctions)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		644, 052	0	1
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		(44.050	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		644, 052	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		644, 052	0	31.00
	Deductibles		044, 032	0	•
	Coinsurance		Ö	0	
	Allowable bad debts (see instructions)		o	0	34.00
	Utilization review		o		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	644, 052	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		O	0	37.00
38.00	Subtotal (line 36 ± line 37)		644, 052	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		644, 052	0	1
	Interim payments		721, 042	0	
42.00	Balance due provider/program (line 40 minus line 41)	111 ONC D 1 45 C	-76, 990	0	1
43. 00	Protested amounts (nonallowable cost report items) in accordance to the start of th	ce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-T059		Date/Time Prepared: 5/28/2019 1:23 pm
	Ti tle XIX	Subprovi der -	Cost
		I RF	

		Title XIX	Subprovi der -	Cost	
			IRF Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CVI OLO I OK II I LEO V OK XI	N OLIVI OLO		
1. 00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routi ne servi ce charges		0	_	8. 00
9.00	Ancillary service charges		0	0	
	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0 0	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		l d	U	12.00
13. 00	Amount actually collected from patients liable for payment for	r services on a charge	l ol	0	13.00
13.00	basis	services on a charge	٥	U	13.00
14. 00	Amounts that would have been realized from patients liable fo	r payment for services on	o	0	14.00
11.00	a charge basis had such payment been made in accordance with		Ĭ	· ·	11.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 0111 31101 10(0)	0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst	,	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	21.00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			00.00
	Other than outlier payments		0	0	
	Outlier payments Program capital payments		0 0	0	24.00
	Capital exception payments (see instructions)				25. 00
	Routine and Ancillary service other pass through costs			0	1
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		o	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		<u> </u>		27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	0	0	
	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41.00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		I I		I

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

Provider CCN: 15-0059 | Period: From 01/01/2

Peri od: Worksheet G
From 01/01/2018
To 12/31/2018 Date/Time Prepared: 5/28/2019 1: 23 pm

UIII y)					5/28/2019 1: 2	3 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1, 00	
1.00	Cash on hand in banks	13, 683, 103	0	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3.00	Notes receivable	0	0	0	1	3.00
4.00	Accounts receivable	33, 927, 347	1	0	0	4.00
5.00	Other receivable	282, 634	0	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	5, 205, 640		0	0	6. 00 7. 00
8. 00	Prepaid expenses	3, 203, 040		0	0	8.00
9. 00	Other current assets	17, 242, 881		0	Ö	9.00
10. 00	Due from other funds	0	ő	0	Ö	10.00
11. 00	Total current assets (sum of lines 1-10)	70, 341, 605	0	0		11.00
	FIXED ASSETS					
12.00	Land	15, 961, 384		0	_	12.00
13. 00	Land improvements	2, 979, 163		0		13.00
14.00	Accumulated depreciation	-3, 830, 259	1	0	-	14.00
15.00	Buildings	133, 479, 199	1	0		15.00
16.00	Accumulated depreciation	-65, 178, 259		0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	1, 366, 441		0	0	17. 00 18. 00
19. 00	Fi xed equi pment	78, 172, 904	_	0	0	19.00
20. 00	Accumul ated depreciation	-32, 082, 508		0	0	20.00
21. 00	Automobiles and trucks	02,002,000	o o	0	Ö	21.00
22. 00	Accumulated depreciation	Ö	o	0	0	22. 00
23. 00	Major movable equipment	105, 208, 757	0	0	0	23.00
