Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 Cl payments made since the beginning of the cost repo	R 413.20(b)).	Failure to rep		in all interi	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	DRT CERTIFICATI	ON Provider C	CN: 15-0059 Pe F Ti	eriod: rom 01/01/2020 o 12/31/2020	
PART I – COST REPORT STATUS		÷			
Provider use only 1. [X] Electronically prepared cost 2. [] Manually prepared cost report 3. [0] If this is an amended report 4. [F] Medicare Utilization. Enter	t	er of times th "L" for low.	e provider res	Date: 7/29/20	
use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: actor No. Initial Report Final Report f	for this Prov or this Provid	ider CCN 12.[ 0	tractor's Vend ]If line 5, c	or Code: 4 olumn 1 is 4: Enter mes reopened = 0-9.
PART II - CERTIFICATION					
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY ( ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT M/ CERTIFICATION BY CHIEF FINANCIAL OFFICER O	DER FEDERAL LAW DR INDIRECTLY O AY RESULT.	. FURTHERMORE F A KICKBACK O	, IF SERVICES R WERE OTHERWI	IDENTIFIED IN	THIS REPORT WERE
			,		
I HEREBY CERTIFY that I have read the above					1 5 5
electronically filed or manually submitted					
Expenses prepared by RIVERVIEW HOSPITAL (					
ending 12/31/2020 and to the best of my kno complete and prepared from the books and ro					
except as noted. I further certify that I					
health care services, and that the services					
laws and regulations.					
[ X ]I have read and agree with the above	certification s	statement I ce	ortify that L i	ntend my elect	roni c
signature on this certification state					
	(Si gn	0 9	0 1	J - J	3
	(Si gi	·	er or Administ	rator of Provid	der(s)
		01110			
		INTERI	M CFO		
		Title			
		(5.1.1			
			when report is	s el ectroni cal	y signed.)
		Date			
		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY 1.00 Hospital	0	284, 035	-154, 483	0	78,001 1.00
2.00 Subprovider - IPF	0	284, 035	- 154, 483	0	0 2.00
3. 00 Subprovider - IRF	0	2, 877	-157		-17, 748 3.00
5.00 Swing Bed - SNF	0	2, 3,7	-137		0 5.00
6.00 Swing Bed - NF	0		Ĵ		0 6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0 7.00
200. 00 Total	0	286, 912		0	
The above amounts represent "due to" or "due from"	the applicable	program for t	he element of	the above comp	lex 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.

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	ATA I	Provider (	CCN: 15-		Period: From 01/01	/2020	Worksh Part I	eet S-2	2
									Date/T	ime Pre 021 10:	
	1.00	2.	00	3.0	00			4.00	112112	021 10.	
	Hospital and Hospital Health Care Co										
00 00	Street: 395 WESTFIELD ROAD City: NOBLESVILLE	PO Box: State: I	N 7:	p Code: 40	4040	Count	ty: HAMILTON	ı			1.
0	CITY. NOBLESVILLE	Component Na		-		Provi der			nt Syst	tem (P.	Ζ.
					mber	Туре	Certified		0, or		
								V	XVIII	-	]
	Userital and Userital Deced Company	1.00		2.00 3	8.00	4.00	5.00	6.00	7.00	8.00	-
00	Hospital and Hospital-Based Componer Hospital	RIVERVIEW HOSPIT		50059 26	6900	1	07/07/1966	b N	Р	0	3.
00	Subprovi der – IPF			20007							4.
00	Subprovider - IRF	RI VERVI EW HOSPI T	AL 15	5T059 26	6900	5	01/01/1994	I N	P	0	5.
0	Subaravidar (Other)	REHAB									
00 00	Subprovider - (Other) Swing Beds - SNF										6.
0	Swing Beds - NF										8.
0	Hospital-Based SNF										9.
00	Hospital-Based NF										10.
00	Hospital-Based OLTC										11.
00 00	Hospital-Based HHA Separately Certified ASC										12.
00	Hospi tal -Based Hospi ce										14.
00	Hospital-Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I										17.
	Renal Dialysis Other										18.
00							From	:	Тс	D:	
							1.00		2.		
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	2020	12/31	/2020	20.
00	Type of Control (see instructions)						9				21.
						1.00	2.00	)	3.	00	
	Inpatient PPS Information										I
00	Does this facility qualify and is it disproportionate share hospital adju					Y	N				22.
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo										
01	Did this hospital receive interim ur					Y	Y				22.
	cost reporting period? Enter in colution the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				t						
	reporting period occurring on or aft										
02	Is this a newly merged hospital that					Ν	N				22
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of th				,						
	October 1.		•								
03	Did this hospital receive a geograph	nic reclassificat	ion from ur	rban to		N	N		Ν	1	22
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c	ds for delineations for delineations for delineations for the second second second second second second second s	ng statisti	cal areas ' for no	5						
	for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41 yes or "N" for no.	2. IUS)? Enter IN	COLUMN 3,	t LOL.							
00	Which method is used to determine Me	edicaid days on l	ines 24 and	d/or 25			3 N				23.
	below? In column 1, enter 1 if date										
	if date of discharge. Is the method				t						
	reporting period different from the reporting period? In column 2, ente										
			In-State	In-State	e Out	t-of	Out-of	Medi cai	id C	ther	
			Medi cai d	Medi cai c	d St	ate	State	HMO dag	ys Me	di cai d	
			paid days	eligible			Medicaid			days	
				unpai d days	pard	days	el i gi bl e unpai d				
			1.00	2.00	3.	00	4.00	5.00		5.00	1
			573			0	0		820		24
00	If this provider is an IPPS hospital	, enter the	0.0				1		1		1
00	in-state Medicaid paid days in colum	n 1, in-state	0,0								
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	nn 1, in-state umn 2,									
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c	nn 1, in-state umn 2, column 3,									
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	nn 1, in-state umn 2, column 3, d days in column									

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	RVIEW HOSP	Provider CC	N: 15-0059	Peri od:		u of For Worksh	eet S-2	
				From 01/0 To 12/3	31/2020	Part I Date/T 7/29/2	ime Pre	epare
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	iys Med	ther di cai d days	
00 If this provider is an LDE optor the in state	1.00	2.00	3.00	4.00	5.00	) ( 87	5.00	25
00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	30	91	0				- Cooge	25.
				1.		Date of 2.		1
00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for	rural.		0 0	the	1	2.		26
00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	~"2" for r cation in	rural. If a column 2.	ppl i cabl e,		1			27
00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	f periods S	CH status i	n Begi n	0 ni na:	Endi	na.	35
				1.		2.		
00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date 00 If this is a Medicare dependent hospital (MDH), enter	es.	·			0			36
<ul> <li>is in effect in the cost reporting period.</li> <li>01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for</li> </ul>	ne MDH trar	nsitional p	ayment in		5			37
<ul> <li>accordance with P 2018 0P3 that fully Enter 1 to a structions)</li> <li>00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.</li> </ul>	s of MDH st	atus. If I	ine 37 is					38
				Y/		Y/		
00 Does this facility qualify for the inpatient hospital	navmont (	diustmont	for low vol		00	2.		39
hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (íi), or the mileage	<sup>-</sup> (iii)? En e requireme	ter in colu nts in	ทท	v	I.	4	39
00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	er "Y" for				XVIII	/ XI X	40
					1.00	2.00	3.00	1
Prospective Payment System (PPS)-Capital 00 Does this facility qualify and receive Capital paymer	nt for dism	proportiona	te share in	accordance	e N	Y	N	45
<ul> <li>with 42 CFR Section §412.320? (see instructions)</li> <li>15 this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wks1</li> </ul>	eption for	extraordi n	ary circums	tances	N	N	N	46
Pt. III. 00 Is this a new hospital under 42 CFR §412.300(b) PPS of 00 Is the facility electing full federal capital payment					N	N	N N	47
Teaching Hospitals 00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i	approved (	GME program	s? Enter "Y	" for yes d	or N			56
GME payment reduction? Enter "Y" for yes or "N" for 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	no in colu period duri yes or "N th of this Y", complet	umn 2. ng which r " for no i cost repor ce Workshee	esidents in n column 1. ting period	approved If column ? Enter ")	1 7"			57
00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement f complete V	°or physici ∥kst. D-5.		es as	N			58
00 Are costs claimed on line 100 of Worksheet A? If yes	s, complete	<u>е wkst. D-2</u>	, Pt. I. NAHE 413.8 Y/N	35 Worksh Li n	neet A e #	Pass-T Qualifi Crite	cation erion	59
						Со		-
00 Are you claiming surging and allied health advertice		te for	1.00 V	2.		Co 3.		40
OO Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent ( adjustement? Enter "Y" for yes or "N" for no in col	85? (see umn 1. If CR) NAHE MA	°column 1	1.00 Y	2.				60

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO		eriod: com 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/29/2021 10:	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				0.00	0.00	61.0
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						61.0
instructions) .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						61.(
<ul> <li>ACA). (see instructions)</li> <li>.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</li> </ul>						61.(
instructions) .04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.0
current cost reporting period. (see instructions). .05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.0
<ul> <li>61.04 minus line 61.03). (see instructions)</li> <li>.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)</li> </ul>						61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.
<ul> <li>specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>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 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME fTE unweighted count.</li> </ul>				0.00		61.2
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				ind for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruct. 01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teach gram. (	ing Health Cer see instructic	nter (THC) into			62.0
Teaching Hospitals that Claim Residents in Nonprovide 4.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1.	ettings	during this c	67. (see instr		N	63.0
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 -This base year	2.00	<u> </u>	
period that begins on or after July 1, 2009 and befor 0.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ty trai n-prima all no d non-p n colum	2 30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0. 00	2		64.0

	EX IDENTIFICATION D	ATA Provider C		eriod: rom 01/01/2020	u of Form CMS- Worksheet S-2	2
			TC		Date/Time Pre	epare
	Program Name	Program Code	Unweighted	Unweighted	7/29/2021 10: Ratio (col.	51 a
	3		FTĔs	FTEsin	3/ (col. 3 +	
			Nonprovider Site	Hospi tal	col. 4))	
—	1.00	2.00	3.00	4.00	5.00	-
00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.
is yes, or your facility trained residents in the base						
year period, the program name						
associated with primary care						
FTEs for each primary care						
program in which you trained residents. Enter in column 2,						
the program code. Enter in						
column 3, the number of						
unweighted primary care FTE						
residents attributable to rotations occurring in all						
non-provider settings. Enter in						
column 4, the number of						
unweighted primary care resident FTEs that trained in						
your hospital. Enter in column						
5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unwei ghted	Unwei ghted	Ratio (col.	
			FTES	FTEs in	1/ (col . 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current Y		n Nonprovider Settin	gsEffective f	or cost report	ing periods	
beginning on or after July 1, 201 00 Enter in column 1 the number of u		ny cara racidant	0.00	0.00	0. 000000	7 44
			0.00	0.00	0.00000	00.
	curring in all nong	provider settings.				
FTEs attributable to rotations oc Enter in column 2 the number of u	nweighted non-prima	ary care resident				
Enter in column 2 the number of u FTEs that trained in your hospita	nweighted non-prima I. Enter in column	ary care resident 3 the ratio of				
Enter in column 2 the number of u	nweighted non-prima I. Enter in column	ary care resident 3 the ratio of	Unwei ghted	Unweighted	Ratio (col.	
Enter in column 2 the number of u FTEs that trained in your hospita	nweighted non-prima I. Enter in column column 2)). (see ir	ary care resident 3 the ratio of astructions)	FTĔs	FTEsin	3/ (col. 3 +	
Enter in column 2 the number of u FTEs that trained in your hospita	nweighted non-prima I. Enter in column column 2)). (see ir	ary care resident 3 the ratio of astructions)	FTĔs Nonprovider			
Enter in column 2 the number of u FTEs that trained in your hospita	nweighted non-prima I. Enter in column column 2)). (see ir	ary care resident 3 the ratio of astructions)	FTĔs	FTEsin	3/ (col. 3 + col. 4))	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	-
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	-
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in col umn 2 the number of u FTEs that trained in your hospita (col umn 1 divided by (col umn 1 + 00 Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in col umn 2 the number of u FTEs that trained in your hospita (col umn 1 divided by (col umn 1 + 00 Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
Enter in col umn 2 the number of u FTEs that trained in your hospita (col umn 1 divided by (col umn 1 + 00 Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care	nweighted non-prima I. Enter in column <u>column 2)). (see ir</u> Program Name	ary care resident 3 the ratio of istructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col. 3 + col. 4)) 5.00	
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F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/29/2021 10:	epared:
6.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions)	or "N" for e with 42 /,	2.00         3.00           N         0	76.00
Long Term Care Hospital PPS		1.00	-
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	) period? Enter	N N	80.00 81.00
<ul> <li>5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes</li> <li>6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.</li> </ul>		N	85.00 86.00
7.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Ν	87.00
	V 1.00	XI X 2.00	-
Title V and XIX Services	1.00	2.00	
D. 00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
<ul> <li>1.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</li> <li>2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see</li> </ul>	N	Y	91.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	Ν	94.00
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95.00 96.00
<ul> <li>7.00 If line 96 is "Y", enter the reduction percentage in the applicable column.</li> <li>8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in</li> </ul>	0.00 Y	0. 00 Y	97.00 98.00
column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Y	98.02
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column '	N	Ν	98.03
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Ν	98.04
8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers	Y	Y	98.06
05.00Does this hospital qualify as a CAH? 06.00If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N N		105.00 106.00
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
08.00/ls this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42	N		108.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 01/01/2020	Worksheet S-	·2
		To		Date/Time Pr	
	Physi cal	Occupati onal	Speech	7/29/2021 10 Respi ratory	
19.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	<u>1.00</u> N	2.00 N	3.00 N	4.00 N	109.
				1.00	-
0.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.
			1.00	2.00	_
1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this can "Y" for yes or "N" for no in column 1. If the response to can integration prong of the FCHIP demo in which this CAH is participated and the theory of the additional services; "B" for additional for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.
		1.00	2.00	3.00	-
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cest participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.
Miscellaneous Cost Reporting Information         5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no         in column 1. If column 1 is yes, enter the method used (A, B, or E only)         in column 2. If column 2 is "E", enter in column 3 either "93" percent         for short term hospital or "98" percent for long term care (includes         psychiatric, rehabilitation and long term hospitals providers) based on					0115.
the definition in CMS Pub.15-1, chapter 22, §2208.1. 0.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.
00 Is this facility legally-required to carry malpractice insu	rance? Enter	Y			117.
"Y" for yes or "N" for no. 3.00 Is the malpractice insurance a claims-made or occurrence pol		2			118.
if the policy is claim-made. Enter 2 if the policy is occur	rence.	Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
.01List amounts of malpractice premiums and paid losses:		935, 894			0118
		733, 074	C	)	
		<u>.</u>	1.00	2.00	_
Administrative and General? If yes, submit supporting scher and amounts contained therein.		than the			118
Administrative and General? If yes, submit supporting sched and amounts contained therein. .00DD NOT USE THIS LINE .00Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendment	dule listing o d Harmless pro n column 1, "\ ualifies for 1	than the cost centers ovision in ACA (" for yes or che Outpatient	1.00		118
<ul> <li>Administrative and General? If yes, submit supporting scherand amounts contained therein.</li> <li>ODD NOT USE THIS LINE</li> <li>OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> </ul>	dule listing o d Harmless pro n column 1, ") ualifies for 1 nts? (see inst	than the cost centers ovision in ACA " for yes or the Outpatient cructions)	1.00 N	2.00	118 119 120
<ul> <li>Administrative and General? If yes, submit supporting sched and amounts contained therein.</li> <li>OD DD NOT USE THIS LINE</li> <li>OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for no.</li> <li>OD Id Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>OD Did this facility incur and report costs for high cost impla- patients? Enter "Y" for yes or "N" for no.</li> <li>OD Does the cost report contain heal thcare related taxes as der Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.</li> </ul>	dule listing of d Harmless pro n column 1, "` ualifies for 1 nts? (see inst antable device fined in §1903	than the cost centers wision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the	1.00 N	2.00	118 119 120
Administrative and General? If yes, submit supporting scher and amounts contained therein. 000 DO NOT USE THIS LINE 001 is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 00 Does this facility operate a transplant center? Enter "Y" for	dule listing of d Harmless pro n column 1, ") ualifies for 1 nts? (see inst antable device fined in §1903 1 is "Y", ente	than the cost centers wision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	1.00 N N	2.00	118 119 120 121 122
Administrative and General? If yes, submit supporting schea and amounts contained therein. .00 D0 NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost impla- patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain heal thcare related taxes as der Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare certified kidney transplant center, enter enter in the state of the formation in the state of the st	dule listing of d Harmless pro n column 1, "` ualifies for 1 nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N' nter the certi	than the cost centers ovision in ACA (" for yes or the Outpatient cructions) es charged to 8(w)(3) of the er in column 2	1.00 N N Y N	2.00	118 119 120 121 122 125
<ul> <li>Administrative and General? If yes, submit supporting schea and amounts contained therein.</li> <li>ODD NOT USE THIS LINE</li> <li>OO Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>OD Did this facility incur and report costs for high cost impla- patients? Enter "Y" for yes or "N" for no.</li> <li>OD Does the cost report contain heal thcare related taxes as der Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>OD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>OI If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2.</li> </ul>	dule listing of d Harmless pro n column 1, "Y ualifies for 1 nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N" nter the certi 2. ter the certif	than the cost centers wision in ACA " for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If fication date	1.00 N N Y N	2.00	118 119 120 121 122 125 126
<ul> <li>Administrative and General? If yes, submit supporting scheral and amounts contained therein.</li> <li>00 DD NOT USE THIS LINE</li> <li>00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies provision in ACA §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Outpatient Y" for yes or "N" for no.</li> <li>00 Did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no.</li> <li>00 Does the cost report contain healthcare related taxes as der Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2.</li> <li>00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2.</li> </ul>	dule listing of d Harmless pro n column 1, ") ualifies for 1 nts? (see inst antable device fined in §1903 1 is "Y", ente or yes and "N' nter the certif 2. ter the certif 2. ter the certif	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If fication date	1.00 N N Y N	2.00	118 119 120 121 122 125 126 127
Administrative and General? If yes, submit supporting schea and amounts contained therein. 2000 DO NOT USE THIS LINE 5000 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1000 Did this facility incur and report costs for high cost impla- patients? Enter "Y" for yes or "N" for no. 2000 Does the cost report contain heal thcare related taxes as der Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liv	dule listing of d Harmless pro n column 1, "Y ualifies for 1 nts? (see inst antable device fined in §1903 1 is "Y", ente fined in §1903 1 is "Y", ente or yes and "N" nter the certif 2. ter the certif 2. ter the certif 2.	than the cost centers ovision in ACA (" for yes or the Outpatient cructions) es charged to 8(w)(3) of the er in column 2 for no. If fication date fication date	1.00 N N Y N	2.00	118 119 120 121 122 125 126 127 128 129
<ul> <li>and amounts contained therein.</li> <li>and amounts contained therein.</li> <li>and amounts contained therein.</li> <li>and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that query Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that query Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that query Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>and the state of the s</li></ul>	dule listing of d Harmless pro n column 1, "Y ualifies for 1 nts? (see inst antable device fined in §1900 1 is "Y", ente or yes and "N" nter the certif 2. ter the certif 2. er the certifi enter the certifi	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If fication date fication date cation date in	1.00 N N Y N	2.00	1118 119 120 121 122 125 126 127 128

Health Financial Systems	RI VERVI EW	HOSPI TAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-005		l: )1/01/2020	Worksheet S-2 Part I	2
				To 1	2/31/2020	Date/Time Pre	
						7/29/2021 10:	51 am
					1.00	2.00	
132.00 If this is a Medicare certified is in column 1 and termination date,			ication d	ate			132.00
133.00 Removed and reserved							133.00
134.00 If this is an organ procurement or and termination date, if applicabl		he OPO number	in column	1			134.00
All Providers							
140.00 Are there any related organization					Y		140.00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the				osts			
1.00	2.0	0			3.00	I	
If this facility is part of a chai office and enter the home office of			ough 143 t	the name a	nd address	of the home	
141.00Name:	Contractor's Name:	leter Humber.	Contr	actor's N	umber:		141.00
142.00 Street:	PO Box:		7: (				142.00
143.00 Ci ty:	State:		Zip C	ode:			143.00
						1.00	
144.00 Are provider based physicians' cos	sts included in Worksheet	A?				Y	144.00
					1.00	2.00	-
145.00 If costs for renal services are cl					Y		145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"	for no in column 2.		•				
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir					N		146.00
yes, enter the approval date (mm/c		15-2, chapter	40, 94020	, , ,			
						1.00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for	no.			1.00 N	147.00
148.00 Was there a change in the order of	f allocation? Enter "Y" fo	r yes or "N" f	or no.			N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? E	nter "Y" for y Part A	es or "N" Part		Fitle V	N Title XIX	149.00
		1.00	2.00		3.00	4.00	-
Does this facility contain a provi							
or charges? Enter "Y" for yes or ' 155.00Hospi tal	N TOP NO TOP each compor	N	N N	B. (See	42 CFR 941 N	3. 13) N	155.00
156.00 Subprovi der – IPF		Ν	N		Ν	N	156.00
157.00Subprovi der – IRF 158.00SUBPROVI DER		N	N		N	N	157.00 158.00
159. 00 SNF		N	N		Ν	N	159.00
160.00 HOME HEALTH AGENCY		Ν	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus 165.00(s this hospital part of a Multica	amous hospital that has on	e or more camp	uses in d	ifferent (	BSAs?	N	165.00
Enter "Y" for yes or "N" for no.							100.00
-	Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00		166.00
campus enter the name in column							
0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Heal th Information Technology (HI						X	1/7 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10					er the	Y	167.00 168.00
reasonable cost incurred for the H	IIT assets (see instructio	ns)					
168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?					rdshi p		168.01
169.00 If this provider is a meaningful u	user (line 167 is "Y") and				enter the	9.99	169.00
transition factor. (see instruction	ons)					l	

Health Financial Systems	RIVERVIEW HO	OSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0059 Period: From 01/01/20				2
					norod.
			0 12/31/2020	Date/Time Pre 7/29/2021 10:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/vyvy)					170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider	have any days for ind	ividuals enrolled in	N	(	171.00
section 1876 Medicare cost plans repor	section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter				
"Y" for yes and "N" for no in column 1 1876 Medicare days in column 2. (see i		enter the number of section	ר		

10SPI	Financial Systems RIVERVIEW F AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	IOSPI TAL Provi der C	CN: 15-0059	Peri od:	Worksheet S-	-2552- -2
				From 01/01/2020 To 12/31/2020	Part II Date/Time Pr	repared
				Y/N	7/29/2021 10 Date	):51 ar
				1.00	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. En			
	mm/dd/yyyy format.		•			
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation		11	N		
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N N		1.0
	Treporting period? IT yes, enter the date of the change fire	or unin 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare P	rogram? If	N			2.
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, includin		N			3.
	contracts, with individuals or entities (e.g., chain home o					
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe					
	relationships? (see instructions)	1 31111101				
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports			-		
1. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	A	07/30/2020	4.
	column 3. (see instructions) If no, see instructions.	_				
5.00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rec			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities		-			
o. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is t	he provider	is N		6.
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see in			Y		7.
8.00	Were nursing school and/or allied health programs approved	and/or renewe	a auring the	N		8.
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medi	cal educatio	n N		9.
. 00	program in the current cost report? If yes, see instruction					1
0.00	Was an approved Intern and Resident GME program initiated o		the current	N		10.
	cost reporting period? If yes, see instructions.					
1.00	Are GME cost directly assigned to cost centers other than I	& R in an Ap	proved	N		11.
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	_
				-	1.00	_
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes	, see instruc	tions.		Y	12.
3.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	olicy change	during this	cost reporting	Ν	13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? I	fyes, see i	nstructions.	N	14.
	Bed Complement				••	- 45
5.00	Did total beds available change from the prior cost reporti	<u> </u>		Par	N	15.
	-	Y/N	t A Date	Y/N	Date	_
	-	1.00	2.00	3.00	4.00	
	PS&R Data					
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Ν		N		16.
	instructions)					
7.00	Was the cost report prepared using the PS&R Report for	Y	02/21/2021	Y	02/21/2021	17.
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
8.00	If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		18.
	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.					
	LOST LEPOLT I YES, SEE HISTINCTIONS.			Ν		19.
9 00		N				
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		IN		

Descr		To 12/31/2020	7/29/2021	Prepared: 10: <u>51 am</u>		
	iption	Y/N	Y/N			
	0	1.00	3.00			
	_	N	N	20.00		
Y/N	Date	Y/N	Date			
	2.00		4.00			
N		N		21.0		
			1.00			
CEPT CHILDRENS	HOSPI TALS)					
a instruction						
		ring the cost		22.0		
e uue to appiai	sals liaue uu	inng the cost		23.0		
red into durino	g this cost r	reporting period?		24.0		
g the cost repo	orting period	l?lfyes, see		25.0		
the cost report	ing period?	lfyes, see		26.0		
he cost reporti	ng period?	fyes, submit		27.0		
	5	5		_		
entered into du	uring the cos	st reporting		28.0		
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 instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						
turity with new	v debt? TT ye	25, 566		30.0		
issuance of new	v debt? If ye	es, see		31.0		
ervi ces furni sł	ned through c	contractual		32.0		
ructions. oplied pertaini	ng to compet	itive bidding? If		33.0		
arrangement wit	th provider-b	based physicians?		34.0		
visting agreem	ants with the	nrovi der-based		35.0		
instructions.	ints with the			35.0		
		Y/N	Date			
		1.00	2.00			
propared by the	bomo offica	2		36.0		
prepared by the		; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;		37.0		
		of		38.0		
		es,		39.0		
e home office?	lfyes, see	3		40.0		
1	1.00					
TI NA		SEVERS		41.0		
BLUE & CO., L	LC			42.0		
		TSEVERS@RI HEAM	DCO COM	43.0		
r 9 th ertti erpeaxi er producti	ee instructions e due to apprai red into during g the cost report the cost report entered into du bond funds (I tructions turity with new ssuance of new ervices furnish uctions. oplied pertaini arrangement wit (isting agreement nstructions. orepared by the ffice different ad of the home her chain compose home office?	N           SEPT CHILDRENS HOSPITALS)           se instructions           edue to appraisals made du           red into during this cost r           g the cost reporting period?           he cost funds (Debt Service           tructions           turity with new debt? If ye           ssuance of new debt? If ye           ssuance of new debt? If ye           hervices furnished through of           turtions.           opplied pertaining to compet           hervices furnished through of           hervices furnished through of           hervices furnished through of           hervices furnished through of           hervice different from that of           he	N         N           SEPT CHILDRENS HOSPITALS)           ee instructions           e due to appraisals made during the cost           red into during this cost reporting period?           g the cost reporting period? If yes, see           the cost reporting period? If yes, submit   entered into during the cost reporting rebond funds (Debt Service Reserve Fund) tructions turity with new debt? If yes, see ssuance of new debt? If yes, see sevices furnished through contractual ructions. pplied pertaining to competitive bidding? If arrangement with provider-based physici ans? kisting agreements with the provider-based nstructions. Y/N 1.00 2. TINA BLUE & CO., LLC	N       N         1.00         1.00         EEPT CHILDRENS HOSPITALS)         Tee instructions         a due to appraisals made during the cost         red into during this cost reporting period?         g the cost reporting period? If yes, see         the cost reporting period? If yes, see         the cost reporting period? If yes, submit         entered into during the cost reporting         to bond funds (Debt Service Reserve Fund)         truity with new debt? If yes, see         suance of new debt? If yes, see         Sector functions.         to competitive bidding? If         arrangement with provider-based physicians?         tisting agreements with the provider-based         non 2.00         The colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2"         The colspan="2"         Adv colspan="2"         time colspan="2"         time colspan="2"         The colspan="2"         time colspan="2"         time colspan="2"         time colspan="2"		

Health Financial Systems RIVERVIE	W HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0059	Period:	Worksheet S-2			
		From 01/01/2020 To 12/31/2020	Part II Date/Time Pre 7/29/2021 10:	pared: 51 am		
	3.00					
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/position	MANAGER			41.00		
held by the cost report preparer in columns 1, 2, and 3,						
respectively.						
42.00 Enter the employer/company name of the cost report				42.00		
preparer.						
43.00 Enter the telephone number and email address of the cost				43.00		
report preparer in columns 1 and 2, respectively.						