24.00	Accumulated depreciation	-65, 512, 316	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	_	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	170, 564, 506	0	0	0	30.00
31. 00	Investments	43, 241, 873	0	0	0	31.00
32. 00	Deposits on Leases	1 43, 241, 079	0	0	1	32.00
33. 00	Due from owners/officers	2, 228, 977		0	l o	33.00
34.00	Other assets	6, 661, 360	1	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	52, 132, 210	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	293, 038, 321	0	0	0	36.00
	CURRENT LIABILITIES					
37. 00	Accounts payable	8, 983, 198		0		37.00
38. 00	Salaries, wages, and fees payable	10, 950, 680	0	0	1	38.00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	E 122 070		0	0 0	39. 00 40. 00
41. 00	Deferred income	5, 123, 970		0	0	41.00
42.00	Accel erated payments			U	0	42.00
43. 00	Due to other funds		0	0	0	43.00
44. 00	Other current liabilities	69, 264, 892	o	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	94, 322, 740		0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	64, 591, 165	0	0	_	47.00
48. 00	Unsecured Loans	0	0	0		48. 00
49. 00	Other long term liabilities	207, 465		0	_	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	64, 798, 630	1	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	159, 121, 370	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	133, 916, 951			I	52. 00
53. 00	Specific purpose fund	133, 710, 731	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			· ·	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	133, 916, 951		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	293, 038, 321	0	0	0	60.00
	[59]	I	1		I	l

RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Period: Worksheet G-1 From 01/01/2018 Provider CCN: 15-0059

					To 12/31/2018	Date/Time Pre 5/28/2019 1:2	pared: 3 pm
		General	Fund	Special P	urpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	144, 439, 914 -10, 522, 963 133, 916, 951		0 0 0 0 0 0 0	0 0 0 0 0	6. 00 7. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) 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	0 133, 916, 951 0 133, 916, 951		0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00	_		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Period: Worksheet G-2 From 01/01/2018 Parts I & II To 12/31/2018 Date/Time Prepared: Provider CCN: 15-0059

	5/28/2019 1: 2	2 nm
Cost Center Description Inpatient Outpatient	Total	3 pili
1.00 2.00	3. 00	
PART I - PATIENT REVENUES	0.00	
General Inpatient Routine Services		
1. 00 Hospi tal 29, 145, 877	29, 145, 877	1.00
2.00 SUBPROVIDER - I PF		2.00
3. 00 SUBPROVI DER - I RF 6, 253, 039	6, 253, 039	3.00
4. 00 SUBPROVI DER		4.00
5.00 Swing bed - SNF 0	0	5.00
6.00 Swing bed - NF 0	0	6.00
7. 00 SKILLED NURSING FACILITY 2, 643, 269	2, 643, 269	7. 00
8. 00 NURSING FACILITY		8.00
9. OO OTHER LONG TERM CARE		9.00
10.00 Total general inpatient care services (sum of lines 1-9) 38,042,185	38, 042, 185	10.00
Intensive Care Type Inpatient Hospital Services		
11. 00 I NTENSI VE CARE UNI T 7, 748, 707	7, 748, 707	11.00
12. 00 CORONARY CARE UNIT		12.00
13.00 BURN INTENSIVE CARE UNIT		13.00
14. 00 SURGICAL INTENSIVE CARE UNIT		14.00
15. 00 OTHER SPECIAL CARE (SPECIFY)		15.00
16.00 Total intensive care type inpatient hospital services (sum of lines 7,748,707	7, 748, 707	16. 00
11-15)		
17.00 Total inpatient routine care services (sum of lines 10 and 16) 45,790,892	45, 790, 892	17. 00
18. 00 Ancillary services 122, 291, 622 240, 114, 23		18. 00
19.00 Outpatient services 5,589,339 41,532,46		19. 00
	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0	0 0	21.00
22.00 HOME HEALTH AGENCY		22. 00
23. 00 AMBULANCE SERVI CES 0	0 0	23. 00
24. 00 CMHC		24.00
25. 00 AMBULATORY SURGI CAL CENTER (D. P.)		25.00
26. 00 HOSPI CE		26. 00
27. 00 PHYSI CI ANS' PRI VATE OFFI CES 0 48, 336, 59		27. 00
27. 01 CLINICS 0 1, 372, 55		
27. 02 PRO FEE 0 5, 536, 41		
	0 37, 450	27. 03
27. 04 OP PHARMACY REVENUE 0 15		27. 04
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 173,709,303 336,892,41 G-3, line 1)	5 510, 601, 718	28. 00
PART II - OPERATING EXPENSES		
29.00 Operating expenses (per Wkst. A, column 3, line 200) 209,626,57	3	29. 00
30. 00 ADD (SPECIFY)	3	30.00
31.00		31.00
32.00		32.00
33.00		33.00
34.00		34.00
35.00		35. 00
	ol	36. 00
37.00 DEDUCT (SPECIFY)		37. 00
38.00		38. 00
39.00		39. 00
40.00		40.00
41.00		41.00
42.00 Total deductions (sum of lines 37-41)	ol	42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 209,626,57	3	43.00
to Wkst. G-3, line 4)		

Heal th Financial Systems RIVERVIEW HOSPITAL In Lie works-2552-10	Uoal +h	Financial Systems RIVERVIEW H	IOSDI TAI	In Lio	of Form CMS 3)552 10
To 12/31/2018 Date/Time Prepared: 5/28/2019 1: 23 pm						
1.00						
1.00						
2.00 Less contractual allowances and discounts on patients' accounts 321, 371, 356 2.00 Net patient revenues (line 1 minus line 2) 189, 230, 362 3.00 Net patient revenues (line 1 minus line 2) 189, 230, 362 3.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 209, 626, 573 4.00 Net income from service to patients (line 3 minus line 4) 2.00, 626, 573 4.00 Net income from service to patients (line 3 minus line 4) 2.00, 306, 269 7.00 Contributions, donations, bequests, etc 3.036, 269 7.00 Income from investments 3.036, 269 7.00 Income from investments 3.036, 269 7.00 Revenues from television and radio service 3.00 8.00 Revenue from television and radio service 3.00 9.00 Purchase discounts 3.00 9.00 Rebates and refunds of expenses 3.00 11.00 Rebates and refunds of expenses 3.00 11.00 12.00 Parking lot receipts 3.00 12.00 13.00 Revenue from laundry and linen service 3.00 14.00 14.00 Revenue from meals sold to employees and guests 3.00 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 3.00 16.00 17.00 Revenue from sale of fedical and surgical supplies to other than patients 3.00 17.00 18.00 Revenue from sale of fedical records and abstracts 3.00 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 3.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 3.00 3.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 3.00 3.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 3.00 3.00 19.00 Color (From Sell of textbooks, uniforms, etc.) 3.00 3.00 19.00 Color (From Sell of textbooks, uniforms, etc.) 3.00 3.00 19.00 Color (From Sell of textbooks, uniforms, etc.) 3.00 3.00 19.00 Color (From Sell of textbooks, uniforms, etc.) 3.00 3.00 19.00 Color (From Sell of textbooks, uniforms,						
3.00 Net patient revenues (line 1 minus line 2) 189, 230, 362 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 209, 626, 573 4.00 5.00 Net income from service to patients (line 3 minus line 4) -20, 396, 211 5.00 THER INCOME -20, 396, 211 7.00 Income from investments -3, 036, 269 7.00 8.00 Revenues from tel ephone and other miscel laneous communication services -3, 036, 269 7.00 8.00 Revenue from tel evision and radio service 0, 9, 00 9.00 Revenue from tel evision and radio service 0, 9, 00 10.00 Purchase discounts 0, 10, 00 11.00 Rebates and refunds of expenses 0, 11, 00 12.00 Parking 10t receipts 0, 12, 00 13.00 Revenue from laundry and linen service 0, 13, 00 14.00 Revenue from meal's sold to employees and guests 0, 14, 00 15.00 Revenue from meal's sold to employees and guests 0, 14, 00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0, 16, 00 16.00 Revenue from sale of medical records and abstracts 0, 18, 00 17.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0, 19, 00 10.00 Rental of vending machines 0, 20, 00 21.00 Rental of bospital space 0, 20, 00 22.00 Rental of bospital space 0, 20, 00 23.00 Rovernue from Guest Revenue from Guest 0, 20, 00 24.01 OTHER EXPENSE 0, 23, 00 25.00 Total (line 5 plus line 25) 24, 00 26.00 Total (line 5 plus line 25) 24, 00 27.00 OTHER EXPENSE (SPECIFY) 0, 27, 00 28.00 Total other expenses (sum of line 27 and subscripts) 0, 28, 00 28.00 Total other expenses (sum of line 27 and subscripts) 0, 28, 00 28.00 Total other expenses (sum of line 27 and subscripts) 0, 28, 00 28.00 Total other expenses (sum of line 27 and subscripts) 0, 28, 00 28.00 Total other expenses (sum of line 27 and subscripts) 0, 28, 00 28.00 Total other expenses (sum of line 27 and subscripts) 0,						