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RI VERVI EW I	Provi der C	CNI 15 0050	Peri od:	u of Form CMS-2 Worksheet S-3	
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 12-0059	From 01/01/2020		
					To 12/31/2020	Date/Time Pre	
						7/29/2021 10:	51 am
						I/P Days /	
						0/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	component	Line Number	NO. OI DEUS	Avai I abl e	CAIT HOULS	nue v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	104	40, 99		0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		104	40, 99	0.00	0	7.00
0 00	beds) (see instructions)	21.00	15	F 40		0	
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00	15	5, 49	0.00	0	8.00 9.00
9.00 10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	12.00
14.00	Total (see instructions)	+3.00	119	46, 48	0.00	-	14.00
15.00	CAH visits		,	,	2 0.00	0	
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	24	8, 78	4	0	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0		0	0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		143			_	27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00 31.00
31.00 32.00	Employee discount days - IRF Labor & delivery days (see instructions)		0		0		31.00
32.00	Total ancillary labor & delivery room		0		0		32.00
JZ. UI	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.01

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC		eriod: rom 01/01/2020 o 12/31/2020		epare
	I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
Component	Title XVIII	Title XIX	Total All	Total Interns		
-	6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10.00	<u> </u>
00 Hospital Adults & Peds. (columns 5, 6, 7 and	4,010	463	12, 212		10.00	1.
8 exclude Swing Bed, Observation Bed and	.,		,			
Hospice days) (see instructions for col. 2						
for the portion of LDP room available beds)						
00 HMO and other (see instructions)	3, 862	2, 269				2
00 HMO I PF Subprovi der	0	0				3
00 HMO IRF Subprovider	1, 108	178				4
00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5
00 Hospital Adults & Peds. Swing Bed NF		0	0			6
00 Total Adults and Peds. (exclude observation	4, 010	463	12, 212			7
beds) (see instructions)						
00 INTENSIVE CARE UNIT	1, 015	0	3, 382			8
00 CORONARY CARE UNIT						9
. OO BURN INTENSIVE CARE UNIT						10
. 00 SURGICAL INTENSIVE CARE UNIT						11
. 00 OTHER SPECIAL CARE (SPECIFY)						12
. 00 NURSERY		0	1, 331			13
.00 Total (see instructions)	5, 025	463	16, 925		1, 031. 77	
.00 CAH visits	0	0	0			15
. 00 SUBPROVIDER - IPF						16
. 00 SUBPROVIDER - IRF	3, 055	30	4, 623	0.00	20. 12	
. 00 SUBPROVI DER						18
. 00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
. 00 NURSING FACILITY						20
. OO OTHER LONG TERM CARE						21
. OO HOME HEALTH AGENCY						22
. 00 AMBULATORY SURGICAL CENTER (D. P. )						23
. 00 HOSPI CE						24
.10 HOSPICE (non-distinct part)			171			24
. OO CMHC - CMHC						25
. OO RURAL HEALTH CLINIC						26
. 25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
.00 Total (sum of lines 14-26)				0.00	1, 051. 89	
.00 Observation Bed Days		0	2, 229			28
.00 Ambulance Trips	0					29
.00 Employee discount days (see instruction)			0			30
.00 Employee discount days - IRF			0			31
.00 Labor & delivery days (see instructions)	0	110	234			32
.01 Total ancillary labor & delivery room			0			32
outpatient days (see instructions)						
.00 LTCH non-covered days	0					33
.01 LTCH site neutral days and discharges	0					33

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RIVERVIEW HO		CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2020 To 12/31/2020	Part I	pared:
		Full Time Equivalents		Dis	scharges		
	Component	Nonpai d	Title V	Title XVII	I Title XIX	Total All	
		Workers				Patients	
1 0 0		11.00	12.00	13.00	14.00	15.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0 1, 0		4, 075	1.00
2.00	HMO and other (see instructions)			6	473		2.00
3.00 4.00	HMO I PF Subprovider				0		3.00 4.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				10		5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	I NTENSI VE CARE UNI T						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, 0	86 88	4, 075	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER – IRF	0.00		0 2	265 2	410	17.00
18.00	SUBPROVIDER						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	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 28.00	Total (sum of lines 14-26) Observation Bed Days	0.00					27.00
28.00	Ambulance Trips						28.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see first detron)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.00	Total ancillary labor & delivery room						32.00
52.01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days				0		33.00
	LTCH site neutral days and discharges			1	Ő		33.01

SPI T.	Financial Systems AL WAGE INDEX INFORMATION			Provider CO		eriod:	Worksheet S-3	
						rom 01/01/2020 o 12/31/2020	Date/Time Pre	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	7/29/2021 10: Average	51
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Salaries (from Wkst.	(col.2 ± col. 3)	Salaries in col. 4	(col. 4 ÷ col. 5)	
		1.00		A-6)			·	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
00	Total salaries (see instructions)	200.00	84, 803, 831	124, 264	84, 928, 095	2, 187, 938. 93	38.82	
00	Non-physician anesthetist Part		0	0	0	0.00	0.00	
00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	
	B Dhuci ci ch Dort A		0		0	0.00	0.00	
00	Physician-Part A - Administrative		0	0	0	0.00	0.00	
)1	Physicians - Part A - Teaching		0	-	0			
00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	!
00	Non-physician-Part B for		0	0	0	0.00	0.00	e
	hospital-based RHC and FQHC services							
00	Interns & residents (in an	21.00	0	0	0	0.00	0.00	
01	approved program) Contracted interns and		0	0	0	0.00	0.00	-
	residents (in an approved programs)							
00	Home office and/or related		0	0	0	0.00	0.00	
00	organization personnel SNF	44.00	0		_	0.00	0.00	
00	Excluded area salaries (see	44.00	26, 960, 989	379, 299	27, 340, 288			
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		1, 267, 679	0	1, 267, 679	16, 700. 00	75. 91	1
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	1
00	management and other		0	0	0	0.00	0.00	
	management and administrative services							
00	Contract Labor: Physician-Part		610, 315	0	610, 315	4, 372. 50	139. 58	1
00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	1
00	organization salaries and		0	0		0.00	0.00	1.
01	wage-related costs Home office salaries		0	0	0	0.00	0.00	1
02	Related organization salaries		0	0	0	0.00	0.00	1
00	Home office: Physician Part A		0	0	0	0.00	0.00	1
00	- Administrative Home office and Contract		0	0	0	0.00	0.00	1
01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0.00	1
01	- Teaching		0	0	0	0.00	0.00	1'
02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	1
	WAGE-RELATED COSTS							1
00	Wage-related costs (core) (see instructions)		12, 729, 707	0	12, 729, 707			1
00	Wage-related costs (other)							1
00	(see instructions) Excluded areas		4, 640, 356	0	4, 640, 356			1
. 00	Non-physician anesthetist Part		4, 040, 350	0	4, 040, 350			20
00	A Non-physician anesthetist Part		0	0	0			2
	В		0					
00	Physician Part A - Administrative		0	0	0			2
01	Physician Part A - Teaching		0	0	О			2
00 00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			2
00	Interns & residents (in an		0	0	0			2
50	approved program) Home office wage-related		~	_	0			2
	(core)		0	0				
51	Related organization wage-related (core)		0	0	0			2
. 52	Home office: Physician Part A		0	0	о			2!
	- Administrative - wage-related (core)							

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25. 53	Home office: Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARI		0	0		0		25. 53
26.00	Employee Benefits Department	4.00	995, 906	0	995, 90	6 17, 711. 75	56.23	26.00
27.00	Administrative & General	5.00	9, 275, 320					
28.00	Administrative & General under		386, 728		386, 72			
20.00	contract (see inst.)		000,720	0	000,72	770.00	070.07	20.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30,00	Operation of Plant	7.00	2, 262, 194	0	2, 262, 19	4 76, 213.00		
31.00	Laundry & Linen Service	8.00	73,073		73,07			31.00
32.00	Housekeepi ng	9.00	1, 147, 208	0	1, 147, 20	8 60, 438. 25	18. 98	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	1, 334, 765	-993, 609	341, 15	6 16, 953. 00	20. 12	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	0	860, 937	860, 93	7 43, 077. 00	19. 99	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	713, 099	0	713, 09	9 17, 440. 00	40.89	38.00
39.00	Central Services and Supply	14.00	637, 325	0	637, 32	5 26, 248. 00	24. 28	39.00
40.00	Pharmacy	15.00	2, 535, 466	-245, 627	2, 289, 83	9 68, 441. 75	33.46	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16.00	816, 600	0	816, 60	0 32, 888. 00	24.83	41.00
42.00	Soci al Servi ce	17.00	617, 057	0	617, 05	7 13, 897. 00	44.40	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		85, 190, 559	124, 264	85, 314, 82	3 2, 188, 908. 93	38. 98	1.00
	instructions)							
2.00	Excluded area salaries (see		26, 960, 989	379, 299	27, 340, 28	B 509, 934. 75	53.62	2.00
	instructions)							
3.00	Subtotal salaries (line 1		58, 229, 570	-255,035	57, 974, 53	5 1, 678, 974. 18	34.53	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 877, 994	0	1, 877, 99	4 21, 072. 50	89. 12	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		12, 729, 707	0	12, 729, 70	7 0.00	21.96	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		72, 837, 271	-255, 035	72, 582, 23	6 1, 700, 046. 68	42.69	6.00
7.00	Total overhead cost (see		20, 794, 741				29.48	7.00
	instructions)							
		I		1	1	· ·		1

	Financial Systems	RI VERVI EW HOSPI TAL		u of Form CMS-2	
iospi 1	AL WAGE RELATED COSTS	Provider CCN: 15-0	From 01/01/2020	Worksheet S-3 Part IV Date/Time Pre 7/29/2021 10:	pared
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List RETIREMENT COST				
00	401K Employer Contributions			1, 466, 094	1.0
. 00 . 00	Tax Sheltered Annuity (TSA) Employer Contrib	aution		1, 400, 094	2.0
. 00	Nongualified Defined Benefit Plan Cost (see			0	3.0
. 00	Qualified Defined Benefit Plan Cost (see ins			0	4.0
. 00	PLAN ADMINISTRATIVE COSTS (Paid to External			0	4.0
. 00	401K/TSA Plan Administration fees			0	5.0
. 00	Legal /Accounting/Management Fees-Pension Pla	an		4, 414	
. 00	Employee Managed Care Program Administration			4,414	
. 00	HEALTH AND INSURANCE COST	11663		0	/.(
. 00	Heal th Insurance (Purchased or Self Funded)			0	8.0
. 00	Heal th Insurance (Sel f Funded without a Thir	rd Party Administrator)		0	
02	Heal th Insurance (Self Funded without a Third F			9, 240, 858	
. 02	Heal th Insurance (Purchased)			, 240, 030	
. 00	Prescription Drug Plan			0	
D. 00	Dental, Hearing and Vision Plan			218, 486	
1.00	Life Insurance (If employee is owner or bene	eficiary)		47, 508	
2.00	Accident Insurance (If employee is owner or			0	
3.00	Disability Insurance (If employee is owner of			0	
4.00	Long-Term Care Insurance (If employee is own			331, 865	
5.00	'Workers' Compensation Insurance			317, 868	
6.00	Retirement Health Care Cost (Only current ye	ear, not the extraordinary accrual re	equired by FASB 106.	0	
	Non cumulative portion)				
	TAXES				
7.00	FICA-Employers Portion Only			5, 633, 368	17.(
8.00	Medicare Taxes - Employers Portion Only			0	18. (
9.00	Unemployment Insurance			58, 231	19.0
0.00	State or Federal Unemployment Taxes			0	20.0
	OTHER				
1. 00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost Reported on Lines 1	through 4 above. (see	0	21.0
2.00	Day Care Cost and Allowances			0	22.0
3.00	Tuition Reimbursement			51, 371	23.0
4. 00	Total Wage Related cost (Sum of lines 1 -23)	)		17, 370, 063	24.(
	Part B - Other than Core Related Cost				

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0059	Peri od:	Worksheet S-3	
			From 01/01/2020 To 12/31/2020		norod.
			To 12/31/2020	Date/Time Pre 7/29/2021 10:	
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identific	cation:			
1.00	Total facility's contract labor and benefit cos	st	1, 267, 679		1.00
2.00	Hospi tal		1, 267, 679	17, 370, 063	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF		0	0	8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00					13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00			0	0	17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems	RI VERVI EW HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		CCN: 15-0059	Period:	Worksheet S-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 10:	
					1.00	
	Uncompensated and indigent care cost computation	on			1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line		ine 202 colum	า 8)	0. 305773	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				3, 190, 861	2.00
3.00 4.00	Did you receive DSH or supplemental payments fulfline 3 is yes, does line 2 include all DSH a		ate from Modie	ai d2	Y Y	3.00 4.00
4.00 5.00	If line 4 is no, then enter DSH and/or suppleme				0	5.00
6.00	Medi cai d charges	antar payments from mearer			46, 242, 758	
7.00	Medicaid cost (line 1 times line 6)				14, 139, 787	7.00
8.00	Difference between net revenue and costs for Me < zero then enter zero)	edicaid program (line 7 mi	nus sum of li	nes 2 and 5; if	10, 948, 926	8.00
	Children's Health Insurance Program (CHIP) (see	e instructions for each li	ne)			
	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for st	tand_alone CHIP (line 11 r	minus lino 0:	f < zero then	0	11.00
12.00	enter zero)		in nus i ne 7,	I < Zero then	0	12.00
	Other state or local government indigent care p	program (see instructions	for each line	)	L	
	Net revenue from state or local indigent care p				0	
14.00	Charges for patients covered under state or loc 10)	cal indigent care program	(Not included	in lines 6 or	0	14.00
	State or local indigent care program cost (line		<i></i>		0	
16.00	Difference between net revenue and costs for st	tate or local indigent ca	re program (li	ne 15 minus line	• 0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost f	for Medicaid CHLP and sta	ate/local_indi	nent care progra	ms (see	
	instructions for each line)	of mean card, offit and ste		gent our e progre		
17.00	Private grants, donations, or endowment income	restricted to funding cha	arity care		0	17.00
	Government grants, appropriations or transfers				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and 8, 12 and 16)	d state and local indigen <sup>.</sup>	t care program	s (sum of lines	10, 948, 926	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each I	ine)	1.00	2.00	3.00	
	Charity care charges and uninsured discounts for		9, 537, 87	7 1, 187, 260	10, 725, 137	20.00
	(see instructions)			, - ,		
21.00	Cost of patients approved for charity care and instructions)	uninsured discounts (see	2, 916, 42	5 1, 187, 260	4, 103, 685	21.00
22.00	Payments received from patients for amounts pre charity care	eviously written off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		2, 916, 42	5 1, 187, 260	4, 103, 685	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include ch	narges for patient days be	eyond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or othe If line 24 is yes, enter the charges for patier	er indigent care program?			0	25.00
	stay limit					
	Total bad debt expense for the entire hospital				11, 814, 067	
	Medicare reimbursable bad debts for the entire Medicare allowable bad debts for the entire hos				81, 010 124, 632	
	Non-Medicare bad debt expense (see instructions				124, 632	
	Cost of non-Medicare and non-reimbursable Medic	<i>·</i>	e instructions	)	3, 617, 936	
	Cost of uncompensated care (line 23 column 3 pl	• •			7, 721, 621	
31.00	Total unreimbursed and uncompensated care cost	(line 19 plus line 30)			18, 670, 547	31.00