4.00 Less total operating expenses (from Wkst. 6-2, Part II, line 43) 209, 626, 573 4.00 Net income from service to patients (line 3 minus line 4) -20,396, 211 -20,396, 212 -20,396, 211 -20,396, 212 -20,396, 212 -20,396, 211 -20,396, 212 -20,396, 211 -20,396, 212 -20,396, 212 -20,396, 211 -20,396, 212 -20,396, 211 -20,396, 212 -20,396, 211 -20,396, 211 -20,396, 211 -20,396, 211 -20,396, 212 -20,396, 211 -20,396, 212 -20,396, 211 -20,396, 211 -20,396, 212 -20,396, 211			unts			
Net income from service to patients (line 3 minus line 4)			40)			
OTHER INCOME O Contributions, donations, bequests, etc 0 6.00 7. 00 Income from investments -3,036,269 7.00 8. 00 Revenues from tell ephone and other miscel laneous communication services 0 8.00 9. 00 Revenue from tell evision and radio service 0 9.00 10. 00 Purchase discounts 0 10.00 11. 00 Rebates and refunds of expenses 0 11.00 12. 00 Parking lot receipts 0 12.00 13. 00 Revenue from laundry and linen service 0 13.00 14. 00 Revenue from laundry and linen service 0 14.00 15. 00 Revenue from laundry and linen service 0 13.00 16. 00 Revenue from laundry and linen service 0 14.00 15. 00 Revenue from laundry and linen service 0 14.00 15. 00 Revenue from meals sold to employees and guests 0 14.00 15. 00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 <			e 43)			
6.00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments -3,036,269 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from sale of medical nad surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of feedical records and abstracts 0 17.00 18.00 Revenue from gale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from glfts, flowers, coffee shops, and canteen 0 20.00	5.00				-20, 396, 211	5.00
7.00 Income from investments -3,036,269 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 11.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 17.00 Revenue from sale of medical and surgical supplies to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 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 hospital space 0	4 00				0	4 00
8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of feedical records and abstracts 0 17.00 18.00 Revenue from gale 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 22.00 Rental of hospital space 0 21.00					- 1	
9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of hospital space 0 22.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.01 OTHER OPERATING REVENUE 12, 280, 167 24.01 25.00 T			on convices			
10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 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 OTHER OPERATING REVENUE AND EXPENSE 629,350 24.01 OTHER OPERATING REVENUE 0 724.01 25.00 Total other income (sum of lines 6-24) 9,873,248 25.00 Total other income (sum of lines 27 and subscripts) 0 28.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00		· •	on services			
11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 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 629, 350 24.00 24.01 OTHER OPERATING REVENUE 12, 280, 167 24.01 25.00 Total other income (sum of lines 6-24) 9, 873, 248 25.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						
12.00					- 1	
13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 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 19.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 19.00 Revenue from gifts Space 0 22.00 19.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 19.00 19.00 19.00 23.00 24.00 Revenue from sale of medical records and abstracts 0 22.00 25.00 Revenue from sale of medical records and abstracts 0 23.00 26.00 Total of the rincome (sum of lines 6-24) 9,873,248 25.00 26.00 Total (line 5 plus line 25) 0 27.00 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00					- 1	