4.00         Deschol Subtrack:         998, 966         8, 866, 7/2         9, 867, 578         31, 31, 959, 969, 99         50           7.00         JOURD UPEANTERN ISTRATTER & GENERAL         2, 262, 184         5, 981, 828         5, 146, 204         0         6, 274, 996, 994         0         6, 274, 924         144, 227         147, 128         1         145, 127         1         0         1         100         101000         101000         101000		Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	RI VERVI EW F F EXPENSES	Provider C		eri od:	u of Form CMS-2 Worksheet A	2552-10		
Cost Denter Description         Set arises         Other         Total (col. 1) (col. 2)         Reclassi frad (col. 4)         Total (col. 2) (col. 4)         Reclassi frad (col. 4)           100         UNIOU CPE RELEDSIS - RUDC & HIT         99,000         8,260 (20, 4)         500         4,300         500           100         DESCO ARMINISTRATUP & CHEMPLET         99,000         8,866 (20, 7)         39,444 (22, 20, 565, 29)         10,420         8,214, 021         11,820         11,820         12,122,773         60,131,722,773         60,131,722,773         60,121,727,778         12,122,773         60,131,727,778         12,122,773         60,121,727,778         12,122,773         60,121,727,778         12,122,773         60,100,94,94,94,94,94,94,94,94,94,94,94,94,94,							Date/Time Pre	pared:		
Incol         2.00         A.60         (col. 3, -)           1.00         2.00         3.00         4.00         (col. 3, -)           1.00         00000 (Abs 1 (ST Coll Edg)         5.00         4.00         (col. 3, -)           1.00         00000 (Abs 1 (ST Coll Edg)         5.00         4.00         (col. 3, -)		Cost Center Description	Sal ari es	Other			Recl assi fi ed			
Introdu         STRUCT         Description         1.00         2.00         3.00         4.00         5.00           4.00         DODORD         FALL COST - CARTER AT IXT         999, 900         A. Re6, 672         9.602, 571         3.77, 706         D.270, 99, 900         A. Re6, 672         9.602, 571         3.67, 706         D.270, 99, 900         A. Re6, 672         9.602, 571         3.67, 706         D.270, 99, 900         A. Re6, 672         9.602, 571         3.67, 706         D.270, 99, 900         A. Re6, 672         9.602, 571         3.67, 706         D.270, 99, 900         A. Re6, 672         9.602, 571         3.67, 706         D.270, 99, 900         A. Strutture         A. Struture <td></td> <td></td> <td></td> <td></td> <td>+ COI. 2)</td> <td></td> <td>(col. 3 +-</td> <td></td>					+ COI. 2)		(col. 3 +-			
Derival         SERVICE         Dot 749, 564         20, 749, 564         154, 227         20, 593, 339         1           1,00         Coloro Derivation of Parkan         9, 975, 900         56, 66, 673, 9, 962, 578         30, 749, 564         114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 382         10, 210, 114, 279, 397, 114, 219, 971         10, 124, 179, 116, 124, 219, 116, 116, 124, 124, 219, 116, 124, 219, 116, 116, 124, 124, 124, 124, 124, 124, 124, 124			1.00	2 00	3 00	4 00				
4.00         00400         EMPLOYEE BURFITS DEFARTMENT         995,906         8,866,672         9,862,578         33.00         10.210,414         4.0           7.00         00700         0PERATION OF PLATT         2,222,142         5,951,858         8,214,024         0         8,214,024         0         8,214,024         0         8,214,024         0         8,214,024         0         8,214,024         0         8,214,024         0         0         0,217,122         10.00										
5.00         DODOOL ADDMINISTRATIVE & LETHERAL         9, 275, 320         30, 195, 502         39, 414, 822         14, 422         35, 550, 69         5, 04         24, 02         35, 550, 69         5, 04         24, 02         35, 550, 60         5, 04         24, 02         35, 550, 60         5, 04         24, 02         35, 550, 60         0<			005 004					1.00		
7.00         000700 (DFERATION 0F PLANT         2, 262, 194         5, 911, 820         8, 214, 024         0         6, 214, 027         8           0.00         000000 (DUDGREEFING)         1, 147, 208         1, 147, 909         0         2, 177, 270         1, 130           11.00         011030 (DIREAL SERVICES SUPPLY         2, 332, 466         1, 334, 349         1, 948, 905         -2, 266, 41         1, 562, 611         1, 579, 168         1, 579, 177, 201         1, 579, 179, 168         1, 579, 168         1, 579, 168 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>5.00</td>								5.00		
9.000 00000 HOUSEKEEN NG 1, 147, 208 1, 015, 570 2, 162, 775 0, 084, 227 10. 0849, 227 10. 0 10 00 1000 PINEMARY		00700 OPERATION OF PLANT		5, 951, 830				7.00		
10.00         01000         DETARY         1, 334, 755         2, 031, 415         3, 366, 160         2, 171, 220         11.0           11.00         011000         CPTFERIA         Simpley         13.00         100, 1000         CPTFERIA         Simpley         10.00         100, 1000         CPTFERIA         Simpley         10.00         1000         CPTFERIA         10.00         CPTFERIA         CPTFERIA         CPTFFERIA         CPTFERIA								8.00		
11:00       0       0       0       0       0       0       0       0       2, 17, 220       17, 17, 220       18, 19, 49       13, 09       14, 09       10, 01, 71, 34       10, 01, 00       14, 09       10, 01, 71, 34       10, 01, 00       11, 09, 00       10, 01, 71, 34       10, 01, 00       14, 00       14, 09       14, 09       14, 09       14, 09       14, 00       1										
14.00       CNNTRAL SERVICES & SUPPLY       637.325       980.085       1.617.970       5.739.168       7.357.078       14.0         15.00       OTHOOD (NAMAXY       253.34.66       1.31.3.497       19.484.905       -266.40       19.512.51       15.0         16.00       OTHOOD SCILL SERVICE       0										
15.00       00       01500       PHARMACY       2.532, 660       17, 713, 249       19, 682, 692       -266, 540       19, 592, 205       15         17.00       01700       SOCIAL       STRVICE       617, 005       179, 203       746, 260       1       122, 252       225       2								13.00		
16. 00 01400 MEDICAL RECORDS & LIBRARY       816.600       496.312       1.312,912       10       1.312,912       11       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       10       1.312,912       12       1.312,912       1.312,912       1.312,912       1.312,912       1.312,912       1.312,912       1.										
17.00       001700       SOCIAL SERVICE       617.07       129.203       746.260       1.0       746.260       1.0       251.252       252.257       252.257       252.257       252.257       252.257       252.257       252.257       252.257       252.257										
INFART ENT ROUT NE SERVICE COST CENTERS         9         120         150         1000         100         100										
30. 00       03000       ADUITS & PEDIATRICS       9. 126, 554       1. 590, 807       10, 717, 381      466, 413       10, 250, 483       30. 0         41. 00       OHOD SUBPROVIDER - IRF       1. 483, 160       1, 200, 702       2, 649, 862       -90, 99       2, 599, 264       41. 0         41. 00       OHOD SUBPROVIDER - IRF       1. 483, 160       1, 200, 702       2, 649, 862       -90, 99       2, 599, 264       41. 0       41. 00       44. 00       0.4400 (SKI LLED MURSI NG FACILLITY       0       0       0       0       43. 0         40. 04400 (SKI LLED MURSI NG FACILLITY       0       0       0       0       0       0       0       0       0       0       0       44. 0         40. 04400 (SKI LLED MURSI NG FACILLITY       0       0       0       11. 648, 371       -2, 504, 575       97. 10. 007, 71. 404, 985       55. 0       55. 0       55. 00       550, 00       550, 00       550, 00       560, 00       10. 667, 713       10. 667, 713       10. 667, 713       10. 667, 713       10. 667, 713       10. 667, 713       10. 667, 714       10. 667, 714       10. 667, 714       10. 667, 714       10. 667, 714       10. 667, 714       10. 660, 714       10. 67, 714       10. 660, 714       10. 667, 714       10. 660, 714       1	23.00		0	0	C	251, 255	251, 255	23.00		
31:00       00:3100       INTERSIVE CARE UNIT       2,899,109       1,206,7109       3,062,729       -292,869       3,275,409       3,275,409       3,0       43.00       04300       NURSERY       0	30 00		9 126 554	1 590 807	10 717 361	-466 413	10 250 948	30.00		
41.00       04100       SUBPROVIDER - I RF       1,483,160       1,206,702       2,689,862       -90.598       2,599,264       41.0         44.00       04400       SKILLED NURSIKG FACILITY       0       0       0       0       0       43.0         50.00       56000       OPENATING ROUM       3,884,283       7,764,088       11,648,371       -2,504,575       9,143,796       50.0       52.01       52.01       52.01       52.01       52.01       52.01       52.01       52.01       52.01       52.01       52.00       50.00       50.00       50.00       50.00       50.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>								31.00		
44.00         04400_SKILLED NURSI NG FACILITY         0			1, 483, 160	1, 206, 702	2, 689, 862	-90, 598	2, 599, 264	41.00		
ACCULARY SERVICE COST CENTRES         Image: Cost Centres           52.00         002000 DEFRATING ROOM         3.884.283         7.764.088         11.648.371         -2.504.572         9.143.796         50.0         55.00         00200 DEFLIVERY ROOM & LABOR ROOM         0         0         0         0         0         2.531.639         -2.531.639         -2.531.639         -0.010         55.00         05500 RADI CLOY-THERAPEUTIC         492.057         57.71         1.069.971         -2.260.1757         -2.63         424.940         57.01         03300 ILTRA SOUND         337.144         40.399         437.754.3         -2.63         424.940         57.01         03300 ILTRA SOUND         8.71.22.668         5.060.0104         8.122.679         -2.821.81         1.728.301         59.00         0.0000 ROOM RIN         8.122.679         -2.822.84         1.726.408         425.268         0         -2.823.81         1.788.84         -0.00         0 <t< td=""><td></td><td></td><td>-</td><td>°,</td><td>0</td><td>0</td><td>-</td><td>43.00</td></t<>			-	°,	0	0	-	43.00		
50. 00         550.00         550.00         550.00         550.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         55.00         66.00         60.00	44.00		0	0	U	u U	0	44.00		
54. 00         05400 RAD LOCX-DI AGNOSTI C         1, 923, 475         608, 164         2, 531, 639         -10, 010         2, 521, 629         54. 00           57. 00         05700 CT SCAN         3340, 706         162, 133         502, 839         -93, 165         1, 069, 974         57. 00           05800 MRI         3300, 137         46, 895         347, 032         -5, 409         341, 623         58. 00           06000 CARDI AC CATHETERI ZATION         8862, 235         1, 848, 467         2, 108, 882         -982, 581         1, 778, 830         159. 0           06000 CARDI AC CATHETERI ZATION         8862, 236         0, 812, 679         -2, 821         8, 179, 858         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         60. 0         66. 0         67. 0         0         0		05000 OPERATING ROOM	3, 884, 283	7, 764, 088	11, 648, 371	-2, 504, 575	9, 143, 796	50.00		
55. 00       05500 (RAD 0LOCY-THERAPEUTIC       492, 057       57. 71       1, 0.69, 711       -236       1, 0.69, 735       55. 05         57. 01       05300 (LTRA SOUND       387, 144       40, 399       427, 543       -2, 603       424, 940       57. 01         58. 00       05900 (ARD AC CATHETERI ZATI ON       862, 235       1, 846, 647       2, 710, 882       -982, 581       1, 728, 301       59. 00       00       0000 (ARD AC CATHETERI ZATI ON       862, 235       1, 846, 647       2, 710, 882       -982, 581       1, 728, 301       59. 00       0			-	-	-	-	-	52.00		
57. 00         05700 CT SCAM         340,706         102,133         502,839         -93,165         409,674         57.0           57. 00         05800 MR         300,137         46,999         427,543         -2,603         424,940         57.0           0         05000 CARDI AC CATHETERI ZATI ON         862,235         1,848,647         2,710,882         -92,821         8,172,883         58.0           0.0000 LABORATORY         3,122,668         5,060,011         8,182,679         -2,821         8,172,883         59.0         63.00         63.00         63.00         1452,268         0         452,268         0         452,268         0         452,268         0         65.00         66.00										
57. 01       03630 (UTRA SOUND       387, 144       40, 399       427, 543       -2, 603       424, 940       57. 03         59. 00       05000 CARDIA C CATHETERIZATI ON       862, 235       1, 848, 647       2, 710, 882       -982, 581       1, 728, 301       59. 00         06001       BLOOD LABORATORY       3, 122, 668       5, 060, 011       8, 182, 679       -2, 821       8, 179, 558       60. 0         06001       BLOOD STORM KG, PROCESSIN & TRANS.       0       452, 268       452, 268       0       64.0       64.0         06400       INTRAVENUS THERAPY       1, 470, 219       385, 617       1, 8536       -92, 250       1, 763, 246       65.         06500       06500 OCLIPATIONAL THERAPY       4, 495, 031       2, 402, 082       68, 97, 113       -6, 280       699, 033       66.0       66.0       66.0       66.0       66.0       66.0       66.0       67.0										
59. 00         6590.0         CARDIA CATHETERIZATION         862, 235         1, 848, 647         2, 710, 882         -982, 581         1, 728, 301         59, 00           00         06000         RLODD LABORATORY         3, 122, 668         5, 060, 011         8, 182, 679         -2, 821         8, 179, 856         60, 01           00         06001         RLOND STRUK, OR, PROCESSING & TRANS.         0         452, 266         452, 266         0         452, 266         6, 800         65, 617         1, 855, 836         -92, 590         1, 763, 246         65, 00           06000         DESDIP RATORY THERAPY         1, 470, 219         385, 617         1, 855, 836         -92, 590         1, 763, 246         65, 00         6600         6600         6600         6600         6600         6600         6600         6600         6600         660, 00         67, 00         0         0         0         0         0         0         0         662, 259         69, 00         662, 259         69, 00         662, 259         69, 01         71, 00         0         0         0         0         0         0         0         0         0         0         73, 00         73, 00         73, 00         73, 00         73, 00         73, 00										
60. 00         06000         LABORATORY         3, 122, 668         5, 060, 011         8, 122, 679         -2, 821         8, 179, 858         60, 0           63. 00         06300         BLODD LABORATORY         0         452, 268         452, 268         452, 268         452, 268         452, 268         452, 269         452, 269         452, 269         452, 269         452, 269         452, 268         453, 269         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         452, 268         450, 414, 413, 780         452, 268										
60.00         0 6000         LABORATORY         1         0										
63. 00         063.00         BLOOD STORI NG, PROCESSI NG & TRANS.         0         452, 268         452, 268         0         0452, 268         63. 00           64.00         06400         INTRAVENDING THERAPY         1, 470, 219         385, 617         1, 855, 836         -92, 590         1, 763, 244         66           66.00         06600         PHYSI CAL. THERAPY         4, 495, 031         2, 402, 082         6, 897, 113         -6, 280         6, 890, 833         66           0         0         0         0         0         0         0         0         67         0           0			3, 122, 008	5,000,011	0, 102, 079			60.00		
65:00         0c500         PESPI RATORY         1, 470, 219         386, 617         1, 855, 836         -92, 590         1, 763, 246         65, 0           66:00         0c6000         PHYSI CAL         THERAPY         4, 495, 031         2, 402, 082, 6187         1, 855, 836         -92, 590         6, 890, 833         66.0           66:00         0c6000         PEECH PATHOLOGY         0         0         0         0         68.0           68:00         0c8000         SPEECH PATHOLOGY         0 </td <td></td> <td>06300 BLOOD STORING, PROCESSING &amp; TRANS.</td> <td>0</td> <td>452, 268</td> <td>452, 268</td> <td>0</td> <td>452, 268</td> <td>63.00</td>		06300 BLOOD STORING, PROCESSING & TRANS.	0	452, 268	452, 268	0	452, 268	63.00		
66.00         066.00         066.00         68.97, 113         -6.280         6,890,833         60,           06.00         067.00         06700         0			0	0	0	0	-	64.00		
67.00         06700         0CUPATI ONAL THERAPY         0										
69.00         06900         ELECTROCARDIOLOGY         518,664         143,780         662,444         -185         662,259         9,0           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0         0         0         0         0         73.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         9,597,252         9,597,252         0         9,597,252         0         9,597,252         74.0         74.00         74.00         74.00         74.00         74.00         74.00         74.00         0         0         0         73.00         0         0         0         0         73.00         0         0         0         0         73.00         0			0	2, 102, 002	0,077,110	0,200		67.00		
11.00       OTOO       DOI CAL       SUPPLIES       CHARGED TO PATIENT       O			0	0	C	0	-	68.00		
72 00         O7200         IMPL         DEV.         CHARGED TO PATI ENTS         0         9, 597, 252         0, 9, 597, 252         0, 9, 597, 252         0, 0         9, 597, 252         0, 0         9, 597, 252         0, 0         0, 73, 0         74, 0         74, 0         74, 0         74, 0         76, 0			518, 664	143, 780	662, 444					
73:00       DPUGS CHARGED TO PATIENTS       0       0       0       0       0       0       73.00         74:00       07400       RENAL DIALYSIS       0       273.560       273.560       -1.138       272.422       74.00         76:00       03020       OTHER ANCILLARY       0 <td></td> <td></td> <td>0 0</td> <td>9, 597, 252</td> <td>9, 597, 252</td> <td>-</td> <td>-</td> <td></td>			0 0	9, 597, 252	9, 597, 252	-	-			
76.00         03202         OTHER ANCILLARY         0         0         0         0         0         0         0         76.00         0<	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0						
76. 01       03140       CARDI AC REHAB       637, 415       1, 081, 389       1, 718, 804       -101, 390       1, 617, 414       76. 0         76. 02       03070       WOMEN'S CENTER       423, 603       155, 399       579, 002       -90, 632       488, 370       76. 0         001       0000       0       0       0       0       0       0       0       0       0       76. 0         001       09001       CLINIC       329, 625       180, 703       510, 328       -43. 491       466, 722       90. 0       90. 0       90. 0       90. 0       216, 722       90. 0 <td></td> <td></td> <td>0</td> <td>273, 560</td> <td>273, 560</td> <td>-1, 138</td> <td></td> <td></td>			0	273, 560	273, 560	-1, 138				
76.02       03070       WOMEN'S CENTER       423,603       155,399       579,002       -90,632       488,370       76.0         0       03330       ENDOSCOPY       0			637 415	U 1 081 389	1 718 804	-101 390	-			
OUTPATIENT SERVICE COST CENTERS         2 <th2< th="">         2         2         <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<></th2<>										
90. 00         09000         CLINIC         329, 625         180, 703         510, 328         -43, 491         466, 837         90. 0           90. 01         09001         UTPATIENT         641, 718         664, 143         1, 305, 861         -144, 482         1, 161, 379         90. 0           90. 02         09002         NEUROPSYCHOLOGY         165, 807         50, 915         216, 722         0         216, 722         90. 0         91. 00         9000         Support         5, 424, 379         18, 293, 231         23, 717, 610         -699, 796         23, 017, 714         91. 0         91. 0         92. 0         0         0         0         0         0         92. 0         0         92. 0         0         92. 0         0         92. 0         0         92. 0         0         92. 0         0         92. 0         0         92. 0         0         92. 0         92. 0         92. 0         92. 0         92. 0         92. 0         92. 0         92. 0         95. 0         95. 0         95. 0         95. 0         95. 0         95. 0         95. 0         95. 0         95. 0         95. 0         92. 0         92. 0         92. 0         92. 0         92. 0         92. 0         92. 0         92. 0	76.03		0	0	C	0	0	76.03		
90.01       09001       0UTPATI ENT       641, 718       664, 143       1, 305, 861       -144, 482       1, 161, 379       90.0         90.02       09002       NEUROPSYCHOLOGY       165, 807       50, 915       216, 722       0       216, 722       90.0         91.00       09100       ENERGENCY       5, 424, 379       18, 293, 231       23, 717, 610       -699, 796       23, 017, 814       91.0       0       0       0       0       92.0         92.00       09200       DBSERVATI ON BEDS (NON-DI STINCT PART       0       0       0       0       0       0       0       92.0         09500       ANBULANCE SERVICES       60, 872       39, 384       100, 256       0       100, 256       95.0         SPECI AL PURPOSE COST CENTERS       50, 872       39, 384       100, 256       0       100, 256 <td>90 00</td> <td></td> <td>320 625</td> <td>180 702</td> <td>510 229</td> <td></td> <td>466 827</td> <td>90.00</td>	90 00		320 625	180 702	510 229		466 827	90.00		
90.02       NEUROPSYCHOLOGY       165,807       50,915       216,722       0       216,722       90.0         91.00       09100       EMERGENCY       5,424,379       18,293,231       23,717,610       -699,796       23,017,814       91.0         92.00       09200       DBSERVATION BEDS (NON-DISTINCT PART       0       0       0       0       92.0         09500       AMBULANCE SERVICES       60,872       39,384       100,256       0       100,256         09500       AMBULANCE SERVICES       60,872       39,384       100,256       0       100,256         09500       AMBURSABLE COST CENTERS										
91. 01       09101       SHORT STAY       0       0       0       0       91. 0         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       92. 0       92. 0         0THER REIMBURSABLE COST CENTERS       0       00, 256       0       100, 256       95. 0         95. 00       09500       AMBULANCE SERVI CES       60, 872       39, 384       100, 256       0       100, 256         95. 00       SPECI AL PURPOSE COST CENTERS       59, 386, 874       142, 496, 514       201, 883, 388       94, 767       201, 978, 155       118. 0         100.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       149, 987       172, 704       322, 691       0       322, 691       190. 0       190. 0         192. 01       19200       PHYSI CLANS' PRI VATE OFFICES       20, 482, 156       8, 416, 680       28, 898, 836       -430, 123       28, 468, 713       192. 0         192. 02       19200       PHYSI CLANS' PRI VATE OFFICES       201, 832       14, 286       216, 118       0       21, 581       192. 0         192. 02       19202       CLI NI CS       872, 753       192, 497       1, 065, 250       -1, 024       1, 064, 226       192. 0         192. 04       19207 <td>90.02</td> <td>09002 NEUROPSYCHOLOGY</td> <td>165, 807</td> <td>50, 915</td> <td>216, 722</td> <td>0</td> <td>216, 722</td> <td>90.02</td>	90.02	09002 NEUROPSYCHOLOGY	165, 807	50, 915	216, 722	0	216, 722	90.02		
92. 00         09200         DBSERVATI ON         BEDS         (NON-DI STI NCT PART         92. 0           0THER         REI MBURSABLE         COST         CENTERS         95. 00         09500         AMBULANCE         SERVI CES         0         100, 256         0         100, 256         0         100, 256         0         100, 256         0         95. 0         95. 0         SPECI AL PURPOSE         COST         CENTERS         118. 00         SUBTOTALS         SUBTOTALS         SUM OF LINES 1 through 117)         59, 386, 874         142, 496, 514         201, 883, 388         94, 767         201, 978, 155         118. 00           190.00         GIFT,         FLOWER, COFFEE SHOP & CANTEEN         149, 987         172, 704         322, 691         0         322, 691         190. 0           192.00         PHYSI CI ANS'         PRI VATE OFFICES         20, 482, 156         8, 416, 680         28, 898, 836         -430, 123         28, 468, 713         192. 0           192.01         POUDATI ON         201, 832         14, 286         216, 118         0         216, 118         192. 0           192.02         PLO20         PLOVDATI ON         201, 832         14, 286         216, 118         0         2, 518         192. 0         192.06         1			5, 424, 379	18, 293, 231	23, 717, 610	-699, 796		91.00		
OTHER         REI MBURSABLE         COST         CENTERS         95.00         OP500         AMBULANCE         SERVICES         60, 872         39, 384         100, 256         0         100, 256         95.0         95.0           SPECIAL         PURPOSE         COST         CENTERS			0	0	C	0	0	91.01		
SPECIAL PURPOSE COST CENTERS           SPECIAL PURPOSE COST CENTERS           118.00           SUBTOTALS (SUM OF LINES 1 through 117)         59, 386, 874         142, 496, 514         201, 883, 388         94, 767         201, 978, 155           118.00           NONREL MBURSABLE COST CENTERS           190.00         190.00         19200         19200         142, 987         172, 704         322, 691         0         322, 691         190.00           19200         19201 FOUNDATI ON         20, 482, 156         8, 416, 680         28, 898, 836         -430, 123         28, 468, 713         192.00           19201 FOUNDATI ON         201, 832         14, 286         216, 118         0         2, 358         0         2, 358         0         2, 358         0         2, 358         0         2, 358         0         2, 358         0         2, 358         0 <th 2"2"2"2"2"2"2"2"2"2"2"2"2"2"2"2"2"2<="" colspan="2" td=""><td></td><td>OTHER REIMBURSABLE COST CENTERS</td><td></td><td></td><td></td><td>· · · · · · · · · · · · · · · · · · ·</td><td></td><td>12.00</td></th>	<td></td> <td>OTHER REIMBURSABLE COST CENTERS</td> <td></td> <td></td> <td></td> <td>· · · · · · · · · · · · · · · · · · ·</td> <td></td> <td>12.00</td>			OTHER REIMBURSABLE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		12.00
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         59, 386, 874         142, 496, 514         201, 883, 388         94, 767         201, 978, 155         118.0           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         149, 987         172, 704         322, 691         0         322, 691         190.0         19200         19200         PHYSI CI ANS' PRI VATE OFFICES         20, 482, 156         8, 416, 680         28, 898, 836         -430, 123         28, 468, 713         192.0         19201         FOUNDATI ON         216, 418         0         216, 422.0         192.0         19202         CLI NI CS         28, 468, 713         192.0         201, 832         14, 286         216, 118         0         216, 422.0         192.0         192.02         LI NI CS         872, 753         192, 497         1, 065, 250         -1, 024         1, 064, 226         192.0         192.03         192.06         HOME HEALTH PARTNERSHI P         0         2, 358         0         2, 358         192.0         192.05         192.03         PRACTI CE MANAGEMENT         436, 160         283, 082         719, 242         0         719, 242         192.0         192.06         192.04         192.06         192.04         192.04         147, 789         144, 789         144, 789         144, 789	95.00		60, 872	39, 384	100, 256	0	100, 256	95.00		
NORREI         MBURSABLE         COST         CENTERS           190.00         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN         149, 987         172, 704         322, 691         0         322, 691         190.0           192.00         19200         PHYSI CI ANS'         PRI VATE OFFICES         20, 482, 156         8, 416, 680         28, 898, 836         -430, 123         28, 468, 713         192.0           192.01         19201         FOUNDATI ON         201, 832         14, 286         216, 118         0         216, 118         192.0           192.02         CLI NI CS         872, 753         192, 497         1, 065, 250         -1, 024         1, 064, 226         192.0           192.04         19207         WESTFI ELD         SCHOOLS         966, 055         146, 982         1, 113, 037         -1, 232         1, 111, 805         192.0           192.05         19203         PRACTI CE         MANAGEMENT         436, 160         283, 082         719, 242         0         719, 242         192.0           192.06         19204         MOB - NOBLESVI LLE         SQUARE         0         14, 789         14, 789         0         14, 789         12.0           192.06	118 00		50 386 874	142 496 514	201 883 388	94 767	201 078 155	118 00		
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       20, 482, 156       8, 416, 680       28, 898, 836       -430, 123       28, 468, 713       192.0         192.01       19201       FOUNDATI ON       201, 832       14, 286       216, 118       0       216, 118       192.0         192.02       19202       CLI NI CS       872, 753       192, 497       1, 065, 250       -1, 024       1, 064, 226       192.0         192.04       19203       WESTFI ELD SCHOOLS       966, 055       146, 982       1, 113, 037       -1, 232       1, 111, 805       192.0         192.06       19204       MOB - NOBLESVI LLE SQUARE       0       14, 789       14, 789       0       14, 789       192.0         192.07       19208       RIVERVI EW MEDI CAL ARTS       0       0       0       0       192.0         192.08       19205       RIVERVI EW MEDI CAL ARTS       0       79, 216       79, 216       0       192.0         192.09       19209       BEHAVI OR CARE       379, 311       149, 481       528, 792       0       79, 216       192.0         192.09       19209       BEHAVI OR CARE       379, 311       149, 481       528, 792       0       528, 792       192.0	110.00		37, 300, 074	142, 470, 514	201, 003, 300	74,707	201, 770, 133	110.00		
192.01       19201       FOUNDATION       201,832       14,286       216,118       0       216,118       192.0         192.02       19202       CLINICS       872,753       192,497       1,065,250       -1,024       1,064,226       192.0         192.03       19206       HOME HEALTH PARTNERSHIP       0       2,358       2,358       0       2,358       192.0         192.05       19207       WESTFIELD SCHOOLS       966,055       146,982       1,113,037       -1,232       1,111,805       192.0         192.06       19204       MOB - NOBLESVILLE SQUARE       0       14,789       14,789       0       14,789       192.0         192.07       19208       PHYSICIANS' PRIVATE OFFICES       0       0       0       192.0         192.08       19205       RIVERVIEW MEDICAL ARTS       0       79,216       79,216       0       192.0         192.09       19209       BEHAVIOR CARE       379,311       149,481       528,792       0       528,792       192.0         193.00       19300       NONPAI D WORKERS       0       0       0       0       0       0       0       193.0		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN								
192.02       19202       CLINICS       872,753       192,497       1,065,250       -1,024       1,064,226       192.0         192.03       19206       HOME HEALTH PARTNERSHIP       0       2,358       2,358       0       2,358       192.0         192.04       19207       WESTFI ELD SCHOOLS       966,055       146,982       1,113,037       -1,232       1,111,805       192.0         192.05       19203       PRACTI CE MANAGEMENT       436,160       283,082       719,242       0       719,242       192.0         192.06       19208       HYSI CI ANS' PRI VATE OFFICES       0       14,789       14,789       0       14,789       192.0         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       79,216       79,216       0       79,216       192.0         192.09       19209       BEHAVI OR CARE       379,311       149,481       528,792       0       528,792       192.0         193.00       19300       NONPAI D WORKERS       0       0       0       0       0       0       0       193.0										
192.03       19206       HOME HEALTH PARTNERSHIP       0       2,358       2,358       0       2,358       192.0         192.04       19207       WESTFI ELD SCHOOLS       966,055       146,982       1,113,037       -1,232       1,111,805       192.0         192.05       19203       PRACTI CE MANAGEMENT       436,160       283,082       719,242       0       719,242       192.0         192.06       19204       MOB - NOBLESVILLE SQUARE       0       14,789       14,789       0       14,789       192.0         192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       0       192.0         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       79,216       79,216       0       79,216       192.0         192.09       IS209       BEHAVI OR CARE       379,311       149,481       528,792       0       528,792       192.0         193.00       19300       NONPAI D WORKERS       0       0       0       0       0       0       193.0										
192.04       19207       WESTFI ELD SCHOOLS       966,055       146,982       1,113,037       -1,232       1,111,805       192.0         192.05       19203       PRACTI CE MANAGEMENT       436,160       283,082       719,242       0       719,242       192.0         192.06       19204       MOB - NOBLESVI LLE SQUARE       0       14,789       14,789       0       14,789       192.0         192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       0       192.0         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       79,216       79,216       79,216       79,216       192.0       <										
192.06       19204       MOB - NOBLESVILLE SQUARE       0       14,789       0       14,789       192.0         192.07       19208       PHYSICIANS' PRIVATE OFFICES       0       0       0       192.0         192.08       19205       RIVERVIEW MEDICAL ARTS       0       79,216       79,216       192.0         192.09       BEHAVI OR CARE       379,311       149,481       528,792       0       528,792       192.0         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.0					1, 113, 037	-1, 232				
192.07       19208       PHYSI CLANS' PRI VATE OFFICES       0       0       0       192.0         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       79, 216       79, 216       192.0         192.09       19209       BEHAVI OR CARE       379, 311       149, 481       528, 792       0       528, 792       192.0         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.0										
192.08       RI VERVI EW MEDI CAL ARTS       0       79, 216       79, 216       192.0         192.09       BEHAVI OR CARE       379, 311       149, 481       528, 792       0       528, 792       192.0         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.0			-							
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 0	192.08	19205 RI VERVI EW MEDI CAL ARTS	0		79, 216	0	79, 216	192.08		
			379, 311	149, 481	528, 792					
		19300 NONPALD WORKERS 19301 PHYSICIAN SERVICES-LYONS	0 89, 504	0 19, 277	0 108, 781					

Health Financial Systems	RI VERVI EW H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider C		Period:	Worksheet A	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/29/2021 10:	
Cost Center Description	Sal ari es	Other	Total (col. '	Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
193. 02 19302 UNI VERSI TY HS ATHLETI CS	45, 978	5, 047	51, 02	5 0	51, 025	193.02
193.03 19303 OB/GYN SPEC NEMUNALTI	531, 876	79, 646	611, 52	2 0	611, 522	193.03
193.04 19304 OB/GYN SPEC GATHERS	-1,000	2, 772	1, 77	2 0	1, 772	193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	387, 035	69, 261	456, 29	6 0	456, 296	193.05
193.06 19306 OUTPATIENT PHARMACY	516, 199	3, 266, 575	3, 782, 77	4 0	3, 782, 774	193.06
194.0007950 WORKMED	359, 111	387, 819	746, 93	0 -548	746, 382	194.00
194.01 07951 MEALS ON WHEELS	0	0		0 338, 160	338, 160	194.01
200.00 TOTAL (SUM OF LINES 118 through 199)	84, 803, 831	155, 798, 986	240, 602, 81	7 0	240, 602, 817	200. 00

CLASSI	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider CCN: 15-00	59 Period: Works From 01/01/2020	sheet A
				To 12/31/2020 Date	/Time Prepare
	Cost Center Description	Adjustments	Net Expenses	//29/	/2021 10:51 a
		(See A-8)	For		
			Allocation		
G	ENERAL SERVICE COST CENTERS	6.00	7.00		
	0100 CAP REL COSTS-BLDG & FIXT	-31,835	20, 563, 504		1.
	0400 EMPLOYEE BENEFITS DEPARTMENT	-425, 990			4.
	0500 ADMINISTRATIVE & GENERAL	-15, 368, 532	24, 200, 517		5.
1	0700 OPERATION OF PLANT	0			7.
	10800 LAUNDRY & LINEN SERVICE 10900 HOUSEKEEPING	0	., .= .,		8.
	1000 DI ETARY	-73, 615			10.
	1100 CAFETERI A	-590, 392			11.
	1300 NURSI NG ADMI NI STRATI ON	-4,355			13
	1400 CENTRAL SERVICES & SUPPLY	-44, 761			14.
	1500 PHARMACY	-4, 865, 523			15
	11600 MEDI CAL RECORDS & LI BRARY 11700 SOCI AL SERVI CE	-151 0			16
	2300 PARAMED ED PRGM PHARMACY	0			23
	NPATIENT ROUTINE SERVICE COST CENTERS	0	201, 200		23
. 00 0	3000 ADULTS & PEDIATRICS	0	10, 250, 948		30
1	3100 I NTENSI VE CARE UNI T	0			31
	4100 SUBPROVIDER - IRF	0			41
	14300 NURSERY 14400 SKILLED NURSING FACILITY	0	0		43
	NCILLARY SERVICE COST CENTERS	0	0		44
	5000 OPERATING ROOM	-2, 517, 349	6, 626, 447		50
. 00  0	5200 DELIVERY ROOM & LABOR ROOM	0	0		52
1	5400 RADI OLOGY-DI AGNOSTI C	-2, 079			54
1	5500 RADI OLOGY-THERAPEUTI C	0	.,		55
	5700 CT SCAN	-1, 617			57
	13630 ULTRA SOUND 15800 MRI	-158			57
	55000 CARDI AC CATHETERI ZATI ON	-735,000			59
	6000 LABORATORY	-218, 898			60
. 01  0	6001 BLOOD LABORATORY	0	0		60
	6300 BLOOD STORING, PROCESSING & TRANS.	0	452, 268		63
	6400 INTRAVENOUS THERAPY	0	0		64
	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	0	1, 763, 246 6, 890, 833		65
	6700 OCCUPATI ONAL THERAPY	0	0, 070, 000		67
	6800 SPEECH PATHOLOGY	0	0		68
. 00  0	6900 ELECTROCARDI OLOGY	-76, 415	585, 844		69
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		71
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 597, 252		72
	17300 DRUGS CHARGED TO PATIENTS 17400 RENAL DIALYSIS	0	0 272, 422		73
	3020 OTHER ANCI LLARY	0	272, 122		74
	3140 CARDI AC REHAB	0			76
	3070 WOMEN' S CENTER	0	488, 370		76
	3330 ENDOSCOPY	0	0		76
	UTPATIENT SERVICE COST CENTERS	0.40/	1/2 /51		
	99000 CLI NI C 19001 OUTPATI ENT	-3, 186 2, 150			90 90
	19001 OUTPATTENT 19002 NEUROPSYCHOLOGY	2, 150			90
	19100 EMERGENCY	-10, 181, 983			91
	9101 SHORT STAY	0			91
	9200 OBSERVATION BEDS (NON-DISTINCT PART				92
	THER REIMBURSABLE COST CENTERS	-			
	9500 AMBULANCE SERVICES	0	100, 256		95
8.00	PECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	-35, 139, 689	166, 838, 466		118
	ONREI MBURSABLE COST CENTERS	33, 137, 007	100,000,400		
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	322, 691		190
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	28, 468, 713		192
	9201 FOUNDATI ON	0	216, 118		192
	9202 CLINICS	0	1,064,226		192
	9206 HOME HEALTH PARTNERSHIP		2,358		192 192
	9207 WESTFI ELD SCHOOLS 9203 PRACTI CE MANAGEMENT		1, 111, 805 719, 242		192
	9204 MOB - NOBLESVILLE SQUARE	0	14, 789		192
	9208 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192
	9205 RI VERVI EW MEDI CAL ARTS	0	79, 216		192
	9209 BEHAVI OR CARE	0	528, 792		192
3.001	9300 NONPALD WORKERS	0	0		193 193
	9301 PHYSI CLAN SERVI CES-LYONS	0	108, 781		

Health Financial Systems	RI VERVI EW	RI VERVI EW HOSPI TAL			In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC	N: 15-0059	Peri od:	Worksheet A		
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 10:		
Cost Center Description	Adjustments	Net Expenses					
	(See A-8)	For					
		Allocation					
	6.00	7.00					
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	611, 522				193.03	
193.04 19304 OB/GYN SPEC GATHERS	0	1, 772				193.04	
193. 05 19305 OB SPECIALI STS DAVENPORT	0	456, 296				193.05	
193. 06 19306 OUTPATI ENT PHARMACY	0	3, 782, 774				193.06	
194. 00 07950 WORKMED	0	746, 382				194.00	
194.0107951 MEALS ON WHEELS	0	338, 160				194.01	
200.00 TOTAL (SUM OF LINES 118 through 199)	-35, 139, 689	205, 463, 128				200.00	

Heal th	Financial Systems		RIVERVIEW H	OSPI TAL		In Lieu	of Form (	CMS-2552-10
RECLAS	SI FI CATI ONS			Provider CCN:	15-0059	Period:	Worksheet	A-6
						From 01/01/2020 To 12/31/2020	Date/Time	Prepared:
							7/29/2021	10:51 am
	Cost Contor	Increases	Calany	Othor				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00				
	A - CAFETERIA RECLASS	3.00	4.00	5.00				
1.00	CAFETERI A	11.00	860, 937	1, 310, 283				1.00
1.00			860, 937	1, 310, 283				1.00
	B - MEALS ON WHEELS RECLASS	I		.,				
1.00	MEALS ON WHEELS	194.01	132, 672	205, 488				1.00
	0		132, 672	205, 488				
	C – INSURANCE RECLASS							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	15 <u>4, 2</u> 27				1.00
	0		0	154, 227				
	D - MED SUPPLY RECLASS	I	I					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5, 739, 168				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0. 00 0. 00	0	0 0				5.00
7.00		0.00	0	0				6.00 7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	Ő				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
18.00		0.00	0	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 0				25.00
28.00 27.00		0.00	0	0				26.00 27.00
27.00	<u> </u>		— — — <u>o</u>	5, 739, 168				27.00
	E - RSMA RECLASS		Ŋ	5,757,100				
1.00	OPERATING ROOM	50, 00	360, 534	0				1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 012				2.00
	0 — — — — — —		360, 534	5,012				
	F - PARAMED ED RECLASS PHARM	RESI DENCY	· · ·					
1.00	PARAMED ED PRGM PHARMACY	23.00	245, 627	5, 628				1.00
	0		245, 627	5, 628				
	G - COMMUNITY RELATIONS RECLA	ASS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	237, 270				1.00
	0			237, 270				
	H - OBGYN SPEC GATHERS RECLAS	SS						
1.00	OB/GYN_SPEC_GATHERS	1 <u>93.</u> 04	1,000	<u>0</u>				1.00
	TOTALS		1,000	0				
	I - ALLOCATED BENEFITS RECLAS							
1 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	342, 824				1 1 00
1.00		<u> </u>	+					1.00
	TOTALS Grand Total: Increases	4.00	00 1, 600, 770	<u>342, 824</u> 342, 824 7, 999, 900				500.00

CLAS	SI FI CATI ONS			Provi der	CCN: 15-005	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet	Prepared
		Decreases						7/29/2021	10.51 am
	Cost Center	Line #	Sal ary	Other	Wkst. A-7	Ref.			
	6.00	7.00	8.00	9.00	10.00	)			
	A - CAFETERIA RECLASS								
00	DI ETARY	10.00	860, 937	1, 310, 28	3	0			1.0
	0	T	860, 937	1, 310, 28	3				
	B - MEALS ON WHEELS RECLASS					I			
00	DI ETARY	10.00	132, 672	205, 48	8	0			1.0
			132,672	205, 48					
	C - INSURANCE RECLASS	I			-				
00	CAP REL COSTS-BLDG & FIXT	1.00	0	154, 22	7	12			1.0
00			0	154, 22					
	D - MED SUPPLY RECLASS		9	101, 22	·				
00	DI ETARY	10.00	0	7, 52	8	0			1.0
00	PHARMACY	15.00	0	15, 28		o			2.0
00	ADULTS & PEDIATRICS	30.00	0			o			3.0
	INTENSIVE CARE UNIT	30.00	0	466, 41		ol			4.0
00	SUBPROVIDER - IRF			292,86					
00		41.00	0	90, 59		0			5.0
00	OPERATING ROOM	50.00	0	2, 499, 56		0			6.0
00	RADI OLOGY-DI AGNOSTI C	54.00	0	10, 01		0			7.0
00	RADI OLOGY-THERAPEUTI C	55.00	0	23		0			8.0
00	CT SCAN	57.00	0	93, 16		0			9.0
). 00	ULTRA SOUND	57.01	0	2,60		0			10.0
. 00	MRI	58.00	0	5,40		0			11.0
2.00	CARDI AC CATHETERI ZATI ON	59.00	0	982, 58	1	0			12.0
3.00	LABORATORY	60.00	0	2, 82	1	0			13.0
l. 00	RESPI RATORY THERAPY	65.00	0	92, 59	0	0			14.0
5.00	PHYSI CAL THERAPY	66.00	0	6, 28	0	0			15.0
5.00	ELECTROCARDI OLOGY	69.00	0	18	5	o			16.0
3.00	RENAL DI ALYSI S	74.00	o	1, 13	8	o			18.0
9.00	CARDI AC REHAB	76.01	0	101, 39		0			19.0
). 00	WOMEN' S CENTER	76.02	0	90, 63		0			20.0
. 00	CLINIC	90.00	0	43, 49		o			21.0
2.00	OUTPATI ENT	90.01	0	144, 48		o			22.0
3.00	EMERGENCY	91.00	0	356, 97		0			23.0
I. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	430, 12		o			24.0
5.00	CLINICS	192.00	0	430, 12		o			24.0
5.00 5.00	WESTFIELD SCHOOLS	192.02	0	1, 02		ol			25.0
			0			ol			
. 00	WORKMED	<u> </u>		54		— 빅			27.0
			U	5, 739, 16	0				
00	E - RSMA RECLASS	F0.00		0/E E4	4	0			- 10
00	OPERATI NG ROOM	50.00	0	365, 54	0	0			1.0
00			0		<u>v                                    </u>	0			2.0
	0		0	365, 54	6				
	F - PARAMED ED RECLASS PHARM				-				
00	PHARMACY		245, 627	<u>5, 6</u> 2	8	0			1.0
	0		245, 627	5, 62	8				
	G - COMMUNITY RELATIONS RECLA	SS							
00	ADMI NI STRATI VE & GENERAL	5.00	237, 270		0	0			1.0
		+	237, 270		o – – –	_ 1			
	H - OBGYN SPEC GATHERS RECLAS	S							
00	OB/GYN SPEC GATHERS	193.04	0	1,00	0	0			1.(
20	TOTALS		0	_ <u>1,0</u> 0		- 4			
	I - ALLOCATED BENEFITS RECLAS		9	1,00	~				
00	EMERGENCY		0	342, 82	4	0			1.0
00		<u> </u>	— — — <u> </u>	<u>342, 8</u> 2 342, 82		— 빅			1.0
	TOTALS Grand Total: Decreases		U	342, 82	4				500.0

	Financial Systems	RI VERVI EW					u of Form CMS-2	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0059		riod: om 01/01/2020 12/31/2020	Worksheet A-7 Part I Date/Time Pre 7/29/2021 10:	pared:
				Acquisition	IS			
		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	T BALANCES						
1.00	Land	15, 961, 384	0		0	0	0	1.00
2.00	Land Improvements	3, 133, 150	27, 084		0	27, 084	0	2.00
3.00	Buildings and Fixtures	0	165, 529, 203		0	165, 529, 203	0	3.00
4.00	Building Improvements	166, 003, 248	0		0	0	164, 603, 393	4.00
5.00	Fixed Equipment	45, 789, 541	6, 024, 838		0	6, 024, 838	0	5.00
6.00	Movable Equipment	119, 113, 921	0		0	0	1, 870, 120	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	350, 001, 244	171, 581, 125		0	171, 581, 125	166, 473, 513	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	350, 001, 244	171, 581, 125		0	171, 581, 125	166, 473, 513	10.00
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	15, 961, 384	0					1.00
2.00	Land Improvements	3, 160, 234	0					2.00
3.00	Buildings and Fixtures	165, 529, 203	0					3.00
4.00	Building Improvements	1, 399, 855	0					4.00
5.00	Fixed Equipment	51, 814, 379	0					5.00
6.00	Movable Equipment	117, 243, 801	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	355, 108, 856	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	355, 108, 856	0					10.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0059	Period: From 01/01/2020	Worksheet A-7 Part II		
				To 12/31/2020			
		SU					
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
				(see instructions)	instructions)		
	9.00	10.00	11.00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	/N 2, LINES 1 a	and 2				
1.00 CAP REL COSTS-BLDG & FIXT	20, 556, 795	0		0 192, 771	0	1.00	
3.00 Total (sum of lines 1-2)	20, 556, 795	0		0 192, 771	0	3.00	
	SUMMARY O	F CAPI TAL					
Cost Center Description	Other	Total (1)					
	Capi tal -Rel at	(sum of cols.					
	ed Costs (see	9 through 14)					
	instructions)						
	14.00	15.00					
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	and 2				
1.00 CAP REL COSTS-BLDG & FIXT	0	20, 749, 566				1.00	
3.00 Total (sum of lines 1-2)	0	20, 749, 566				3.00	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
	COMPUTATION OF RATIOS ALLOCATION OF					
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 CAP REL COSTS-BLDG & FIXT	355, 108, 856	0	355, 108, 85	6 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	355, 108, 856		355, 108, 85	6 1.000000	0	3.00
					F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1	1		
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 20, 556, 795		1.00
3.00 Total (sum of lines 1-2)	0	0		0 20, 556, 795	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	-31, 835	38, 544		0 0	20, 563, 504	1.00
3.00 Total (sum of lines 1-2)	-31, 835	38, 544		0 0	20, 563, 504	3.00

Heal th Financial	Systems
AD ILISTMENTS TO E	YDENSES

	Financial Systems MENTS TO EXPENSES		RI VERVI EW		In Lie eriod:	u of Form CMS-2 Worksheet A-8	2552-10
ADJUSTI	IENTS TO EAFENSES				om 01/01/2020		
				Expense Classification on To/From Which the Amount is t			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1 00		1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4.00	5.00	1.00
	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)				1.00	0	1.00
	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
	Investment income - other (chapter 2)		0		0.00	0	3.00
	Trade, quantity, and time		0		0.00	о	4.00
	discounts (chapter 8) Refunds and rebates of		о		0.00	0	5.00
	expenses (chapter 8) Rental of provider space by		o		0.00	0	6.00
	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
	Television and radio service (chapter 21)		0		0.00	0	8.00
10.00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -17, 652, 169		0.00	0 0	9.00 10.00
	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
	Related organization transactions (chapter 10)	A-8-1	238, 588	3		0	12.00
14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -373, 006	CAFETERI A	0. 00 11. 00	0 0	14.OC
	Rental of quarters to employee and others		0		0.00	0	15.00
	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. OC
	books, etc.) Vending machines		0		0. 00	О	20.00
	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
2.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
4.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
5.00	limitation (chapter 14) Utilization review – physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
7.00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
8.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
80. 00	Physicians' assistant 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 & PEDI ATRI CS	30. 00		30. 99

Heal th	Fi nano	ci al	Systems
AD JUST	MENTS	TO F	XPENSES

Health Financial Systems		RI VERVI EW	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				eriod:	Worksheet A-8	
				rom 01/01/2020 o 12/31/2020		pared:
			Expense Classification on	Worksheet A	7/29/2021 10:	<u>51 am</u>
			To/From Which the Amount is			
				, , , , , , , , , , , , , , , , , , ,		
Cost Center Descr	ription Basis/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	Allouite		Erne "	Ref.	
	1.00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00		31.00
pathology costs in exc	ess of					
limitation (chapter 14						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Inter		0.010.000		F 00		
33.00 HAF EXPENSE			ADMINI STRATI VE & GENERAL	5.00		
33. 01 PHYSI CI AN RECRUI TMENT 33. 02 OTHER REV MEDI CAL REPO			ADMINISTRATIVE & GENERAL MEDICAL RECORDS & LIBRARY	5.00 16.00		
33. 03 OTHER REVENUES ->PURCH			ADMINISTRATIVE & GENERAL	5.00		
DI SCOUNTS		-5,777	COMPANY CALIFIC A GENERAL	5.00		33.03
33. 04 RADI OLOGY - OTHER REVEN	UE-CDS B	-2,079	RADI OLOGY-DI AGNOSTI C	54.00	0	33.04
FOR LEG		, .				
33. 05 AMBULANCE OTHER REVENU	E B	0	AMBULANCE SERVICES	95.00	0	33.05
33.06 LABORATORY -> OTHER RE	VENUE B	-217, 943	LABORATORY	60.00	0	33.06
33. 07 MATERNI TY CENER OTHER		0	ADULTS & PEDIATRICS	30.00	0	33.07
33.08 INFORMATION SYSTEMS OT			ADMI NI STRATI VE & GENERAL	5.00		
33.09 ADMINISTRATION LEAN TE			ADMI NI STRATI VE & GENERAL	5.00		
33.10 EDUCATION -> OTHER REV			ADMI NI STRATI VE & GENERAL	5.00		
33. 11 SHO/UNCLAI MED REFUNDS	В		ADMI NI STRATI VE & GENERAL	5.00		
33. 12 OP PHARMACY REVENUE	A	-4, 865, 523		15.00		
33. 13 DI ETARY SALES PR DEDUC			CAFETERIA	11.00		
33. 14 WELLNESS SERVICES - EXTERNAL->-OTHER	В	-20, 310	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33. 15 OTHER REV PREMIER PROG	RAM B	-11 761	CENTRAL SERVICES & SUPPLY	14.00	0	33.15
33. 16 WESTFI ELD BI STRO-OTHER			DI ETARY	10.00		
33. 17 NON-OP REV -> MI SCELLA			CAP REL COSTS-BLDG & FIXT	1.00		
INTEREST						
33.18 COMMUNITY RELATIONS	A	-2, 347, 628	ADMI NI STRATI VE & GENERAL	5.00	0	33.18
33.19 COMMUNITY RELATIONS BE	NEFITS A	-28, 320	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33. 20 CRNA	A	-675,000	OPERATING ROOM	50.00	0	33.20
33.21 I HA LOBBYING EXPENSE	A	-5, 016	ADMI NI STRATI VE & GENERAL	5.00		33.21
33. 22 OTHER REVENUE FITNESS	В		ADMI NI STRATI VE & GENERAL	5.00		
33. 23 CV SERVICES-OTHER REVE			ELECTROCARDI OLOGY	69.00		
33. 24 CT SCAN-OTHER REVENUE	В		CT SCAN	57.00		
33. 25 BLOOD BANK OTHER REVEN	UE B	0	BLOOD STORING, PROCESSING &	63.00	0	33.25
33. 26 MATERIAL MANAGEMENT RE	NTAL B	0	TRANS. OPERATION OF PLANT	7.00	0	33.26
I NCOME	NTAL B	0	OFERATION OF FEANT	7.00	0	33.20
33. 27 FISCAL SERVICES COMMER	CE BANK B	-83 128	ADMI NI STRATI VE & GENERAL	5.00	О	33.27
REBATE		00, 120		5.00		/
33. 28 ULTRASOUND - OTHER REV	ENUE B	-158	ULTRA SOUND	57.01	0	33.28
33.29 HHS STIMULUS (COVID) -			NURSING ADMINISTRATION	13.00		
REVENUE						
33.30 WOUND CARE-OTHER REVEN			OUTPATI ENT	90.01		
33.31 NON-OP EXPENSE INVESTM			ADMINISTRATIVE & GENERAL	5.00		
33. 32 OTHER MISC REVENUE	В		ADMINISTRATIVE & GENERAL	5.00		
33. 33 RVH MEDICATION MGMT CL			LABORATORY	60.00		
33. 34 ADMI NI STRATI ON	A	-2, 108	ADMINISTRATIVE & GENERAL	5.00	0	33.34
RECRUITMENT/SPECIAL E	thruu (0)	DE 100 (00				E0.00
50.00 TOTAL (sum of lines 1 (Transfer to Worksheet		-35, 139, 689				50.00
column 6, line 200.)						
	references in this c		CMC Dub 1E 1		I	I

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	RI VERVI EW	/ HOSPI TAL	In Lieu of Form CMS-2552-10		
STATEMI OFFI CE		RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0059		Period: From 01/01/2020	Worksheet A-8	3-1
				To 12/31/2020	Date/Time Pre 7/29/2021 10:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	OPERATING ROOM	624, 640	386, 052	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			624, 640	386, 052	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas not	been posted to worksheet A,	corumns r and/or 2,	the amount a	riowable sn	nould be indicated in co	biumn 4 of this part	•		
					Related Organization(s)	and/or Home Office			
				_					
	Symbol (1)	Name	Perc	centage of	Name	Percentage of			
			Ov	wnershi p		Ownershi p			
	1.00	2.00		3.00	4.00	5.00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

r or mour oome					
6.00	В	RSMA	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00 G. (	Other (financial or				100.00
non-	-financial) specify:				

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

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

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

organi zati on.

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

Health Financial Systems RIVERVIEW	OSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOM	Provider CCN: 15-0059	Period: From 01/01/2020	Worksheet A-8-1
OFFICE COSTS			Date/Time Prepared:

			7/29/2021 10:	51 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	238, 588	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	238, 588			5.00

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

nas not	been posted to worksheet A,	COLUMNS 1 a	anu/or z,	the amount	arrowabre	shourd be	i nui cateu	III COLUMIT 4 OF	this part.	
	Related Organization(s)									
	and/or Home Office									
	Tuna of Ducinooo									
	Type of Business									
	6.00									
	B. INTERRELATIONSHIP TO RELATIONSHIP	TED ORGANIZ	ATLON(S)	AND/OR HOME	OFFLCE:					