14. 00 Revenue from meals sold to employees and guests 0 14. 00 15. 00 Revenue from rental of living quarters 0 15. 00 16. 00 Revenue from sale of medical and surgical supplies to other than patients 0 16. 00 17. 00 Revenue from sale of drugs to other than patients 0 17. 00 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 629, 350 24. 00 24. 01 OTHER OPERATING REVENUE 12, 280, 167 24. 01 25. 00 Total other income (sum of lines 6-24) 9, 873, 248 25. 00 27. 00 OTHER EXPENSES (SPECIFY) -10, 522, 963 26. 00 28. 00 Total other expenses (sum of line 27 and subscripts) </td <td></td> <td></td> <td></td> <td></td> <td>- 1</td> <td></td>					- 1	
15.00 Revenue from rental of living quarters Revenue from sale of medical and surgical supplies to other than patients Revenue from sale of drugs to other than patients Revenue from sale of drugs to other than patients Revenue from sale of medical records and abstracts Revenue from sale of medical records and abstracts Diagrams Revenue from gifts, flowers, coffee shops, and canteen Rental of vending machines Rental of vending machines Rental of hospital space Rental of hospital space Rental of hospital space Rental of PERATING REVENUE AND EXPENSE Total other income (sum of lines 6-24) Rental (line 5 plus line 25) Total other expenses (sum of line 27 and subscripts) 15.00 15.00 16.00 16.00 17.00 18.00 17.00 18.00 19.					- 1	
16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 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 629, 350 24.00 25.00 OTHER OPERATING REVENUE 12, 280, 167 24.01 25.00 Total other income (sum of lines 6-24) 9, 873, 248 25.00 27.00 OTHER EXPENSES (SPECIFY) -10, 522, 963 26.00 27.00 Total other expenses (sum of line 27 and subscripts) 0 28.00					- 1	
17. 00 Revenue from sale of drugs to other than patients 0 17. 00 18. 00 Revenue from sale of medical records and abstracts 0 18. 00 19. 00 Tui ti on (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 629, 350 24. 00 24. 01 OTHER OPERATING REVENUE 12, 280, 167 24. 01 25. 00 Total other income (sum of lines 6-24) 9, 873, 248 25. 00 26. 00 Total (line 5 plus line 25) -10, 522, 963 6.00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00			than patients			
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 24.01 OTHER OPERATING REVENUE AND EXPENSE 629, 350 24.00 24.01 OTHER OPERATING REVENUE 12, 280, 167 24.01 25.00 Total other income (sum of lines 6-24) 9, 873, 248 25.00 26.00 Total (line 5 plus line 25) -10, 522, 963 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00			than path sints			
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 629, 350 24.00 24.01 There OPERATING REVENUE 12, 280, 167 24.00 25.00 Total other income (sum of lines 6-24) 9, 873, 248 25.00 26.00 Total (line 5 plus line 25) -10, 522, 963 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						
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 629, 350 24.00 24.01 There OPERATING REVENUE 12, 280, 167 24.00 25.00 Total other income (sum of lines 6-24) 9, 873, 248 25.00 26.00 Total (line 5 plus line 25) -10, 522, 963 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00					0	
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-OPERATI NG REVENUE AND EXPENSE 629, 350 24. 00 24. 01 OTHER OPERATI NG REVENUE 12, 280, 167 24. 01 25. 00 Total other income (sum of lines 6-24) 9, 873, 248 25. 00 26. 00 Total (line 5 plus line 25) -10, 522, 963 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00					0	
22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 NON-OPERATING REVENUE AND EXPENSE 629,350 24.00 24.01 OTHER OPERATING REVENUE 12,280,167 24.01 25.00 Total other income (sum of lines 6-24) 9,873,248 25.00 26.00 Total (line 5 plus line 25) -10,522,963 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00					0	21. 00