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

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

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

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

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

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

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

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

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

Health Financial Systems		RI VERVI EW	IVERVIEW HOSPITAL In Lieu			eu of Form CMS-	2552-10	
	R BASED PHYSIC			Provider 0		Period:	Worksheet A-8	3-2
						From 01/01/2020 To 12/31/2020		norod.
						To 12/31/2020	Date/Time Pre 7/29/2021 10:	51 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	<u>U uni</u>
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	377, 360		C			1.00
2.00		ADMINISTRATIVE & GENERAL	4, 192, 953		C			2.00
3.00		NURSING ADMINISTRATION	4, 355		C	-	-	3.00
4.00		OPERATING ROOM	2, 080, 937	2, 080, 937	C	0	0	4.00
5.00		CARDIAC CATHETERIZATION	735, 000		C	0	0	5.00
6.00		ELECTROCARDI OLOGY	76, 395		C	0	-	6.00
7.00		CLINIC	3, 186		C	0	0	7.00
8.00		EMERGENCY	10, 181, 983		C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0. 00		0	0	C	, s	0	10.00
200.00	William A. L. Saa //	Cost Costos (Dhusi si sa	17, 652, 169 Unadj usted RCE		Cost of		U Dhuai ai an Caat	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Limit	Unadjusted RCE		Provider Component	Physician Cost of Malpractice	
		Identifier		Limit	Continuing	Share of col.	Insurance	
				LI IIII L	Education	12	Thisurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	0.00	0	12.00			1.00
2.00		ADMI NI STRATI VE & GENERAL	0	-	-	-	-	2.00
3.00		NURSING ADMINISTRATION	0	0	C			3.00
4.00		OPERATING ROOM	0	0	C	0	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	0	C	0	0	5.00
6.00	69.00	ELECTROCARDI OLOGY	0	0	C	0	0	6.00
7.00	90.00	CLINIC	0	0	C	0	0	7.00
8.00	91.00	EMERGENCY	0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0	C	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
1.00	1.00		15.00	16.00	17.00	18.00		1 00
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	C			1.00
2.00		ADMI NI STRATI VE & GENERAL	0	0	C			2.00
3.00		NURSING ADMINISTRATION	0	0	C			3.00
4.00		OPERATING ROOM	0	-	0	2/000//0/		4.00
5.00 6.00		CARDI AC CATHETERI ZATI ON ELECTROCARDI OLOGY		0	C			5.00 6.00
	69.00	CLINIC	0	0	-			
7.00 8.00		EMERGENCY		0	C			7.00 8.00
8.00 9.00	91.00 0.00			0				8.00 9.00
9.00 10.00	0.00		0	0	C	-		9.00 10.00
200.00	0.00			0				200.00
200.00		1	0	I U		17,052,109	I	200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	RI VERVI EW	HOSPITAL Provider CO	CN: 15-0059 Pe	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
0001 //					om 01/01/2020	Part I	narod
					0 12/31/2020	7/29/2021 10:	51 am
			CAPI TAL RELATED COSTS				
	Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI V	
		for Cost		BENEFI TS		E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		<u>col.7)</u> 0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS		1.00	1.00		0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	20, 563, 504					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 784, 424		9, 880, 131			4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	24, 200, 517	1, 498, 533	1,063,923	26, 762, 973	26, 762, 973	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	8, 214, 024 1, 421, 971	7, 490, 295 48, 605	266, 296 8, 602	15, 970, 615 1, 479, 178	2, 517, 017 233, 123	
9.00	00900 HOUSEKEEPI NG	2, 162, 778		135, 045	2, 337, 141	368, 340	
10.00	01000 DI ETARY	775, 657	412, 891	40, 160	1, 228, 708	193, 648	
	01100 CAFETERI A	1, 580, 828	0	101, 346	1, 682, 174	265, 116	
	01300 NURSING ADMINISTRATION	877, 614		83, 943	961, 557	151, 544	
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	7, 312, 317 14, 716, 842	232, 669	75, 023	7,620,009	1, 200, 936	
	01600 MEDICAL RECORDS & LIBRARY	14, 716, 842	290, 159 77, 200	269, 551 96, 127	15, 276, 552 1, 486, 088	2, 407, 630 234, 212	
	01700 SOCIAL SERVICE	746, 260		72, 637	873, 782	137, 711	
	02300 PARAMED ED PRGM PHARMACY	251, 255		28, 914	285, 347	44, 972	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	10, 250, 948		1,074,341	14, 389, 534	2, 267, 834	
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	3, 275, 409 2, 599, 264		340, 094 174, 592	4, 074, 527 3, 245, 407	642, 158 511, 486	
	04300 NURSERY	2, 377, 204	471, 551	0	3, 243, 407	0	
	04400 SKILLED NURSING FACILITY	0	, i i i i i i i i i i i i i i i i i i i	0	0	0	1
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	6, 626, 447	1, 761, 167	499, 683	8, 887, 297	0	
	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 519, 550 1, 069, 735		226, 424 57, 923	3, 189, 865 1, 367, 375	502, 732 215, 502	
57.00	05700 CT SCAN	408, 057	237, 717	40, 107	448, 164	70, 632	
	03630 ULTRA SOUND	424, 782	0	45, 573	470, 355	74, 129	
58.00	05800 MRI	341, 623		35, 331	376, 954	59, 409	
	05900 CARDI AC CATHETERI ZATI ON	993, 301	93, 301	101, 499	1, 188, 101	187, 248	
60.00 60.01	06000 LABORATORY 06001 BLOOD LABORATORY	7, 960, 960	478, 666	367, 588 0	8, 807, 214 0	1, 388, 043 0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	452, 268	68, 080	0	520, 348	82,008	
64.00	06400 I NTRAVENOUS THERAPY	02,200	00,000	0	020,010	02,000	
65.00	06500 RESPI RATORY THERAPY	1, 763, 246	36, 211	173, 068	1, 972, 525	310, 876	65.00
66.00	06600 PHYSI CAL THERAPY	6, 890, 833		529, 137	7, 576, 909	1, 194, 144	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	585, 844	0 221, 678	0 61, 055	0 868, 577	0 136, 890	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	005, 044	221,070	01,035	000, 377		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 597, 252	0	0	9, 597, 252	1, 512, 556	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DI ALYSI S	272, 422	31, 034	0	303, 456	47, 826	
	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	0	0 292, 598	0 75, 034	1 005 046	212.040	
	03070 WOMEN' S CENTER	1, 617, 414 488, 370		49, 865	1, 985, 046 846, 133	312, 849 133, 353	
	03330 ENDOSCOPY	0		47,005	040, 133	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	463, 651	80, 540	38, 802	582, 993	91, 881	
	09001 OUTPATI ENT	1, 163, 529		75, 540	1, 356, 355	213, 766	
	09002 NEUROPSYCHOLOGY	216, 722		19, 518	245, 694 14, 182, 629	38, 722	
	09100 EMERGENCY 09101 SHORT STAY	12, 835, 831	708, 262	638, 536 0	14, 182, 629	2, 235, 225	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	100, 256	9, 120	7, 166	116, 542	18, 367	95.00
110 00	SPECIAL PURPOSE COST CENTERS	1// 000 ///	10 204 100	6 070 440	140 540 074	20,001,005	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	166, 838, 466	19, 296, 102	6, 872, 443	162, 563, 376	20, 001, 885	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	322, 691	201, 769	17, 656	542, 116	85, 439	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	28, 468, 713		2, 411, 048	31, 945, 394	5, 034, 649	
	19201 FOUNDATI ON	216, 118	0	23, 759	239, 877	37, 805	192.01
	19202 CLI NI CS	1, 064, 226		102, 737	1, 166, 963	183, 917	
192.02	ACCOLUCIE LIEAL TH DADTHEDCHLD	2, 358	0	0	2, 358		192.03
192. 02 192. 03	19206 HOME HEALTH PARTNERSHIP			440 70-	4 005 555	400 4	
192. 02 192. 03 192. 04	19207 WESTFIELD SCHOOLS	1, 111, 805		113, 720	1, 225, 525	193, 146	
192. 02 192. 03 192. 04 192. 05	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT	1, 111, 805 719, 242	0	51, 343	770, 585	121, 447	192.05
192.02 192.03 192.04 192.05 192.06	19207 WESTFIELD SCHOOLS	1, 111, 805	0			121, 447 2, 331	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CO		Period: From 01/01/2020 To 12/31/2020		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS BLDG & FI XT	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
	0	1.00	4.00	4A	5.00	
192. 09 19209 BEHAVI OR CARE	528, 792	0	44,65	573, 443	90, 376	192.09
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	108, 781	0	10, 53	6 119, 317	18, 805	193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	51, 025	0	5, 41	2 56, 437	8, 895	193.02
193.03 19303 OB/GYN SPEC NEMUNALTI	611, 522	0	62, 61	0 674, 132	106, 245	193.03
193.04 19304 OB/GYN SPEC GATHERS	1, 772	0		0 1,772	279	193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	456, 296	0	45, 56	501, 856	79, 094	193.05
193. 06 19306 OUTPATI ENT PHARMACY	3, 782, 774	0	60, 76	3, 843, 539	605, 753	193.06
194. 00 07950 WORKMED	746, 382	0	42, 27	3 788, 655	124, 294	194.00
194.01 07951 MEALS ON WHEELS	338, 160		15, 61		55, 756	194.01
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	205, 463, 128	20, 563, 504	9, 880, 13	205, 463, 128	26, 762, 973	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	RI VERVI EW	HOSPI TAL Provi der C		In Lie eriod: om 01/01/2020	u of Form CMS-: Worksheet B Part I	2552-10
				To		Date/Time Pre 7/29/2021 10:	epared: 51 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7. 00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	18, 487, 632	4 700 500				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	78, 281 63, 324	1, 790, 582 0				8.00 9.00
10.00	01000 DI ETARY	664, 988	0		2, 097, 743		10.00
11.00	01100 CAFETERIA	0	0	72, 795	0	2, 020, 085	1
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0 374, 728	0 14, 511	Ŭ	0	30, 322 45, 637	
15.00	01500 PHARMACY	467, 321	0		Ō	118, 998	1
16.00	01600 MEDICAL RECORDS & LIBRARY	124, 336	0	,	0	57, 181	
17.00 23.00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM PHARMACY	88, 396 8, 339	0	-	0	24, 162 3, 677	
201 00	INPATIENT ROUTINE SERVICE COST CENTERS	0,007		· ·		0,0,,	20100
30.00	03000 ADULTS & PEDIATRICS	4, 935, 168			1, 356, 696	419, 542	
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	739, 288 759, 464	141, 074 150, 836		177, 466 563, 581	108, 424 72, 763	
43.00	04300 NURSERY	0	0		0	0	1
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	2, 836, 475	187, 377	278, 180	0	182, 745	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		Ö	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	714, 916	113, 054		0	100, 111	1
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	386, 080 0	15, 619 0		0	19, 096 16, 764	
57.01	03630 ULTRA SOUND	0	0		0	15, 050	1
58.00	05800 MRI	0	0	2,000	0	13, 264	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	150, 268 770, 923	49, 812 0		0	31, 922 154, 311	
60.01	06001 BLOOD LABORATORY	0	0	0, 774	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	109, 648	0	0	0	0	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 58, 321	0	0 7, 799	0	0 70, 482	
66. 00	06600 PHYSI CAL THERAPY	252, 760	16, 279		0	232, 525	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 357, 027	0 16, 569	-	0	0 27, 188	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0, 307	0	0	27, 100	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 49, 982	0	0	0	0	
	03020 OTHER ANCI LLARY	49,982	0	0	0		76.00
76.01	03140 CARDI AC REHAB	471, 248			0	40, 155	76.01
76.02	03070 WOMEN' S CENTER 03330 ENDOSCOPY	495, 889 0	9, 630 0		0	25, 136 0	76.02
70.05	OUTPATIENT SERVICE COST CENTERS	0	0		0	0	70.03
90.00	09000 CLINIC	129, 716	2, 612		0	19, 355	
90. 01 90. 02	09001 OUTPATI ENT 09002 NEUROPSYCHOLOGY	188, 897 15, 226	52, 451 0		0	31, 145 7, 075	1
91.00	09100 EMERGENCY	1, 140, 702	260, 592		0	115, 300	
91.01	09101 SHORT STAY	0	0	0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	14, 688	0	0	0	3, 769	95.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)           NONREIMBURSABLE COST CENTERS	16, 446, 399	1, 636, 976	2, 620, 615	2,097,743	1, 986, 099	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	324, 962	0	2,600	0	13, 581	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 716, 271	152, 287	0	0		192.00
	19201 FOUNDATI ON 29902 CLI NI CS	0	0 686	0 145, 590	0		192.01 192.02
	19202 CENTICS 19206 HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
	19207 WESTFI ELD SCHOOLS	0	0		0		192.04
	19203 PRACTICE MANAGEMENT 19204 MOB - NOBLESVILLE SQUARE	0	633		0		192.05 192.06
	19204 MOB - NOBELSVILLE SCOARE	0	0	0	0	0	192.00
	19205 RI VERVI EW MEDI CAL ARTS	0	0	0	0	0	192.08
	9 19209 BEHAVI OR CARE 0 19300 NONPAI D WORKERS	0	0	0	0		192.09 193.00
	19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0		193.00
193.02	19302 UNI VERSI TY HS ATHLETI CS	0	0	0	0		193.02
193.03	3 19303 OB/GYN SPEC NEMUNAI TI	0	0	0	0	0	193.03

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0059	Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020		
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	0	193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	0	0		0 0	0	193.05
193. 06 19306 OUTPATI ENT PHARMACY	0	0		0 0	0	193.06
194. 00 07950 WORKMED	0	0		0 0	0	194.00
194.0107951 MEALS ON WHEELS	0	0		0 0	11, 746	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	18, 487, 632	1, 790, 582	2, 768, 80	2, 097, 743	2, 020, 085	202.00

COST ALLIGATION - GENERAL SERVICE COSTS         IPPO dir CCR 15-007         Prin dir CR 15-007 <th>Health Financial Systems</th> <th>RI VERVI EW I</th> <th>HOSPI TAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-:</th> <th>2552-10</th>	Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
To         12/31/2002         To         12/31/2002         To				CN: 15-0059	Period <sup>.</sup>	Worksheet B	
Cost Center Description         NUMBER NOT ADMINISTRATE         CENTRAL SUBJECT         PRAMACY ADMINISTRATE         PRAMACY SUBJECT         ALTER COL A         SUBJECT         ALTER COL A				-	To 12/31/2020	Date/Time Pre	
N         SHPVY         LIBMAY         LIBMAY         LIBMAY           0.00         0100 CAP SEL COST CHUESE         13.00         17.00         17.00         17.00           0.00         0000 CAP SEL COST CHUESE         13.00         17.00         17.00         4.00           5.00         0000 CAP SEL COST CHUESE         13.00         17.00         4.00           5.00         00000 CAP SEL COST CHUESE         10.00         4.00         5.00           0.0000 CAP SEL COST CHUESE         10.00         11.00 <td< td=""><td>Cost Center Description</td><td>NURSI NG</td><td>CENTRAL</td><td>PHARMACY</td><td>MEDI CAL</td><td></td><td></td></td<>	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
EMERGIN STRANT DEVELOPMENTS         13.00         14.00         15.00         15.00         15.00         17.00           4.00         DODOOD PRINT TE PREFIT IS DEPARTURY T.         0.00000						SERVI CE	
Debacks_Dervice_Opt Centres         Image: Contress opt Centress           0         000000000000000000000000000000000000	-			15.00		17 00	
4.00         Doubding Hard PLAYE PRIVENCE STATURAT         4.00         4.00           7.00         DOUDDING HARTENT INTERVIENT ANTARAL         5.00         5.00           7.00         DOUDDING HARTENT INTERVIENT ANTARAL         5.00           7.00         DOUDDING PLANIESTRY INTERVIENT         5.00           10.00         DITAGE INTERVIENT         1.143,423           9.00         DOUDDING PLANIESTRY INTERVIENT         1.143,423           11.00         DITAGE ALTERNA         1.143,423           11.00         DITAGE ALTERNA         1.143,423           11.00         DITAGE ALTERNA         0         0         0         1.00           11.00         DITAGE ALTERNA         1.144,431         0         0         0         1.02           11.00         DITAGE ALTERNA         0         0         0         0         1.02	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
5.00         DODDOL JANNEY SERVICE         5.00           6.00         DODDOL JANSEY AL LIMIN SERVICE         7.00           6.00         DODDOL JANSEY AL LIMIN SERVICE         1.00           6.00         DODDOL JANSEY AL LIMIN SERVICE         1.00           6.00         DODDOL JEANY         1.143.423           7.00         DOTDOL SERVICE         1.00           1.00         DITODOL JEANY         1.143.423           7.00         DOTDOL DELAW         1.00           1.00         DITODOL DELAW         0           1.00         DITODOL DELAW         0           0.00         DOTDOL DELAW         0           0.00         DOTDOL DELAW         0         0           1.00         DITODO SELAL SENVEL         1.1724 (B1         1.00           1.00         DITODO SELAL SENVEL         DITODO SELAL SENVEL         0         1.124 (B1           1.00         DITODO SELAL SENVEL         DITODO SELAL SENVEL         0         1.00         1.00           1.00         DITODO SELAL SENVEL         DITODO SELAL SENVEL         0         0         1.00         1.00           1.00         DITODO SELAL SENVEL         DITODO SELAL SENVEL         0         0         1.00         1.							1
7.00         00700         0PERATION 0F         PLANT         1         7.00         0.00							
9.00 00000 HUSEKEEN NG 11.00 01000 CRETERN NG 11.00 01000 CRETERN NG 11.00 01000 CRETERN NG 11.00 01000 CRETERN NG							1
10. D0         010000         01000         01000         01000         01000         01000         01000         01000         010000         010000         010000         010000         010000         010000         010000         010000         010000         010000         010000         010000         0100000         0100000         0100							1
11.00       01100       CAFETERIA       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 423       1, 143, 35, 446       1, 144, 145							
13.00         D1300         NURSI NG AMAN NI STRATION         1, 143, 423         9, 258, 421         18, 335, 446         17, 914, 816         1, 100           13.00         D1500         PARAMACY         0							1
15.00       01500       PHARMACY       0       0       10.0		1, 143, 423					1
16. 00         01:000/EDICAL BECROPS & LIBBARY         0         0         1				40.005.40	,		1
17. 00         00         0         0         0         0         0         0         0         22. 80           10. 00         000000000000000000000000000000000000		0	-				
IMPART FUNT ROUTINE SERVICE COST CENTERS		0	-			1, 124, 051	1
9.0 00         02000 ANULTS A PEDIATRICS         660,964         0         0         312,318         951,621         30.0         03.0           10.0 03100 JURSERV         0         0         128,388         660,674         31.00         0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>23.00</td></td<>		0	0		0 0	0	23.00
31.00     0100     INTERSIVE CARE UNIT     173,141     0     0     128,368     69,674     31.00       43.00     04300     MARSERY     0 </td <td></td> <td>660 964</td> <td>0</td> <td></td> <td>342 313</td> <td>051 621</td> <td>30.00</td>		660 964	0		342 313	051 621	30.00
43. 00         04300 NURSERY         0			1				1
44.00         0 <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td></td> <td>1</td>			-		-		1
ANCILLARY SERVICE COST CENTRES           52.00         05200 (PERATINE ROW         0         0         0         716,719         0         55.00           52.00         05200 (PERATINE ROW         0         0         0         0         55.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
50.00         5500 (DeFEATING ROOM         0         0         0         0         716,719         0         50.00           52.00         05200 (PELVERY ROOM         0         0         0         0         55.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00 <td></td> <td>0</td> <td>0</td> <td></td> <td><u> </u></td> <td>0</td> <td>44.00</td>		0	0		<u> </u>	0	44.00
54. 00         65400 (SA00) RADIOLOCY-IN LARMENTIC         0         0         0         0         0         57. 00         60. 00         66. 00         67. 00         67. 00         67. 00         67. 00         67. 00         67.	50. 00 05000 OPERATI NG ROOM			1	716, 719	0	50.00
55. 00         05500         05500         05500         21. 395         0         55. 00           03.30         ULTRA SOUND         0         0         0         0         57. 01           03.60         05600         0         0         0         0         57. 01           05000         05900         0         0         0         0         0         55. 00           05000         05900         0.00         0         0         0         0         0         55. 00           06001         LABORATORY         0<		-			-	-	
57. 00         05700 CT SCAN         0         0         0         0         0         0         57. 00         67. 00         68. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         66. 00         67. 00		0	-		-		1
58. 00         0 SSB00 MRI         0		0	-				
59.00         05900         CARDIA CATHETERIZATION         0         0         0         0         59.00         0		0	-		-		1
60.00         06000         LABDRATORY         0         0         10.097         0         0.00         00.01         06001         00.01<		0	-				1
63. 00         00000 STORI NG, PROCESSI NG & TRANS.         0         0         0         0         63. 00           64.00         06400 (INTRAVENDES THERAPY         0         0         0         0         66. 00           66.00         06500 (PHS) RATORY THERAPY         0         0         0         0         66. 00           66.00         06700 OCUPATI ONAL THERAPY         0         0         0         66. 00           66.00         06700 OCUPATI ONAL THERAPY         0         0         0         66. 00           68.00         06900 SPECEL PATHOLOGY         0         0         64. 184         0         69. 00           71. 00         07100 IMPL, DEV, CHARGED TO PATI ENTS         0         0         0         0         71. 00           72. 00         07300 IMPL, DEV, CHARGED TO PATI ENTS         0         0         0         0         0         73. 00         73. 00         0         0         0         0         0         0         73. 00         74. 00         74. 00         74. 00         76. 00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	-		0		1
64.00         06400         INTRAVENUUS THERAPY         0<		0	-		0 0	-	1
65. 00         06500         PESPI PATORY THERAPY         0		0	-				1
67 00         0 <td></td> <td>0</td> <td>-</td> <td></td> <td>-</td> <td>-</td> <td>1</td>		0	-		-	-	1
68:00         00         00         0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>1</td>		0	0				1
69         00         00         0         64, 184         0         69, 00           71         00         07100 MEDICAL SUPPLIES CHARGED TO PATIENT         0		0	0				
71 00       00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       9, 258, 421       0       0       0       71.00         72.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       74.00       74.00       0       0       0       0       0       74.00       74.00       0       0       0       0       0       74.00       0       0       0       0       0       74.00       0		0	-				1
73.00         ORIGS CHARGED TO PATIENTS         O         18.335,496         O         O         73.00           74.00         07400 RENAL DIALYSIS         O<		0	9, 258, 421			0	
74.00       07400       RENAL DI ALYSI S       0       0       0       0       0       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       0       0       0       76.00         76.01       03140       CARDIA C REHAB       0       0       0       171,157       76.01         76.02       03070       WOREN'S CENTER       0       0       0       0       0       76.02         00.00       09001       CLINIC       0       <		0	-		0	-	
76.00         03202         OTHER ANCI LLARY         0         0         0         76.00         76.01           76.01         03140         CARDI AC REHAB         0         0         0         171,157         0         76.01           76.02         03330         ENDOSCOPY         0         0         0         0         0         76.02           00000         CLINIC         0		0	0	18, 335, 49			
76. 02         03070         WOMEN'S CENTER         0         0         0         0         0         0         0         76. 02         76. 03           0100         09000         CLINIC         0 </td <td></td> <td>Ő</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>		Ő	0		0 0		
76. 03       03330 [ENDOSCOPY       0       0       0       0       76. 03         00. 00       OOD000 [CLI NI C       0		0	0				
OUTPATIENT SERVICE COST CENTERS         90.00         OUTPATIENT SERVICE COST CENTERS         90.00         O 0000         O 0 <td></td> <td>0</td> <td>-</td> <td></td> <td>-</td> <td></td> <td></td>		0	-		-		
90.01         09001         0UTPATIENT         0				· · · · · · · · · · · · · · · · · · ·	<u> </u>		1 / 0. 00
90. 02         09002         NEUROPSYCHOLOGY         0 <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td>			1				
91.00       09100       EMERGENCY       184, 122       0       0       117, 670       0       91.00         91.01       09101       SHORT STAY       0       0       0       0       0       91.01         92.00       OBSERVATION BEDS (NON-DISTINCT PART       0       0       0       0       0       92.00         09500       AMBULANCE SERVICES       0       0       0       0       0       0       92.00         95.00       O9500 (AMBULANCE SERVICES       0       0       0       0       0       95.00         SPECI AL PURPOSE COST CENTERS        0       0       0       0       0       92.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       1, 143, 423       9, 258, 421       18, 335, 496       1, 839, 935       1, 124, 051       118.00         190.00       190200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         192.01       FOUNDATI ON       0       0       0       0       0       192.02         192.02       19202 (LINICS       0       0       0       0       0       192.03         192.04       19207 WESTFI ELD SCHOOLS			0				
92.00         O9200         OBSERVATION BEDS (NON-DISTINCT PART         92.00           OTHER REIMBURSABLE COST CENTERS         95.00         O9500         AMBULANCE SERVICES         0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0 117,670</td> <td></td> <td></td>		0	0		0 0 117,670		
OTHER         REI MBURSABLE         COST         CENTERS           95.00         OPSOO[ AMBULANCE SERVI CES         0         0         0         0         0         0         95.00           SPECI AL         PURPOSE         COST         CENTERS         0         0         0         0         0         0         0         0         95.00           SPECI AL         PURPOSE         COST         CENTERS         0 <t< td=""><td></td><td></td><td>0</td><td></td><td>0 0</td><td>0</td><td></td></t<>			0		0 0	0	
95.00         OP500 AMBULANCE SERVICES         0							92.00
SPECIAL PURPOSE COST CENTERS           SPECIAL PURPOSE COST CENTERS           SUBTOTALS (SUM OF LINES 1 through 117)         1, 143, 423         9, 258, 421         18, 335, 496         1, 839, 935         1, 124, 051           NONRE IMBURSABLE COST CENTERS           190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           19200 PHYSI CIANS' PRIVATE OFFICES         0         0         0         0         0         192.00           19202 CLINICS         0         0         0         0           19202 CLINICS         CLINICS         0         0           19203 PACTICE MANAGEMENT         0         0         0           19203 PRACTICE MANAGEMENT         0         0         0         0           19203 PRACTICE MANAGEMENT         0         0         0         0         0         0         0         0         0         0          19203 PRACTICE MANAGEMENT		0	0	1	0 0	0	95.00
NORRET MBURSABLE         COST         CENTERS           190.00         19000         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         0         0         0         190.00           192.00         19200         PHYSI CI ANS'         PRI VATE         OFFICES         0         0         0         0         192.00           192.01         19200         PHYSI CI ANS'         PRI VATE         OFFICES         0         0         0         0         192.00           192.01         19201         FOUNDATI ON         0         0         0         0         192.01           192.02         19202         CLI NI CS         0         0         0         0         192.02           192.03         19206         HOME         HEALTH         PARTNERSHI P         0         0         0         192.02           192.05         19203         PRACTI CE         MANAGEMENT         0         0         0         0         192.05           192.06         19204         MOB - NOBLESVI LLE         SOUARE         0         0         0         0         192.07           192.06         19204         MOB - NOBLESVI LLE         SOUARE							
190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.00         192.01       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.00         192.02       119201       FOUNDATI ON       0       0       0       0       0       192.01         192.02       19202       CLI NI CS       0       0       0       0       192.02         192.03       19206       HOME HEALTH PARTNERSHI P       0       0       0       0       192.03         192.04       19207       WESTFI ELD SCHOOLS       0       0       0       0       192.04         192.05       19203       PRACTI CE MANAGEMENT       0       0       0       0       192.05         192.06       19204       MOB - NOBLESVI LLE SQUARE       0       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       0       192.07         192.09       BEHAVI OR CARE       0       0       0       0		1, 143, 423	9, 258, 421	18, 335, 49	6 1, 839, 935	1, 124, 051	118.00
192.01       19201       FOUNDATION       0       0       0       192.01         192.02       19202       CLINICS       0       0       0       74,881       0       192.02         192.03       19206       HOME HEALTH PARTNERSHIP       0       0       0       0       192.03         192.04       19207       WESTFI ELD SCHOOLS       0       0       0       0       192.04         192.05       19203       PRACTICE MANAGEMENT       0       0       0       0       192.05         192.06       19204       MOB - NOBLESVILLE SQUARE       0       0       0       0       192.06         192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       0       192.07         192.08       19209       RIVERVIEW MEDI CAL ARTS       0       0       0       192.08       192.09       192.09       192.09       192.09       192.09       192.09       192.09       0       0       192.08       192.09       192.09       192.09       192.09       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       0       0       0       0       192.09     <		0	0		0 0	0	190.00
192.02       19202       CLINICS       0       0       74,881       0       192.02         192.03       19206       HOME HEALTH PARTNERSHIP       0       0       0       0       192.03         192.04       19207       WESTFI ELD SCHOOLS       0       0       0       0       192.04         192.05       19203       PRACTI CE MANAGEMENT       0       0       0       0       192.05         192.06       19204       MOB - NOBLESVI LLE SQUARE       0       0       0       0       192.06         192.07       19208       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08       192.09       192.09       192.09       192.09       192.09       192.09       192.09       192.09       0       0       0       192.08       192.09       192.09       192.09       0       0       0       192.08       192.09       192.09       192.09       192.09       192.09       0       0       0       192.08       192.09       192.09       192.09       192.09       0       0       0       192.09		0	0				
192.03       19206       HOME HEALTH PARTNERSHIP       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 - NOBLESVI LLE SOUARE       0       0       0       0       192.06         192.07       19208       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       0       192.08         192.09       PHASI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.08         192.09       RI VERVI EW MEDI CAL ARTS       0       0       0       0       192.08         192.09       BEHAVI OR CARE       0       0       0       0       192.09       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       PHYSI CI AN SERVICES-LYONS       0       0       0       0       193.01		0	0		0		
192.04       19207       WESTFI ELD SCHOOLS       0       0       0       192.04         192.05       19203       PRACTI CE MANAGEMENT       0       0       0       0       192.05         192.06       19204       MOB - NOBLESVI LLE SOUARE       0       0       0       0       192.05         192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       0       192.08         192.09       BEHAVI OR CARE       0       0       0       0       192.09         192.09       BEHAVI OR CARE       0       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.01         193.01       19301       PHYSI CI AN SERVICES-LYONS       0       0       0       0       193.01		0	0		0 0		
192.06       19204       MOB - NOBLESVILLE SQUARE       0       0       0       192.06         192.07       19208       PHYSICIANS' PRIVATE OFFICES       0       0       0       0       192.07         192.08       19205       RI VERVI EW MEDICAL ARTS       0       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       0       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       PHYSICI AN SERVICES-LYONS       0       0       0       0       193.01	192.04 19207 WESTFIELD SCHOOLS	Ō	0		o o	0	192.04
192.07       19208       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.07         192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       0       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       PHYSI CI AN SERVICES-LYONS       0       0       0       0       193.01		0	0		0		
192.08       19205       RI VERVI EW MEDI CAL ARTS       0       0       0       192.08         192.09       19209       BEHAVI OR CARE       0       0       0       0       192.09         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       PHYSI CI AN SERVICES-LYONS       0       0       0       0       193.01			0				
193.00         19300         NONPAI D         WORKERS         0         0         0         193.00           193.01         19301         PHYSI CI AN         SERVICES-LYONS         0         0         0         0         193.01	192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	0		0 0	0	192.08
193. 01 19301 PHYSI CI AN SERVICES-LYONS 0 0 0 0 193. 01		0	0		0 0		
		0	0				
		0	0				

Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lieu of Form CMS-2552-1		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0059	Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13.00	14.00	15.00	16.00	17.00	
193.03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 (	0 193.03	
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	0 193.04	
193.05 19305 OB SPECIALISTS DAVENPORT	0	0		0 0	0 193.05	
193. 06 19306 OUTPATIENT PHARMACY	0	0		0 0	0 193.06	
194. 00 07950 WORKMED	0	0		0 (	0 194.00	
194.0107951 MEALS ON WHEELS	0	0		0 (	0 194.01	
200.00 Cross Foot Adjustments					200.00	
201.00 Negative Cost Centers	0	0		0 (	0 201.00	
202.00 TOTAL (sum lines 118 through 201)	1, 143, 423	9, 258, 421	18, 335, 4	96 1, 914, 810	1, 124, 051 202. 00	

5. 00         00500 ADM IN STRATT VE & GENRAL         , 00         5. 00         00700 PERATI 00 0 FEAIT 00         7. 00           8. 00         00800 LAUNORY & LINN SERVICE         , 00         0. 00000 ILCANORY & LINN SERVICE         , 00           9. 00         000000 ILCANORY & LINN SERVICE         , 00<		Financial Systems	RI VERVI EW I	HOSPI TAL		In Lie	u of Form CMS-25	552-10
Cost Center Description         PRAMEO FT PISA         Subtotal         Intern # Intern # Subtotal         Total         Total           00000 CAP RELOSTS-BLOG & FIXT         23:00         24:00         25:00         26:00           1:00         00000 CAP RELOSTS-BLOG & FIXT         4:00         4:00         4:00         4:00           0:00         00000 CAP RELOSTS-BLOG & FIXT         4:00         4:00         4:00         4:00           0:00         00000 CAP RELOSTS-BLOG & FIXT         4:00         4:00         4:00         4:00           0:00         00000 CAP RELOSTS-BLOG & FIXT         4:00         4:00         4:00         4:00           0:00         00000 CAP RELOSTS-BLOG & FIXT         4:00         4:00         4:00         4:00           0:00         00000 CAP RELOSTS & SUBSTRUE         4:00         4:00         4:00         4:00           0:00         00000 CAP RELOSTS & SUBSTRUE         4:00         4:00         4:00         4:00           0:00         00000 CAP RELOSTS & SUBSTRUE         0:00         4:00         4:00         4:00           0:0000 CAP RELOSTS & SUBSTRUE         0:00         0:000         0:000         0:000         0:000           0:0000 CAP RELOSTS & SUBSTRUE         0:00         0:0	COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	Fr	om 01/01/2020	Part I	
PRGN FINAMUCY         Rest dents           22.00         24.00         24.00         26.00           1.00         00100 GAP REL 05TS END & FIXT         4.00         5.00         26.00           1.00         00100 GAP REL 05TS END & FIXT         4.00         5.00         5.00         5.00           1.00         00100 GAP REL 05TS END & FIXT         4.00         5.00         5.00         5.00           1.00         00100 GAP REL 05TS END & FIXT         4.00         5.00         5.00         5.00           1.00         00100 GAP REL 05TS END & FIXT         4.00         5.00					То	12/31/2020	Date/Time Prep 7/29/2021 10:5	ared:
Cost & Post Stephological Distribution         Cost & Post Stephological Distribution         Cost & Post Distribution           1.00         DOTOD CAP REL COST CENTERS         78.00         76.00           1.00         DOSOD (APA REL COST SELIDG & FIXT Cost & Post Distribution         1.00         DOSOD (APA REL COSTS-ELIDG & FIXT Cost & Post Distribution         1.00           0.0000 (APA REL COSTS-ELIDG & FIXT Cost & Post Distribution         1.00         DOSOD (APA REL COSTS-ELIDG & FIXT Cost & Post Distribution         1.00           0.0000 (APA REL COSTS-ELIDG & FIXT Cost & Post Distribution         1.00         DOSOD (APA REL COSTS-ELIDG & FIXT Cost & Post Distribution         1.00           0.0000 (APA REL COSTS-ELIDG & FIXT Distribution         1.00         DOSOD (APA REL COSTS & COSTS Distribution         1.00           0.0000 (APA REL COSTS & COSTS & COSTS DISTRIBUTION         1.00         DOSOD (APA REL COSTS & COSTS DISTRIBUTION         1.00           1.00         DISTRIBUTION         DISTRIBUTION         1.00         DISTRIBUTION         1.00           1.00         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION           1.00         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION         DISTRIBUTION           1.00         DISTRIBUTION         DIST		Cost Center Description		Subtotal		Total		
Adjustments         Adjustments           1000         Extended SERVICE COST CENTRES         23.00         24.00         25.00         25.00           1000         Extended SERVICE COST CENTRES         24.00         25.00         25.00         25.00           1000         Extended SERVICE COST CENTRES         24.00         25.00         25.00         25.00           1000         Extended SERVICE COST CENTRES         0.00					Cost & Post			
CONTRAL SERVICE COST CENTERS         23.00         24.00         26.00           10.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00         1.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00           10.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00         1.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00           10.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00         1.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00           10.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00           10.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00         DOTAD CAP HI LOSIS, BLIGE A LIXI         1.00           11.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA         1.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA         1.00           11.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA         1.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA         1.00           11.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA         SERVICE         3.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA         1.00           11.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA         0         2.70, 0.5, 5.00         2.70, 0.5, 5.00         DOTAD CAP HI LOSIS, BLIGE A LIXIA           11.00         DOTAD CAP HI LOSIS CAP HI LOSIS         SEL								
1.00         00100 CAP REL COSTS-BLOG & FIXT         1.00           4.00         00400 MARIN SINATUY & CARANAL         4.00           5.00         00500 MARIN SINATUY & CARANAL         5.00           6.00         00500 MARIN SINATUY & CARANAL         5.00           6.00         00500 MARIN SINATUY & CARANAL         5.00           6.00         00500 MARINESERVICE         9.00           7.00         00100 CARTERIA AND SINATUY         5.00           8.00         00500 MARINESERVICE & SUPPLY         10.00           8.00         01000 CARARED ED PROPERATION OF PROVINE         342, 335           1.00         01000 CARTERIA AND SINATUY         342, 335           1.00         01000 CARARED ED PROPERATION OF SATURES         0           1.00         01000 CARTERIA SINATUY         342, 335           1.00         01000 MITERIA SINATUY         342, 335           1.00         01000 MITERIA PROPERATION OF CARTERIA         0           1.00         01000 MITERIA SINATUY         342, 335           1.00         0.00         0         0           1.00         0.4100 SINTERIA PROPERATION OF CARTERIA         0           0.00         0.000 MITERIA PROPERATION OF CARTERIA         0           0.00         0			23.00	24.00		26.00		
4.00         00400( FMPLOVEC BRVET ITS DEPARTMENT         4.00           5.00         00500( DPERATION OF PLANT         5.00           0.00         00700( DPERATION OF PLANT         5.00           0.00         00700( DPERATION OF PLANT         7.00           0.00         00500( DPERATION OF PLANT         7.00           0.00         00500( DPERATION OF PLANT         7.00           1.00         011000( DETERSY ALLESSENTCE         7.00           0.00         00500( DETERSY ALLESSENTCE         7.00           0.00         01300( RURSING ADMINISTRATION         11.00           1.00         011000( DETERSY ALLESSENTCE         9.19PLY           1.00         01100( DITERSING CARENER)         11.00           1.00         01300( RURSING ADMING SERVICE COST CINTERS         0           0.00         03000( ADMILTS A FEDI ATRICS         9.12, 05.58         0           0.00         03000( ADMILTS A FEDI ATRICS         0         6.44.3, 007         11.00           1.00         0100( DURSERY PLANT KOND         13.000, 7.90         0         6.44.3, 007         13.00           1.00         0100( DURSERY PLANT KOND         13.000, 7.91         1.000, 7.91         1.000         1.000         1.000         1.000         1.000	1.00							1.00
7. 00         00700 OPEEATINO OF FLANT         7. 00         8. 00           80. 00         00800 UNKEYN & LINN STERVICE         9. 00         00700 UNKEYN & LINN STERVICE         9. 00           9. 00         00700 UNKEYN & LINN STERVICE         9. 00         00700 UNKEYN & LINN STERVICE         9. 00           11. 00         01100 CAFETERIA         ISTRATION         11. 00         11. 00         11. 00           12. 00         01500 PHARMACY         FARATION         11. 00         11. 00         11. 00           13. 00         01500 PHARMACY         SERVICE         342, 335         27. 063, 528         0         55. 00         55. 00	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
8. 00         000000 LAUMORY & LI NN SERVICE         9. 00           9. 00         000000 DISEKEET NA         9. 00           10. 00         01000 DISTARY         11. 00           11. 00         01000 DISTARY         11. 00           11. 00         01000 CIRTIAL SERVICE S & SUPPLY         13. 00           15. 00         01000 CIRTIAL SERVICE SA         11. 00           17. 00         01000 PHARANCY         342, 335           17. 00         01000 DIFESIVE CARE SERVICE COST CENTERS         -           30. 00         03000 ADULTS & PEDIATRICS         0         27. 06.3, 528         0. 0           30. 00         03000 ADULTS & PEDIATRICS         0         27. 06.3, 528         0. 0         30. 00           30. 00         03000 ADULTS & PEDIATRICS         0         27. 06.3, 528         0. 0         30. 00           30. 00         03000 ADULTS & PEDIATRICS         0         27. 06.3, 528         0. 0         30. 00           30. 00         03000 ADULTS & PEDIATRICS         0         27. 06.3, 528         0. 0         30. 00           30. 00         03000 ADULTS & ADONSTIC         0         13. 088, 793         55. 00         55. 00           50. 00         05500 DISSILES MOR ADUSINGY - 0. 0         1. 300, 733, 560								5.00
10.00         0 TODOD DI ETARY         10.00         110.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>8.00</td></td<>								8.00
11.00       01100 CAFETERIA       11.00         12.00       13.00       13.00       13.00         14.00       01400 CENTRAL SERVICES & SUPPLY       13.00         15.00       15.00       15.00       15.00         16.00       01400 CENTRAL SERVICES & SUPPLY       342,335       23.00         17.00       17.00       17.00       17.00       17.00         17.00       17.00       17.00       17.00       17.00         17.00       17.00       17.00       17.00       17.00         18.00       02300 PARAMACY       342,335       27.043.528       27.043.528         10.00       03100 INTERNIVE CARE UNIT       0       6.66,277       0       6.66,277       1.660,277       1.662,562,77       1.662,562,77       1.662,562,77       1.662,563,560,577       1.662,563,560,577       1.602,515,560,577,50       1.002,515,560,577,50       1.002,515,560,517,50       1.002,515,560,517,50       1.002,515,560,517,70       1.27,77,70       1.27,77,70       1.27,77,70       1.27,77,70       1.27,77,70       1.27,77,70       1.27,77,70       1.27,77,70       1.27,77,70       1.202,11,55,50       57,70       1.607,751       1.57,70       1.22,182       1.002,511,55,50       57,70       1.22,182       0.00       0.002,515								9.00
13. 00       01300 NURESING ADM IN STRATION       13. 00         14. 00       01400 CHIRAL SERVICES & SUPPLY       14. 00         15. 00       01500 PHARMACY       16. 00         16. 00       01700 SOCIAL SERVICE       342, 335         INPART ENT BOUTINE SERVICE COST CENTERS         10. 00         0. 01300 SAULTS & PERMU PHARMACY         34. 00         1.00         0. 01300 SINERYOI DEL NER SERVICE COST CENTERS         0. 01300 INTENT VE CARE UNIT         0         0. 01300 SINERYOI DEL NER RECOBST CENTERS         0         0. 01300 SINERYOI DEL NER RECOBST CENTERS         0         0. 00 COOD OPEGAT ING ROOM         0         0. 00 COOD OPEGAT ING ROOM         0.								10.00
15:00       01500       PHARMACY       15:00         16:00       01700       SOLAL SERVICE       16:00         17:00       01700       SOLAL SERVICE       23:00         18:00       01700       SOLAL SERVICE       342:335         19:00       0200       0200       0200       0200         10:00       1000       SUBPROVIDES CARE UNIT       0       6,443,907       0       6,433,907         11:00       04100       SUBPROVIDES INFORMENT PERMITICE       0       5,666,277       0       5,666,277       10         10:00       04300       NURLES REVIEW       0	13.00	01300 NURSING ADMINISTRATION						13.00
16:00       11600       VEDICAL, RECORDS & LIBRARY       16:00       16:00       16:00       23:00       16:00       23:00       17:00       11:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00       11:00:00:00       11:00:00:00:00:00:00:00:00:00:00:00:00:0								
23.00         0         0         23.00         PARAMED ED PREM PHARMACY         342,335         23.00           0.00         0.0000 ADULTS & PEDI ATRICS         0         27.063,528         0         27.063,528         30.00           31.00         0.0100 SUPPROVIDER - IRF         0         6.443,907         0         6.443,907         0         6.443,907         0         6.443,907         0         6.443,907         0         6.443,907         0         6.443,907         0         6.443,907         0         6.443,907         0         13.068,793         0 <td< td=""><td>16.00</td><td>01600 MEDI CAL RECORDS &amp; LI BRARY</td><td></td><td></td><td></td><td></td><td></td><td>16.00</td></td<>	16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
INPATIENT NOUTINE SERVICE COST CENTERS         Image of the interval of the in			242 225					17.00
31.00       03100       INTENSIVE CARE UNIT       0       6.443,907       0       6.443,907       31.00         41.00       04000       SUBPROVIDER - 1 RF       0       5.686,277       0       5.686,277       41.00         43.00       04000       SERVE       0       0       0       0       43.00         44.00       SERVE       0       0       0       0       0       43.00         50.00       OSCOO (DECATI NER ROM       0       13.088,793       0       13.088,793       50.00         50.00       OSCOO (DECATI NER ROM       0       13.088,793       0       53.056       50.00         51.00       OSCOO (DECATI NER ROM       0       2.051.065       2.051.065       55.00       55.00         52.00       OSCOO (CLUVERY ROM & LABOR ROM       0       559.534       559.534       57.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.534       550.534       550.534       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00       550.00	23.00		542, 555					23.00
41.00       04100       SUBPROVIDER - IRF       0       5.686.277       0       5.686.277       0       4.00         43.00       Odd00 NURSERY       0       0       0       0       0       4.00         44.00       SAG00 NURSERY       0       0       0       0       0       0       4.00         44.00       SAG00 NURSERY       0       0       0       0       0       0       4.00         50.00       05000 DELUTERY ROWA       LAGOR ROOM       0       13.088.793       52.00       52.00       52.00       55.06       55.00       55.06       55.00<		03000 ADULTS & PEDIATRICS			-			30.00
43.00       043.00       NURSERY       0       0       0       43.00         44.00       044.00       044.00       0       0       0       0       44.00         AMCULLARY SERVICE COST CENTERS			-		-			
ANCILLARY SERVICE COST CENTERS         Image: Control of Control Control of Contrel of Contrecontrol of Control of Control of Control of Contrec			-		0	0		43.00
50. 00       05000       00       0       13.088,793       0       13.088,793       0       0       50.00         52.00       05200       05200       0       0       0       0       0       52.00       0       55.00       055.00       0       55.00       055.00       0       55.00       0       55.00       55.00       55.00       55.00       55.00       55.00       55.56.0       55.56.0       55.56.0       55.00	44.00		0	0	0	0		44.00
54.00     054.00     RADI OLGOY-DI ARMOSTI C     0     4, 727, 270     0     4, 727, 270     54.00       55.00     05500     COSON RADI OLGOY-THERAPEUTI C     0     2, 051, 065     0, 051, 065     55.00       57.00     05700     CT SCAN     0     559, 534     0     559, 534     57.00       58.00     05800     MRI     0     1452, 227     0     452, 227     58.00       59.00     05800     ARDI AC CATHETERI ZATI ON     0     1, 607, 351     0     1, 607, 351       60.00     06000     LABORATORY     0     11, 222, 182     0     60.00       60.00     06001     BLOOD LABORATORY     0     11, 222, 182     60.00       60.00     06000     PIRAVENDY THERAPY     0     0     0     0       61.00     06500     PIRAVENDY THERAPY     0     0     0     0     64.00       65.00     06500     PIRAVENDY THERAPY     0     9, 540, 049     0     0     64.00       66.00     0     0     0     0     0     0     66.00       66.00     0     0     0     0     0     0     67.00       66.00     0     0     0     0     0     0	50.00		0	13, 088, 793	0	13, 088, 793		50.00
55.00       00       05500       RADIOLOCY-THERAPEUTIC       0       2,051,065       0       2,051,065       55.00         57.00       07500       CTSCAN       0       555,554       57.00         58.00       0500       RNI       0       452,227       0       452,227       58.00         59.00       05000       CARDIA C CATHETERI ZATION       0       1,607,351       0,703       59.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       6			0	-		-		52.00
57.00       05700       CT SCAN       0       535, 560       57.00       535, 560       57.00         57.01       053600       LTRA SOUND       0       559, 534       0       559, 534       57.00         58.00       05800       ARDI AC CATHETERI ZATI 0N       0       1, 607, 351       0       1, 607, 351       58.00         60.00       06000       LABORATORY       0       11, 222, 182       0       11, 222, 182       60.00         60.01       DEGODOL LABORATORY       0       11, 222, 182       0       60.01       60.00         61.00       DEGODOL LABORATORY       0       11, 222, 182       60.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       6			0		-			54.00 55.00
58.00       05800       NRI       0       452, 227       0       452, 227       58.00         59.00       05900       CARDIAC CATHETRIZATION       0       1, 607, 351       0       1, 607, 351       59.00         60.00       06000       LABORATORY       0       11, 222, 182       0       11, 222, 182       60.01         60.01       06000       LABORATORY       0       0       0       0       60.01         61.00       06000       DAGOB LADD STORING, PROCESSING & TRANS.       0712,004       0       712,004       63.00         65.00       6500 RESPIRATORY THERAPY       0       2,420,003       0,2,420,003       65.00       66.00         66.00       06600       PHYSICAL THERAPY       0       0       0       0       66.00         67.00       06700       0       0       0       0       0       68.00       6800       68.00       6800       68.00       6800       68.00       68.00       68.01       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00<	57.00	05700 CT SCAN	0	535, 560	-	535, 560		57.00
59:00       OS900       CARDIAC CATHETERIZATION       0       1, 607, 351       0       1, 607, 351       59:00         60:00       O6000       LABORATORY       0       11, 222, 182       0       11, 222, 182       60:00         60:01       O6001       BLODD LABORATORY       0       0       0       0       60:01         60:00       O6001       BLODD LABORATORY       0       0       0       60:01         60:00       O6000       RESPIRATORY THERAPY       0       712,004       63:00       64:00         60:00       O6000       RESPIRATORY THERAPY       0       9,540,049       0       0       66:00         66:00       O6700       OCCUPATI ONAL THERAPY       0       9,540,049       0       67:00       0       67:00       0       0       67:00       0       0       67:00       0       0       68:00       68:00       68:00       69:00       69:00       69:00       69:00       69:00       68:00       69:00       69:00       69:00       69:00       69:00       69:00       67:00       69:00       60:00       71:00       71:00       71:00       71:00       71:00       71:00       71:00       71:00       71:			0					
60.01       60.01       60.01       60.01       60.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00 <td< td=""><td></td><td></td><td>0</td><td></td><td>-</td><td></td><td></td><td>59.00</td></td<>			0		-			59.00
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       712,004       0       712,004       63.00         64.00       0       0       0       0       0       0       64.00         65.00       06500       RESPIRATORY THERAPY       0       2,420,003       0,2,420,003       65.00         66.00       06600       PHYSICAL THERAPY       0       9,540,049       0       0       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       9,540,049       0       0       66.00         68.00       06800       SPEECH PATHOLOGY       0       1,548,430       0       1,548,430       69.00         69.00       06900       ELECTROCARDI OLOGY       0       11,109,808       11,109,808       71.00       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       342,335       18,677,831       9,258,421       71.00       73.00       73.00       73.00       73.00       0       401,264       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02       76.02<			0		-			60.00
64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPIRATORY THERAPY       0       2,420,003       0       2,420,003       66.00         66.00       06600       PHYSICAL THERAPY       0       9,540,049       0       9,540,049       66.00         67.00       06600       SPECH PATHOLOGY       0       0       0       67.00         68.00       06800       SPECH PATHOLOGY       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0       1,548,430       0       1,548,430       69.00         71.00       07100       MEDI CAL       SUPPLIES CHARGED TO PATIENTS       0       11,109,808       72.00       73.00       73.00       73.00       73.00       18,677,831       73.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.02       3,052,075       0       3,052,075       76.01       76.01         76.01       03140       CARDIAC REHAB       0       3,052,075       0			0	0	-	-		63.00
66:00       06600       PHYSI CAL THERAPY       0       9, 540, 049       0       9, 540, 049       66:00         67:00       06700       00       0       0       0       0       67:00         68:00       06800       SPECCH PATHOLOGY       0       0       0       0       68:00         69:00       06900       ELECTROCARDI OLOGY       0       1, 548, 430       0       1, 548, 430       69:00         71:00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       11, 109, 808       0       11, 109, 808       72:00       72:00         73:00       07300       DRUGS CHARGED TO PATI ENTS       342, 335       18, 677, 831       0       18, 677, 831       73:00         74:00       07400 RENAL DI ALYSI S       0       401, 264       0       401, 264       74:00         76:01       03140       CARPIA ACREHAB       0       3, 052, 075       0       3, 052, 075       76:01       76:00         76:02       03070       WOMEN'S CENTER       0       1, 562, 137       76:00       76:00       76:00       76:00         76:03       03330 ENDOSCOPY       0       0       0       0       76:00       76:00       76:00 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>64.00</td>			0	0	0	0		64.00
67.00       06700       0CUPATI ONAL THERAPY       0       0       0       67.00       68.00       06800       SPECH PATHOLOGY       0       0       0       0       68.00       67.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76			0		0			65.00 66.00
69.00       06900       ELECTROCARDIOLOGY       0       1, 548, 430       0       1, 548, 430       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       9, 258, 421       0       9, 258, 421       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       11, 109, 808       0       11, 109, 808       72.00         73.00       07300       REUGS CHARGED TO PATIENTS       342, 335       18, 677, 831       0       18, 677, 831       73.00         74.00       07400       RENAL DI ALYSI S       0       401, 264       0       401, 264       74.00         76.01       03140       CARDIAC REHAB       0       3, 052, 075       0       3, 052, 075       76.01         76.02       03070       WOMEN'S CENTER       0       1, 562, 137       0       1, 562, 137       76.02         0       09000       CLI NI C       0       826, 557       0       826, 557       90.00         90.01       090001       ULIVATIENT       0       1, 860, 813       0       1, 860, 813       90.01         90.02       090002       NEUROPSYCHOLOGY       0       553, 700       553, 700       90.02       90.02 </td <td>67.00</td> <td>06700 OCCUPATI ONAL THERAPY</td> <td>0</td> <td></td> <td>-</td> <td></td> <td></td> <td>67.00</td>	67.00	06700 OCCUPATI ONAL THERAPY	0		-			67.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       9, 258, 421       0       9, 258, 421       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       11, 109, 808       0       11, 109, 808       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       342, 335       18, 677, 831       0       18, 677, 831       73.00         74.00       07400       RENAL DI ALYSIS       0       401, 264       0       401, 264       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       3, 052, 075       0       3, 052, 075       76.00         76.02       03070       WORN'S CENTER       0       1, 562, 137       0       1, 562, 137       76.02         76.03       03330       ENDOSCOPY       0       0       826, 557       0       826, 557       70.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00			0	0 1 548 430	-	0		
73.00       07300       DRUGS CHARGED TO PATIENTS       342,335       18,677,831       0       18,677,831       73.00         74.00       07400       RENAL DI ALYSI S       0       401,264       0       401,264       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       3,052,075       0       3,052,075       76.00         76.02       03070       WOMEN'S CENTER       0       1,562,137       0       1,562,137       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.03         090.00       09000       CLI NI C       0       826,557       0       826,557       90.00         90.00       09001       OUTPATI ENT       0       1,860,813       90.01       90.02         90.01       09002       NEUROPSYCHOLOGY       0       553,700       0       553,700       90.02         91.00       09101       SHORT STAY       0       0       0       0       91.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART       0       0       0       92.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 258, 421	-			71.00
74.00       07400       RENAL DI ALYSI S       0       401, 264       0       401, 264       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       3, 052, 075       0       3, 052, 075       76.00         76.02       03070       WOMEN'S CENTER       0       1, 562, 137       0       1, 562, 137       76.02         76.03       0330       ENDOSCOPY       0       0       0       0       76.03         0000       CLINIC       0       826, 557       0       826, 557       90.00         90.00       09000       NEUROPSYCHOLOGY       0       533, 700       90.02         90.02       09010       EMERGENCY       0       18, 236, 240       91.00         91.00       09100       EMERGENCY       0       18, 236, 240       91.00         91.01       09101       SHORT STAY       0       0       92.00         92000       DBESERVATI ON BEDS (NON-DI STINCT PART       0       0       91.00         92000       OBSERVATI ON BEDS (NON-DI STINCT PART       0       153, 366       95.00			0		0			72.00
76.00       03020       OTHER ANCI LLARY       0       0       0       76.00         76.01       03140       CARDI AC REHAB       0       3,052,075       0       3,052,075       76.01         76.02       03070       WOMEN'S CENTER       0       1,562,137       0       1,562,137       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       76.02         76.04       03330       ENDOSCOPY       0       0       0       0       76.02         76.02       03330       ENDOSCOPY       0       0       0       0       76.02         0000       CLINIC       0       826,557       0       826,557       90.00       90.00         90.01       09001       OUTPATI ENT       0       1,860,813       0       1,860,813       90.01         90.02       P90.02       NEUROPSYCHOLOGY       0       553,700       0       553,700       90.02         91.01       09101       ENGRENCY       0       18,236,240       0       18,236,240       91.00         92.00       092200       DSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00       92.			342, 335		0			73.00
76. 02       03070       WOMEN'S CENTER       0       1,562,137       0       1,562,137       76. 02         76. 03       03330       ENDOSCOPY       0       0       0       0       76. 03         00100       00000       CLINIC       0       826,557       0       826,557       90. 00         90. 00       09000       CLINIC       0       1,860,813       0       1,860,813       90. 01         90. 02       09002       NEUROPSYCHOLOGY       0       553,700       0       553,700       90. 02         91. 00       09100       EMERGENCY       0       18,236,240       0       18,236,240       91. 01         92. 00       09200       DBSERVATION BEDS (NON-DI STINCT PART       0       0       0       92. 00         95. 00       09500       AMBULANCE SERVICES       0       153, 366       0       153, 350, 392       95. 00         95. 00       09500       AMBULANCE SERVICES       0       153, 350, 392       118. 00       118. 00         NONREI MBURSABLE COST CENTERS       1       118. 00       153, 350, 392       118. 00       118. 00         190. 00       GIPTALS (SUM OF LINES 1 through 117)       342, 335       153, 350, 392 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>76.00</td>			0	0	0	0		76.00
76. 03       03330       ENDOSCOPY       0       0       0       0       76. 03         0UTPATI ENT SERVICE COST CENTERS       0 <td></td> <td></td> <td>0</td> <td></td> <td>Ű</td> <td></td> <td></td> <td></td>			0		Ű			
90.00       09000       CLINIC       0       826, 557       0       826, 557       90.00         90.01       09001       0UTPATIENT       0       1, 860, 813       0       1, 860, 813       90.01         90.02       09002       NEUROPSYCHOLOGY       0       553, 700       0       553, 700       90.02         91.00       09100       EMERGENCY       0       18, 236, 240       0       18, 236, 240       91.00         91.01       09101       SHORT STAY       0       0       0       0       91.00         92.00       092200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       0       92.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       92.00       92.00         95.00       09500       AMBULANCE SERVICES       0       153, 366       0       153, 366       95.00         95.00       SPECIAL PURPOSE COST CENTERS       0       153, 350, 392       0       153, 350, 392       118.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       342, 335       153, 350, 392       0       153, 350, 392       118.00         190.00       I9000       GI FT, FLOWER, COFFEE SHOP & CANT		03330 ENDOSCOPY	0		0			76.03
90. 01       09001       0UTPATIENT       0       1,860,813       0       1,860,813       90. 01         90. 02       09002       NEUROPSYCHOLOGY       0       553,700       0       553,700       90. 02         91. 00       09100       EMERGENCY       0       18,236,240       0       18,236,240       91. 00         91. 01       09101       SHORT STAY       0       0       0       0       91. 01         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       91. 01         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92. 00         0       07HER       REI MBURSABLE COST CENTERS       0       153, 366       0       153, 366       95. 00         95. 00       SPECI AL PURPOSE COST CENTERS       0       153, 350, 392       0       153, 350, 392       118. 00         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       342, 335       153, 350, 392       0       153, 350, 392       118. 00         190. 00       I9000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       968, 698       0       968, 698       190. 00	90 00			826 557	0	826 557		90.00
91.00       09100       EMERGENCY       0       18, 236, 240       0       18, 236, 240       91.00         91.01       09101       SHORT STAY       0       0       0       0       91.01         92.00       09200       DBSERVATION       BEDS (NON-DISTINCT PART       0       0       0       91.01         92.00       09200       DBSERVATION       BEDS (NON-DISTINCT PART       0       0       92.00       92.00         0500       AMBULANCE SERVICES       0       153, 366       0       153, 366       95.00         95.00       OSOO AMBULANCE SERVICES       0       153, 350, 392       0       153, 350, 392       118.00         NONREI MBURSABLE COST CENTERS       118.00       SUBTOTALS (SUM OF LINES 1 through 117)       342, 335       153, 350, 392       0       153, 350, 392       118.00         100.00       19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       968, 698       0       968, 698       190.00			0		0			90.00 90.01
91. 01       09101       SHORT STAY       0       0       0       0       91. 01         92. 00       09200       DBSERVATION       BEDS (NON-DI STINCT PART       0       0       0       92. 00         07HER       REI MBURSABLE       COST CENTERS       0       153, 366       0       153, 366       95. 00         95. 00       09500       AMBULANCE       SERVICES       0       153, 366       0       153, 366       95. 00         SPECIAL PURPOSE COST CENTERS         118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       342, 335       153, 350, 392       0       153, 350, 392       118. 00         NONREI MBURSABLE COST CENTERS         190. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       968, 698       0       968, 698       190. 00			0		0			90.02
92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       92. 00         OTHER REI MBURSABLE COST CENTERS       0       153, 366       0       153, 366       95. 00         95. 00       09500       AMBULANCE SERVI CES       0       153, 366       0       153, 366       95. 00         SPECI AL PURPOSE COST CENTERS         118. 00       SUBTOTALS (SUM OF LI NES 1 through 117)       342, 335       153, 350, 392       0       153, 350, 392       118. 00         NONREI MBURSABLE COST CENTERS         190. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       968, 698       0       968, 698       190. 00			0	18, 236, 240 0	0	18, 236, 240		91.00 91.01
95. 00       09500       AMBULANCE SERVICES       0       153, 366       0       153, 366       95. 00         SPECIAL PURPOSE COST CENTERS       118. 00       SUBTOTALS (SUM OF LINES 1 through 117)       342, 335       153, 350, 392       0       153, 350, 392       118. 00         NONREI MBURSABLE COST CENTERS       1190. 00       968, 698       0       968, 698       190. 00		09200 OBSERVATION BEDS (NON-DISTINCT PART			0	_		92.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         342, 335         153, 350, 392         0         153, 350, 392         118.00           NONREI MBURSABLE COST CENTERS         1190.00         968, 698         0         968, 698         190.00	95 00		0	153 366	0	153 366		95 00
NONREI MBURSABLE COST CENTERS         968, 698         968, 698         190. 00	70.00							
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 968, 698 0 968, 698 190. 00	118.00		342, 335	153, 350, 392	0	153, 350, 392	1	18.00
	190.00		0	968, 698	0	968, 698	1	190.00
		19200 PHYSI CLANS' PRI VATE OFFI CES	0	38, 848, 601	0	38, 848, 601		192.00
192. 01       FOUNDATI ON       0       286, 341       192. 01         192. 02       192.02       CLI NI CS       0       1, 572, 037       0       1, 572, 037			0		-			
192. 03 19206 HOME HEALTH PARTNERSHI P 0 2, 730 0 2, 730 192. 03	192.03	19206 HOME HEALTH PARTNERSHIP	0	2, 730	Ő	2, 730	1	192.03
192. 04         192.07         WESTFI ELD SCHOOLS         0         1, 418, 671         0         1, 418, 671         192. 04           192. 05         19203         PRACTI CE MANAGEMENT         0         892, 665         0         892, 665         192. 05			0		0			
192.06 19204 MOB - NOBLESVILLE SQUARE 0 17, 120 0 17, 120 192.06	192.06	19204 MOB - NOBLESVILLE SQUARE	0		0		1	192.06
192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 07			0	01 701	0	0		
192.08       19205       RI VERVI EW MEDI CAL ARTS       0       91, 701       192.08         192.09       192.09       BEHAVI OR CARE       0       663, 819       0       663, 819       192.09			0		0			
193. 00 19300 NONPAI D WORKERS 0 0 193. 00	193.00	19300 NONPAI D WORKERS	0		0			