23. 00 Governmental appropriations 0 23. 00 24. 00 NON-OPERATI NG REVENUE AND EXPENSE 629, 350 24. 00 24. 01 OTHER OPERATI NG REVENUE 12, 280, 167 24. 01 25. 00 Total other income (sum of lines 6-24) 9, 873, 248 25. 00 27. 00 OTHER EXPENSES (SPECIFY) -10, 522, 93 26. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 27. 00	22. 00				0	22. 00
24. 00 NON-OPERATING REVENUE AND EXPENSE 629, 350 24. 00 24. 01 OTHER OPERATING REVENUE 12, 280, 167 24. 01 25. 00 Total other income (sum of lines 6-24) 9, 873, 248 25. 00 26. 00 Total (line 5 plus line 25) -10, 522, 963 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	23. 00				0	23. 00
24. 01 OTHER OPERATING REVENUE 12, 280, 167 24. 01 25. 00 Total other income (sum of lines 6-24) 9, 873, 248 25. 00 26. 00 Total (line 5 plus line 25) -10, 522, 963 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	24.00				629, 350	24.00
25. 00 Total other income (sum of lines 6-24) 26. 00 Total (line 5 plus line 25) 27. 00 OTHER EXPENSES (SPECIFY) 28. 00 Total other expenses (sum of line 27 and subscripts) 9, 873, 248 25. 00 -10, 522, 963 26. 00 27. 00 27. 00 28. 00	24. 01					
27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	25.00	Total other income (sum of lines 6-24)			9, 873, 248	25.00
27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	26.00	Total (line 5 plus line 25)			-10, 522, 963	26.00
					0	27. 00
29.00 Net income (or loss) for the period (line 26 minus line 28) -10,522,963 29.00	28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
	29. 00	Net income (or loss) for the period (line 26 minus line 28)			-10, 522, 963	29. 00

	EL	10001 711		6.5. 010.4	
	Financial Systems RIVERVIEW F ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0059	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
-		Title XVIII	Hospi tal	5/28/2019 1: 2 PPS	3 pm
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			1, 115, 915	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			1, 113, 719	1.00
2. 00	Capital DRG outlier payments			51, 775	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructi ons)	44. 95	3.00
4. 00	Number of interns & residents (see instructions)			0. 00	
5.00	Indirect medical education percentage (see instructions)		1! 1!	0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by t 1.01) (see instructions)	ne sum of lines I and I.O	i, corumns i and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	1. 54	7. 00
8. 00	Percentage of Medicaid patient days to total days (see inst	ructions)		14. 85	8.00
9. 00	Sum of lines 7 and 8			16. 39	
10.00	Allowable disproportionate share percentage (see instruction	ons)		3. 38	10.00
	Disproportionate share adjustment (see instructions)			37, 718	1
12. 00	Total prospective capital payments (see instructions)			1, 205, 408	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta	unaca (aca i natruati ana)		0	
3.00	Net program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2)	linces (see Flistructrons)		0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordina	ry circumstances (line 2	x line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as app		1 11 0)	0	
10. 00 11. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	1 1 3 1	,	0	
	Worksheet L, Part III, line 14)				
	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent	1 3 1	· · · · · · · · · · · · · · · · · · ·	0	
14. 00	Carryover of accumulated capital minimum payment level over			0	
17.00	(if line 12 is negative, enter the amount on this line)	Sapital payment for the	rorrowing period	U	17.00
15. 00	Current year allowable operating and capital payment (see i	nstructions)		0	15.00
	Current year operating and capital costs (see instructions)	•		0	1 . 0 . 0 0
17. 00	Current year exception offset amount (see instructions)			0	17. 00