Health Financial Systems	NS RI VERVI EW HOSPI TAL					
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0059	Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020		
				10 12/31/2020	7/29/2021 10: 51 am	
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM PHARMACY		Residents			
			Cost & Post			
			Stepdown			
			Adjustments			
	23.00	24.00	25.00	26.00		
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	138, 122		0 138, 122		
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	65, 332		0 65, 332		
193.03 19303 OB/GYN SPEC NEMUNALTI	0	780, 377		0 780, 377	193.03	
193.04 19304 OB/GYN SPEC GATHERS	0	2, 051		0 2,051	193.04	
193. 05 19305 OB SPECIALISTS DAVENPORT	0	580, 950		0 580, 950	193.05	
193. 06 19306 OUTPATI ENT PHARMACY	0	4, 449, 292		0 4, 449, 292	193.06	
194. 00 07950  WORKMED	0	912, 949		0 912, 949	194.00	
194.0107951 MEALS ON WHEELS	0	421, 280		0 421, 280	194.01	
200.00 Cross Foot Adjustments	0	0		0 0	200.00	
201.00 Negative Cost Centers	0	0		0 0	201.00	
202.00 TOTAL (sum lines 118 through 201)	342, 335	205, 463, 128		0 205, 463, 128	202.00	

	Financial Systems TION OF CAPITAL RELATED COSTS	RI VERVI EW	HOSPI TAL Provi der C		eri od:	u of Form CMS-:  Worksheet B	2552-10
				FI Te	rom 01/01/2020 p 12/31/2020	Date/Time Pre	
	Cost Center Description	Directly Assigned New	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI V E & GENERAL	51 am
		Capital Related Costs			DEPARTMENT		
	GENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0			95, 707	1 600 034	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT		.,,		10, 303 2, 579	1, 508, 836 141, 899	
8.00	00800 LAUNDRY & LINEN SERVICE	C	48, 605		83	13, 142	
9.00	00900 HOUSEKEEPI NG	C	39, 318		1, 308	20, 765	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A		412, 891		389 981	10, 917 14, 946	
13.00	01300 NURSI NG ADMI NI STRATI ON	C	0	0	813	8, 543	
	01400 CENTRAL SERVICES & SUPPLY	C	232, 669		727	67, 704	
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY		290, 159 77, 200		2, 610 931	135, 732 13, 204	
	01700 SOCI AL SERVI CE	0			703	7, 764	
23.00	02300 PARAMED ED PRGM PHARMACY	C	5, 178	5, 178	280	2, 535	23.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	C	3, 064, 245	3, 064, 245	10, 404	127, 851	30.00
	03100 I NTENSI VE CARE UNI T	0			3, 294	36, 202	1
	04100 SUBPROVI DER - I RF	C	471, 551	471, 551	1, 691	28, 835	
	04300 NURSERY 04400 SKILLED NURSING FACILITY		~		0	0	
44.00	ANCI LLARY SERVICE COST CENTERS		, <u> </u>	0	0	0	1 44.00
	05000 OPERATING ROOM	C			4, 839	0	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C		0 0 443, 891	-	0 2, 193	0 28, 342	52.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		239, 717		561	12, 149	
	05700 CT SCAN	C	0	0	388	3, 982	
57.01 58.00	03630 ULTRA SOUND 05800 MRI	0	0	0	441 342	4, 179	
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON		93, 301	-	342 983	3, 349 10, 556	
60.00	06000 LABORATORY	C	478, 666		3, 560	78, 252	
60.01	06001 BLOOD LABORATORY	C	0 (0.000	0	0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		68, 080 0	68, 080 0	0	4, 623 0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	C	36, 211	-	1, 676	17, 526	
66.00	06600 PHYSI CAL THERAPY	C	156, 939		5, 124	67, 321	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			0	0	0	
	06900 ELECTROCARDI OLOGY	0	221, 678	-	591	7, 717	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	C	0	0	0	-	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0	0	85, 272	72.00 73.00
74.00	07400 RENAL DIALYSIS	C	31, 034	31, 034	0	2, 696	
	03020 OTHER ANCI LLARY	C	0	0	0	0	76.00
	03140 CARDIAC REHAB 03070 WOMEN'S CENTER		292, 598 307, 898		727 483	17, 637 7, 518	
	03330 ENDOSCOPY	C	0		0	0	1
00.00			00 540	00 E 40	274	E 100	
	09000 CLI NI C 09001 OUTPATI ENT		80, 540 117, 286		376 732	5, 180 12, 051	
90. 02	09002 NEUROPSYCHOLOGY	C	9, 454		189	2, 183	90.02
	09100 EMERGENCY	0	708, 262		6, 184	126, 013	
	09101 SHORT STAY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0	0	0	0	91.01 92.00
	OTHER REIMBURSABLE COST CENTERS	I	1	-			
95.00	09500 AMBULANCE SERVICES	C	9, 120	9, 120	69	1, 035	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	C	19, 296, 102	19, 296, 102	66, 554	1, 127, 620	118.00
100.00	NONREI MBURSABLE COST CENTERS		201 7(0	201 7/0	171	4 017	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		201, 769 1, 065, 633		171 23, 378		190.00 192.00
192.01	19201 FOUNDATI ON	C	0	0	230		192.01
	19202 CLINICS	0	0	0	995		192.02
	19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS			0	0 1, 101		192.03 192.04
192.05	19203 PRACTI CE MANAGEMENT	C	0	0	497	6, 847	192.05
	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192.06
	19208 PHYSI CLANS' PRI VATE OFFICES 19205 RI VERVI EW MEDI CAL ARTS			0	0		192.07 192.08
	19209 BEHAVI OR CARE	0	0		432		192.09
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Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-255		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0059	Period: From 01/01/2020 To 12/31/2020		pared: 51 am
Cost Center Description	Di rectly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI V E & GENERAL	
	0	1.00	2A	4.00	5.00	
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	0		0 102	1, 060	193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0		0 52	501	193.02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 606	5, 990	193.03
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	16	193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	0	0		0 441	4, 459	193.05
193. 06 19306 OUTPATI ENT PHARMACY	0	0		0 588	34, 150	193.06
194. 00 07950 WORKMED	0	0		0 409	7,007	194.00
194.01 07951 MEALS ON WHEELS	0	0		0 151	3, 143	194.01
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		o o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	20, 563, 504	20, 563, 50	4 95, 707	1, 508, 836	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	RI VERVI EW		2N 15 0050 D		u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2020 p 12/31/2020	Worksheet B Part II Date/Time Pre 7/29/2021 10:	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00       00100       CAP REL COSTS-BLDG & FIXT         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       01100       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       0100       MEDI CAL RECORDS & LI BRARY         17.00       01700       SOCI AL SERVI CE	7, 634, 773 32, 328 26, 151 274, 618 0 154, 750 192, 988 51, 346 36, 505	94, 158 0 0 0 763 0 0 0 0 0 0	87, 542 329 2, 302 0 82 2, 055 411 0	699, 144 0 0 0 0 0 0 0 0 0	18, 229 274 412 1, 074 516 218	13.00 14.00 15.00 16.00
23.00 O2300 PARAMED ED PRGM PHARMACY	3, 444	0	0	0	33	23.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000         ADULTS & PEDI ATRI CS           31.00         03100         INTENSI VE CARE UNI T           41.00         04100         SUBPROVI DER - I RF           43.00         04300         NURSERY           44.00         SKI LLED         NURSI NG FACI LI TY           ANCI LLARY         SERVI CE COST CENTERS	2, 038, 058 305, 301 313, 633 0 0	31, 824 7, 418 7, 932 0 0	35, 592 6, 001 5, 179 0 0	452, 164 59, 147 187, 833 0 0	3, 786 978 657 0 0	30. 00 31. 00 41. 00 43. 00 44. 00
50. 00 05000 OPERATI NG ROOM	1, 171, 369	9, 853	8, 795	0	1, 649	50.00
52.00         05200         DELIVERY         ROOM & LABOR         ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C         0	0 295, 236 159, 438 0 0	0 5, 945 821 0 0	0 3, 370 822 0 0	0 0 0 0	0 903 172 151 136	52.00 54.00 55.00 57.00
	0	0	82	0	120	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	62, 056 318, 365	2, 619 0	0 2, 877	0	288 1, 393	59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	0	2,077	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	45, 281	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0 24, 085	0	0 247	0	0 636	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	104, 381	856	0	0	2,098	
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 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	147, 440	871	2,466	0	245 0	69.00 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	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 DIALYSIS	20, 641	0	0	0	0	74.00
76. 00  03020  0THER_ANCI LLARY 76. 01  03140  CARDI AC_REHAB	0 194, 610	75	2, 219	0	0 362	
76.02 03070 WOMEN' S CENTER	204, 786	506		0	227	76.02
76. 03 03330 ENDOSCOPY	0	0	0	0	0	76.03
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	53, 568	137	0	0	175	90.00
90. 01 09001 OUTPATI ENT	78, 008	2, 758	575	0	281	90.01
90. 02 09002 NEUROPSYCHOLOGY	6, 288	0	7, 809	0	64	90.02
91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY	471, 072	13, 703 0	0	0	1, 040 0	91.00 91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Ŭ	0	Ŭ	0	0	92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	6, 066	0	0	0	34	95.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)	6, 791, 812	86, 081	82, 857	699, 144	17, 922	118.00
NONREI MBURSABLE COST CENTERS	0, 771, 012	00,001	02,007	0,7,111	11,722	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	134, 198	0	82	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATI ON	708, 763	8, 008	0	0		192.00 192.01
192. 02 19202 CLI NI CS	0	36	4, 603	0		192.01
192. 03 19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192.03
192. 04 19207 WESTFI ELD SCHOOLS	0	0 33	0	0		192. 04 192. 05
192. 05 19203 PRACTI CE MANAGEMENT 192. 06 19204 MOB - NOBLESVI LLE SQUARE	0	33 0	0	0		192.05 192.06
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES	Ō	0	0	Ō	0	192.07
192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	0	0	0		192.08
192. 09 19209 BEHAVI OR CARE 193. 00 19300 NONPAI D WORKERS	0	0	0	0		192.09 193.00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	Ő	0	0	Ō	0	193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	0	0		193.02
193. 03 19303 OB/GYN SPEC NEMUNAI TI	0	0	0	0	0	193.03

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0059	Period: From 01/01/2020	Worksheet B Part II	
				To 12/31/2020	Date/Time Pre	pared:
					7/29/2021 10:	<u>51 am</u>
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	0	193.04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	0		0 0	0	193.05
193. 06 19306 OUTPATI ENT PHARMACY	0	0		0 0	0	193.06
194. 00 07950 WORKMED	0	0		0 0	0	194.00
194.0107951 MEALS ON WHEELS	0	0		0 0	106	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	7, 634, 773	94, 158	87, 54	699, 144	18, 229	202.00

Heal th	Financial Systems	RI VERVI EW H	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0059	Period: From 01/01/2020	Worksheet B Part II	
					To 12/31/2020		epared: 51 am
	Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	
		N	SUPPLY		LI BRARY		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00		0 ( 20					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	9, 630	457, 107				13.00
15.00	01500 PHARMACY	0	0	624, 6	18		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 143, 608		16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	100, 075	
23.00	02300 PARAMED ED PRGM PHARMACY	0	0		0 0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	5, 642	0		0 25, 673	84, 724	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 458	0		0 9,627	6, 203	
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	979	0		0 0 0 0	9, 148	
43.00 44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	0	
	ANCILLARY SERVICE COST CENTERS	· · ·	-		-		
50.00	05000 OPERATING ROOM	0	0		0 53, 753	0	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	0		0 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 1,605	0	
57.00	05700 CT SCAN	0	0		0 0	0	
57.01	03630 ULTRA SOUND	0	0		0 0	0	
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	58.00 59.00
60.00	06000 LABORATORY	0	0		0 802	0	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0		0 0	0	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0 20,057	0	
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 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 457, 107		0 4, 814 0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	437,107		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	624, 6	18 0	0	
	07400 RENAL DI ALYSI S	0	0		0 0	0	
76. 00 76. 01	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	0	0		0 0 0 12,836	0	
76.02	03070 WOMEN' S CENTER	0	0		0 0	0	1
76.03	03330 ENDOSCOPY	0	0		0 0	0	76.03
00 00	OUTPATIENT SERVICE COST CENTERS		0			0	90.00
90.00 90.01	09000 CLINIC 09001 0UTPATI ENT	0	0 0		0 0 0 0	0	
90.02	09002 NEUROPSYCHOLOGY	0	0		0 0	0	90.02
91.00	09100 EMERGENCY	1, 551	0		0 8, 825	0	
91.01 92.00	09101 SHORT STAY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	91.01 92.00
92.00	OTHER REIMBURSABLE COST CENTERS	<u>                                     </u>					92.00
95.00	09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
	SPECIAL PURPOSE COST CENTERS		157 107	(01.4)		400.075	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	9, 630	457, 107	624, 6	18 137, 992	100, 075	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	19201 FOUNDATI ON	0	0		0 0		192.01
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP	0	0		0 5,616 0 0		192.02 192.03
	19207 WESTFIELD SCHOOLS	0	0		0 0		192.03
192.05	19203 PRACTI CE MANAGEMENT	0	0		0 0	0	192.05
	19204 MOB - NOBLESVILLE SQUARE	0	0		0 0		192.06
	19208 PHYSICIANS' PRIVATE OFFICES 19205 RIVERVIEW MEDICAL ARTS	0	0				192.07 192.08
	19209 BEHAVIOR CARE	0	0		0 0		192.08
193.00	19300 NONPAI D WORKERS	0	0		0 0	0	193.00
	19301 PHYSI CI AN SERVI CES-LYONS	0	0		0 0		193.01
193.02	19302 UNI VERSI TY HS ATHLETI CS	0	0		0 0	0	193.02

Health Financial Systems	RI VERVI EW I	HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0059	Period:	Worksheet B
				From 01/01/2020 To 12/31/2020	
					7/29/2021 10:51 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE
	N	SUPPLY		LI BRARY	
	13.00	14.00	15.00	16.00	17.00
193.03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 0	0 193.03
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	0 193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	0	0		0 0	0 193.05
193. 06 19306 OUTPATI ENT PHARMACY	0	0		0 0	0 193.06
194. 00 07950 WORKMED	0	0		0 0	0 194.00
194.0107951 MEALS ON WHEELS	0	0		0 0	0 194.01
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	9, 630	457, 107	624, 6	18 143, 608	100, 075 202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	RI VERVI EW	Provider C	CN: 15-0059 P	In Lie eriod:	u of Form CMS-2552 Worksheet B
ALLOON	THOR OF ONE THE REALED COSTS				rom 01/01/2020	Part II
	Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1				1.
$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY					4. 5. 7. 8. 9. 10. 11. 13. 14. 15. 16.
	01700 SOCIAL SERVICE	11 170				17.
23.00	02300 PARAMED ED PRGM PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11, 470				23.
31.00 41.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS		5, 879, 963 894, 653 1, 027, 438 0 0	0 0 0 0	5, 879, 963 894, 653 1, 027, 438 0 0	30. 31. 41. 43. 44.
50.00	05000 OPERATING ROOM		3, 011, 425	0	3, 011, 425	50.
52.00 54.00	05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C		0 779, 880	0	0 779, 880	52. 54.
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN		415, 285 4, 521	0	415, 285 4, 521	55. 57.
57.00	03630 ULTRA SOUND		4, 756		4, 756	57.
	05800 MRI		3, 893	0	3, 893	58.
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY		169, 803 883, 915	0	169, 803 883, 915	59. 60.
60.00 60.01	06001 BLOOD LABORATORY		003, 915	0	003, 915	60.
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		117, 984	0	117, 984	63.
64.00	06400 I NTRAVENOUS THERAPY		0	0	0	64.
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		80, 381 356, 776	0	80, 381 356, 776	65. 66.
	06700 OCCUPATI ONAL THERAPY		0	0	0	67.
	06800 SPEECH PATHOLOGY		0	0	0	68.
69.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		385, 822	0	385, 822 457, 107	69. 71
71.00 72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		457, 107 85, 272		457, 107 85, 272	71.
	07300 DRUGS CHARGED TO PATIENTS		624, 618	0	624, 618	73.
	07400 RENAL DI ALYSI S		54, 371	0	54, 371	74.
	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB		0 521, 064	-	0 521, 064	76. 76.
	03070 WOMEN' S CENTER		523, 062			76.
76.03	03330 ENDOSCOPY		0	0	0	
90.00	OUTPATIENT SERVICE COST CENTERS		139, 976	0	139, 976	90.
	09001 0UTPATI ENT		211, 691	0	211, 691	90.
	09002 NEUROPSYCHOLOGY		25, 987	0	25, 987	90.
	09100 EMERGENCY		1, 336, 650		1, 336, 650	91.
	09101 SHORT STAY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0	0	0	91. 92.
72.00	OTHER REIMBURSABLE COST CENTERS	II		0		72.
95.00	09500 AMBULANCE SERVICES		16, 324	0	16, 324	95.
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	18, 012, 617	0	18, 012, 617	118.
110.00	NONREI MBURSABLE COST CENTERS	0	10,012,017	0	10, 012, 017	110.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		341, 160			190.
	19200 PHYSI CLANS' PRI VATE OFFI CES		2,089,669		2,089,669	192.
	19201 FOUNDATI ON 19202 CLI NI CS		2, 439 21, 618		2, 439 21, 618	192. 192.
	19206 HOME HEALTH PARTNERSHIP		21,010	0	21,010	192.
	19207 WESTFI ELD SCHOOLS		11, 990	0	11, 990	192.
	19203 PRACTI CE MANAGEMENT		7, 377	0	7, 377	192.
	19204 MOB - NOBLESVILLE SQUARE 19208 PHYSICIANS' PRIVATE OFFICES		131 0		131 0	192. 192.
	19205 RI VERVI EW MEDI CAL ARTS		704	0	704	192.
	19209 BEHAVI OR CARE		5, 527		5, 527	192.
193.00	19300 NONPAI D WORKERS		0	0	0	193.

Health Financial Systems	RI VERVI EW H	OSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0059	Period:	Worksheet B
				From 01/01/2020 To 12/31/2020	
				10 12/31/2020	7/29/2021 10:51 am
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM PHARMACY		Resi dents		
			Cost & Post		
			Stepdown		
			Adjustments		
	23.00	24.00	25.00	26.00	
193. 01 19301 PHYSI CI AN SERVI CES-LYONS		1, 162		0 1, 162	193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS		553		0 553	193.02
193. 03 19303 OB/GYN SPEC NEMUNALTI		6, 596		0 6, 596	193.03
193.04 19304 OB/GYN SPEC GATHERS		16		0 16	193.04
193.05 19305 OB SPECIALISTS DAVENPORT		4, 900		0 4, 900	193.05
193. 06 19306 OUTPATIENT PHARMACY		34, 738		0 34, 738	193.06
194. 00 07950 WORKMED		7, 416		0 7,416	194.00
194.0107951 MEALS ON WHEELS		3, 400		0 3,400	194.01
200.00 Cross Foot Adjustments	11, 470	11, 470		0 11, 470	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118 through 201)	11, 470	20, 563, 504		0 20, 563, 504	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	RI VERVI EW H		CN: 15-0059 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	
		CAPI TAL				7/29/2021 10:	51 am
	Cost Center Description	RELATED COSTS BLDG & FIXT	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		(SQUARE FEET)	<b>BENEFITS</b>	n	E & GENERAL	PLANT	
			DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
			SALARI ES)				
	GENERAL SERVI CE COST CENTERS	1.00	4.00	5A	5.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	615, 574					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2,865	83, 932, 189		1/0 010 050		4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	44, 859 224, 224	9, 038, 050 2, 262, 194				5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 455	73, 073				
9.00	00900 HOUSEKEEPI NG	1, 177	1, 147, 208		2, 337, 141	1, 177	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	12, 360	341, 156 860, 937		1, 228, 708 1, 682, 174		1
	01300 NURSI NG ADMI NI STRATI ON	0	713, 099	-	.,		
	01400 CENTRAL SERVICES & SUPPLY	6, 965	637, 325				
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	8, 686 2, 311	2, 289, 839 816, 600		,		
17.00	01700 SOCIAL SERVICE	1, 643	617, 057	C C	1		
23.00	02300 PARAMED ED PRGM PHARMACY	155	245, 627	0	285, 347	155	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	91, 729	9, 126, 554	C	14, 389, 534	91, 729	30.00
31.00	03100 I NTENSI VE CARE UNI T	13, 741	2, 889, 109			13, 741	
	04100 SUBPROVIDER - IRF	14, 116	1, 483, 160		-,,	14, 116	
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0 0	-	-		
	ANCILLARY SERVICE COST CENTERS			1	-		1
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	52, 721	4, 244, 817	-8, 887, 297 0		-	50.00 52.00
52.00	05400 RADI OLOGY-DI AGNOSTI C	13, 288	1, 923, 475		-	-	
	05500 RADI OLOGY-THERAPEUTI C	7, 176	492, 057	C	1, 367, 375	7, 176	55.00
57.00 57.01	05700 CT SCAN 03630 ULTRA SOUND	0	340, 706 387, 144				
58.00	05800 MRI	0	300, 137				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 793	862, 235	C	1, 188, 101	2, 793	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	14, 329	3, 122, 668	0	8, 807, 214	14, 329	60.00 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,038	0		520, 348		1
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	-	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 084 4, 698	1, 470, 219 4, 495, 031		.,,		
67.00	06700 OCCUPATI ONAL THERAPY	4,070	4, 475, 051	d d		0	1
	06800 SPEECH PATHOLOGY	0	0	C		-	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	6, 636	518, 664 0		,	6, 636 0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	c c	-	0	72.00
	07300 DRUGS CHARGED TO PATI ENTS	0	0	0	0	0	73.00
	07400 RENAL DI ALYSI S 03020 OTHER ANCI LLARY	929	0			929	
	03140 CARDI AC REHAB	8, 759	637, 415	-	-	-	76.01
	03070 WOMEN' S CENTER 03330 ENDOSCOPY	9, 217	423, 603				
76.03	OUTPATIENT SERVICE COST CENTERS	0	0	y 0	0	0	76.03
90.00	09000 CLI NI C	2, 411	329, 625	1			
	09001 OUTPATI ENT 09002 NEUROPSYCHOLOGY	3, 511 283	641, 718 165, 807		1, 356, 355 245, 694		
	09100 EMERGENCY	203	5, 424, 379				
	09101 SHORT STAY	0	0	C	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVI CES	273	60, 872	C	116, 542	273	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	577, 634	58, 381, 560	-35, 650, 270	126, 913, 106	305, 686	110 00
116.00	NONREI MBURSABLE COST CENTERS	577,034	36, 361, 300	-35, 850, 270	120, 913, 100	303, 888	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 040	149, 987				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FOUNDATI ON	31, 900	20, 482, 156 201, 832				192.00 192.01
	19202 CLINICS	0	872, 753			0	192.02
	19206 HOME HEALTH PARTNERSHI P	0	0	0	2,358		192.03
	19207 WESTFIELD SCHOOLS 19203 PRACTICE MANAGEMENT	0	966, 055 436, 160		1, 225, 525 770, 585		192. 04 192. 05
	19204 MOB - NOBLESVILLE SQUARE	0	-30, 100		14, 789		192.05
	19208 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.07
192.08	19205 RI VERVI EW MEDI CAL ARTS	0	0	0	79, 216	0	192.08

COST ALLOCATION - STATISTICAL BASIS         Provider CCN: 15-0059         Period: From 01/01/2020 To 12/31/2020         Worksheet B-1 Date/Time Prepared: 7/29/2021 10:51 am           Cost Center Description	Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
Cost Center Description         CAPITAL RELATED COSTS BLDG & FIXT (SOUARE FEET)         EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)         Reconciliatio n         ADMINISTRATIV E & GENERAL (ACCUM, COST)         OPERATION OF PLANT (SOUARE FEET)           192.09         BHAVIOR CARE         0         379,311         0         573,443         0         192.09           193.00         19300         NORPAID WORKERS         0         379,311         0         573,443         0         192.09           193.00         19300         NORPAID WORKERS         0         0         0         0         0         0         193.02           193.02         UNIVERSITY HS ATHLETICS         0         89,504         0         1193.02         0         193.02         0         193.02         0         193.02         0         193.02         0         193.02         0         193.02         0         193.02         0         193.02         0         193.02         0         193.02         0         193.02         193.02         193.03         193.03         193.03         193.03         193.03         193.02         193.03         193.02         193.03         193.02         193.02         193.02         193.02         193.02         193.02         193.02	COST ALLOCATION - STATISTICAL BASIS		Provider C	F	rom 01/01/2020	Date/Time Pre	pared:
Cost Center Description         ReLATED COSTS BLG & FLXT (SUURE FEET)         EMPLOYEE BENEFITS SALARIES         Reconciliatio n         ADMINISTRATIV (ACCUM. COST)         OPERATION OF PLANT (SOURE FEET)           192.09         BEHAVIOR CARE         0         5.00         7.00           192.09         BEHAVIOR CARE         0         379, 311         0         573, 443         0         192.09           193.00         19300         NONPAID WORKERS         0         0         0         0         0         193.01           193.01         19302         NONPAID WORKERS         0         39, 504         0         1193.01         0         193.01         193.02         193.02         193.02         193.02         193.02         193.02         193.04         193.01         193.01         193.01         193.01         193.01         193.01         193.01         193.02         193.04         193.						7/29/2021 10:	<u>51 am</u>
Cost Center Description         BLDG & FIXT (SOUARE FEET)         EMPLOYEE BENEFITS DEPARTMENT (CROSS         Reconciliatio BENEFITS DEPARTMENT (CROSS         ADMINISTRATIV E & GENERAL (ACCUM. COST)         OPERATION OF PLANT (SUARE FEET)           192.09         BEHAVIOR CARE         0         379,311         0         573,443         0         192.09           193.00         19300         NONPAID WORKERS         0         0         0         0         0         0         193.01         193.07         0         56.437         0         193.02         193.02         NV EVENT YH SATHLETI CS         0         45.978         0         56.437         0         193.02           193.02         DV EVENT YH SATHLETI CS         0         45.978         0         56.437         0         193.03         193.03         193.03         0         0         0         1.772         0         193.03         193.04         193.04         193.05         193.05         1.372         0         193.04         193.04         193.04         193.04         193.04         193.04         193.04         193.04         193.04         193.05         193.05         193.05         193.05         193.05         193.05         193.05         193.04         193.04         193.04 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
Image: Constraint of the second sec							
DEPARTMENT (GROSS SALARIES)         DEPARTMENT (GROSS SALARIES)         (ACCUM. COST)         (SQUARE FEET)           192.09         DEHAVIOR CARE         0         379.311         573.443         0         192.09           193.00         19300         NONPAID <workers< td="">         0         0         0         0         0         193.00           193.01         19301         PHYSICIAN SERVICES-LYONS         0         89,554         0         119,317         0         193.01           193.02         19302         UNI VERSITY HS ATHLETICS         0         45,978         0         66,437         0         193.03           193.04         19304         0B/GVN SPEC MEMUNALTI         0         531.876         0         674.132         0         193.04           193.05         DB SPECIALISTS DAVENPORT         0         387.035         0         501.856         0         193.06           193.06         OUTPATIENT PHARMACY         0         516.199         3.843.539         0         193.06           194.00         O750         WORKMED         0         359,111         788.655         0         194.01           200.00         Cross Foot Adjustments         0         132.672         0         <t< td=""><td>Cost Center Description</td><td></td><td></td><td>Reconciliatio</td><td></td><td></td><td></td></t<></workers<>	Cost Center Description			Reconciliatio			
Image: Constraint of the second sec		(SQUARE FEET)		n			
Image: Non-Section of the section of the sectin the section of the section of the section of the sectio					(ACCUM. COST)	(SQUARE FEET)	
1.00         4.00         5A         5.00         7.00           192.09         19209         BEHAVI OR CARE         0         379, 311         0         573, 443         0         192.09           193.00         019300         NONPAI D         WORKERS         0         0         0         0         0         0         0         0         193.01         193.02         193.02         193.02         193.02         193.02         193.02         193.02         193.03         0B/GYN SPEC NEMUNAI TI         0         531, 876         0         674, 132         0         193.03         03         193.03         0B/GYN SPEC ALLISTS DAVENPORT         0         387, 035         0         501, 856         0         193.05         193.05         0         393.04         193.04         193.04         193.04         193.04         193.04         193.04         193.04         193.04         193.05         193.05         0         501, 856         0         193.05         193.05         0         501, 856         0         193.05         193.06         193.06         00 07950         00RKMED         0         359, 111         0         788, 655         0         194.00         194.00         0         194.01							
192.09       19209       BEHAVI OR CARE       0       379, 311       0       573, 443       0       192.09         193.00       19300       NONPAID       WORKERS       0       193.00       00       0       0       0       0       0       0       0       193.03       00       193.04       193.04       00       0       0       1,772       0       193.03       03       00       0       0       1,772       0       193.06       193.06       0       0       387.035       0       50       50       50       50       50       193.06       193.06       193.06       193.06       193.06       193.06       193.06       193.06       193.05       0       132.672       0       353.778       0       194.00       194.00							
193.00       19300       NONPAID       WORKERS       0       0       0       0       193.00         193.01       19302       INVERSITY       AS SERVICES-LYONS       0       89,504       0       119,317       0       193.01         193.02       UNIVERSITY       HS ATHLETICS       0       45,978       0       56,437       0       193.02         193.04       19303       0B/GYN       SPEC NEMUNALTI       0       531.876       0       674.132       0       193.04         193.05       19305       0B/GYN SPEC CATHERS       0       0       0       1,772       0       193.04         193.05       19305       0B/SPECIALISTS DAVENPORT       0       387,035       0       501,856       0       193.06         193.06       19306       0TPATIENT PHARMACY       0       359,111       0       788,655       0       194.00         194.00       07950       WORKMED       0       359,111       0       788,655       0       194.00       206.00       206.00       207.00       207.00       208,003       194.01       200.00       207.00       208,0131       26,762,973       18,487,632       202.00       207.00       208,003<		1.00					
193.01       19301       PHYSICIAN SERVICES-LYONS       0       89,504       0       119,317       0       193.01         193.02       19302       UNIVERSITY HS ATHLETICS       0       45,978       0       56,437       0       193.02         193.03       19303       0B/GYN SPEC NEMUNALTI       0       531,876       0       674,132       0       193.03         193.04       19304       0B/GYN SPEC GATHERS       0       0       0       1,772       0       193.04         193.05       19305       0B SPECIALISTS DAVENPORT       0       387,035       0       501,856       0       193.06         194.00       07950       WORKED       0       516,199       0       3,843,539       0       193.06         194.01       07950       WORKED       0       132,672       0       353,778       0       194.01         200.00       Cross Foot Adjustments       0       132,672       0       353,8778       200.00       201.00         201.00       Regative Cost Centers       0       132,672       0       353,801610       203.00       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716		0	379, 311	(	573, 443		
193.02       19302       UNIVERSITY HS ATHLETICS       0       45,978       0       56,437       0       193.02         193.03       19303       0B/GYN SPEC NEMUNALTI       0       531,876       0       674,132       0       193.03         193.04       19304       0B/GYN SPEC GATHERS       0       0       0       1,772       0       193.03         193.05       19305       0B SPECIALISTS DAVENPORT       0       387,035       0       501,856       0       193.06         193.06       09306       UTPATIENT PHARMACY       0       516,199       0       3,843,539       0       193.06         194.00       07950       WORKMED       0       359,111       0       788,655       0       194.00         200.00       Cross Foot Adjustments       0       132,672       0       353,778       0       194.01         200.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       0.001140		0	0	(	0 0		
193.03       0B/GYN SPEC NEMUNALTI       0       531,876       0       674,132       0       193.03         193.04       19304       0B/GYN SPEC GATHERS       0       0       0       1,772       0       193.04         193.05       19305       0B SPECIALISTS DAVENPORT       0       387,035       0       501,856       0       193.05         193.06       19306       0UTPATIENT PHARMACY       0       516,199       0       3,843,539       0       193.05         194.00       07950       WORKMED       0       359,111       0       788,655       0       194.00         194.01       07951       MEALS ON WHEELS       0       132,672       0       353,778       0       194.01         200.00       Corss Foot Adjustments       20,563,504       9,880,131       26,762,973       18,487,632       202.00       201.00         203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.008885       22.218263       205.00         205.00       Unit cost multiplier (Wkst. B, Part I)       0.001140		0					
193.04       19304       0B/GYN SPEC GATHERS       0       0       0       1,772       0       193.04         193.05       19305       0B SPECIALISTS DAVENPORT       0       387,035       0       501,856       0       193.05         193.06       19306       0UTPATIENT PHARMACY       0       516,199       0       3,843,539       0       193.06         194.00       07950       WORKMED       0       359,111       0       788,655       0       194.00         194.01       07950       WORKMED       0       359,111       0       788,655       0       194.01         200.00       Cross Foot Adjustments       0       132,672       0       353,778       200.00         201.00       Negative Cost Centers       0       132,672       0       353,778       202.00         202.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.008885       22.218263       205.00         11)       11       11       0.001140       0.008885       22.218263       205.00       206.00		0					
193.05       19305       OB       SPECIALISTS DAVENPORT       0       387,035       0       501,856       0       193.05         193.06       19306       OUTPATIENT PHARMACY       0       516,199       0       3,843,539       0       193.06         194.00       07950       WORKMED       0       359,111       0       788,655       0       194.00         194.01       07951       MEALS ON WHEELS       0       359,111       0       788,655       0       194.00         200.00       Cross Foot Adjustments       0       132,672       0       353,778       200.00       201.00         201.00       Negative Cost Centers       20,563,504       9,880,131       26,762,973       18,487,632       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         205.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.001140       0.008885       22.218263       205.00         10       Unit cost multiplier (Wkst. B, Part I)       0.001140		0	531, 876	(			
193.06       19306       OUTPATIENT PHARMACY       0       516, 199       0       3, 843, 539       0       193.06         194.00       07950       WORKMED       0       359, 111       0       788, 655       0       194.00         194.01       07951       MEALS ON WHEELS       0       132, 672       0       353, 778       0       194.01         200.00       Cross Foot Adjustments       0       132, 672       0       353, 778       0       194.01         201.00       Negative Cost Centers       0       132, 672       0       353, 778       0       194.01         202.00       Cost to be allocated (per Wkst. B, Part I)       20, 563, 504       9, 880, 131       26, 762, 973       18, 487, 632       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.008885       22.218263       205.00         11)       Unit cost multiplier (Wkst. B, Part I)       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. D,       0       001140		0	-				
194.00       07950       WORKMED       0       359,111       0       788,655       0       194.00         194.01       07951       MEALS ON WHEELS       0       132,672       0       353,778       0       194.01         200.00       Cross Foot Adjustments       0       132,672       0       353,778       0       194.01         201.00       Negative Cost Centers       0       132,672       0       353,778       200.00         201.00       Cost to be allocated (per Wkst. B, Part I)       20,563,504       9,880,131       26,762,973       18,487,632       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.008885       22.218263       205.00         205.00       Unit cost multiplier (Wkst. B, Part I)       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. D,       0.001140       0.008885       22.218263       205.00         207.00       NAHE unit cost multiplier (Wkst. D,       0.00140       0.007140       206.00       206.00 <td></td> <td>0</td> <td>387, 035</td> <td>(</td> <td>501, 856</td> <td></td> <td></td>		0	387, 035	(	501, 856		
194.01       07951       MEALS ON WHEELS       0       132,672       0       353,778       0       194.01         200.00       Cross Foot Adjustments       0       132,672       0       353,778       0       194.01         201.00       Negative Cost Centers       20,563,504       9,880,131       26,762,973       18,487,632       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         205.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.001140       0.008885       22.218263       205.00         205.00       Unit cost multiplier (Wkst. B, Part I)       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. B, Part I)       0.001140       0.008885       22.218263       206.00         207.00       NAHE unit cost multiplier (Wkst. D,       0       0.01140       207.00	193. 06 19306 OUTPATI ENT PHARMACY	0	516, 199	(	3, 843, 539	0	193.06
200.00       Cross Foot Adjustments       200.00       200.00       201.00         201.00       Negative Cost Centers       20.563,504       9,880,131       26,762,973       18,487,632       202.00         202.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         205.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         205.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. D,       0.001140       0.008885       22.218263       205.00         207.00       NAHE unit cost multiplier (Wkst. D,       207.00       207.00       207.00		0	359, 111	(	788, 655	0	194.00
201.00         Negative Cost Centers         201.00           202.00         Cost to be allocated (per Wkst. B, Part I)         20,563,504         9,880,131         26,762,973         18,487,632         202.00           203.00         Unit cost multiplier (Wkst. B, Part I)         33.405413         0.117716         0.157603         53.801610         203.00           204.00         Cost to be allocated (per Wkst. B, Part I)         33.405413         0.117716         0.157603         53.801610         203.00           205.00         Unit cost multiplier (Wkst. B, Part I)         0.001140         0.001140         0.008885         22.218263         205.00           206.00         NAHE adjustment amount to be allocated (per Wkst. D,         0.001140         0.008885         22.218263         206.00           207.00         NAHE unit cost multiplier (Wkst. D,         0.001140         207.00	194.0107951 MEALS ON WHEELS	0	132, 672	(	353, 778	0	194.01
202.00       Cost to be allocated (per Wkst. B, Part I)       20,563,504       9,880,131       26,762,973       18,487,632       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         205.00       Unit cost multiplier (Wkst. B, Part I)       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. B, 20)       NAHE unit cost multiplier (Wkst. D, 207.00       207.00	200.00 Cross Foot Adjustments						200.00
Part I)       203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part II)       33.405413       0.117716       1,508,836       7,634,773       204.00         205.00       Unit cost multiplier (Wkst. B, Part II)       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. B-2)       0.001140       0.001140       206.00       206.00         207.00       NAHE unit cost multiplier (Wkst. D,       0.001140       207.00       207.00	201.00 Negative Cost Centers						201.00
203.00       Unit cost multiplier (Wkst. B, Part I)       33.405413       0.117716       0.157603       53.801610       203.00         204.00       Cost to be allocated (per Wkst. B, Part II)       33.405413       0.117716       1,508,836       7,634,773       204.00         205.00       Unit cost multiplier (Wkst. B, Part II)       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. B-2)       0.001140       0.001140       206.00         207.00       NAHE unit cost multiplier (Wkst. D,       0.001140       207.00       207.00	202.00 Cost to be allocated (per Wkst. B,	20, 563, 504	9, 880, 131		26, 762, 973	18, 487, 632	202.00
204.00       Cost to be allocated (per Wkst. B, Part II)       95,707       1,508,836       7,634,773       204.00         205.00       Unit cost multiplier (Wkst. B, Part II)       0.001140       0.008885       22.218263       205.00         206.00       NAHE adjustment amount to be allocated (per Wkst. B-2)       0.001140       0.001140       206.00       206.00         207.00       NAHE unit cost multiplier (Wkst. D,       0.001140       0.001140       207.00							
Part II)       Part II)         205.00       Unit cost multiplier (Wkst. B, Part II)         206.00       NAHE adjustment amount to be allocated (per Wkst. B-2)         207.00       NAHE unit cost multiplier (Wkst. D,	203.00 Unit cost multiplier (Wkst. B, Part I)	33. 405413	0. 117716		0. 157603	53.801610	203.00
205.00         Unit cost multiplier (Wkst. B, Part         0.001140         0.008885         22.218263         205.00           11)         206.00         NAHE adjustment amount to be allocated (per Wkst. B-2)         207.00         NAHE unit cost multiplier (Wkst. D,         207.00         207.00         207.00	204.00 Cost to be allocated (per Wkst. B,		95, 707		1, 508, 836	7, 634, 773	204.00
206.0011) NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00							
206.0011) NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00	205.00 Unit cost multiplier (Wkst. B, Part		0. 001140		0. 008885	22. 218263	205.00
207.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	11)						
207.00 NÄHE unit cost´multiplier (Wkst. D, 207.00	206.00 NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
Dente (11) and (11)	207.00 NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	RI VERVI EW	HOSPI TAL Provi der CC	CN: 15-0059 Pe	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
			Fr To	rom 01/01/2020 0 12/31/2020	Date/Time Pre	pared:
Cost Center Description	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	7/29/2021 10: NURSI NG ADMI NI STRATI 0 N (DI RECT NRSI NG HR)	<u>51 am</u>
	8.00	9.00	10.00	11.00	13.00	
GENERAL         SERVI CE         COST         CENTERS           1. 00         00100         CAP         REL         COSTS-BLDG & FIXT           4. 00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5. 00         00500         ADMI NI STRATI VE         & GENERAL           7. 00         00700         OPERATI ON OF PLANT           8. 00         00800         LAUNDRY         & LI NEN SERVICE           9. 00         00900         HOUSEKEEPI NG         0           10. 00         01000         DI ETARY           11. 00         01100         CAFETERI A           13. 00         01300         NURSI NG ADMI NI STRATI ON           14. 00         01400         CENTRAL         SERVI CES         SUPPLY           15. 00         01500         PHARMACY         1         0         01600         MEDI CAL         RECORDS         & LI BRARY           17. 00         01700         SOCI AL         SERVI CE         0         02300         PARAMED ED         PRGM         PHARMACY           1         INPATI ENT         ROUTI NE         SERVI CE         COST CENTERS	67, 867 0 0 0 0 550 0 0 0 0 0 0 0 0	1, 065 4 28 0 1 1 25 5 0 0	66, 195 0 0 0 0 0 0 0 0 0	1, 161, 855 17, 440 26, 248 68, 442 32, 888 13, 897 2, 115	411, 825 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 23.\ 00 \end{array}$
30.00         03000         ADULTS         & PEDI ATRICS           31.00         03100         I NTENSI VE         CARE         UNI T	22, 936 5, 347	433 73	42, 811 5, 600	241, 300 62, 360	241, 300 62, 360	31.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	5, 717 0 0	63 0 0	17, 784 0 0	41, 850 0 0	41, 850 0 0	43.00
ANCI LLARY SERVI CE COST CENTERS	7, 102	107	0	105, 106	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC 55. 00 05500 RADIOLOGY-THERAPEUTIC 57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND	0 4, 285 592 0 0	0 41 10 0	0 0 0 0 0	0 57, 579 10, 983 9, 642 8, 656	0 0 0 0 0	50.00 52.00 54.00 55.00 57.00 57.01
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 1, 888 0	35	0 0 0	7, 629 18, 360 88, 752	0 0 0	58.00 59.00 60.00
60. 01       06001       BLOOD       LABORATORY         63. 00       06300       BLOOD       STORI NG, PROCESSI NG & TRANS.         64. 00       06400       I NTRAVENOUS       THERAPY         65. 00       06500       RESPI RATORY       THERAPY         66. 00       06600       PHYSI CAL       THERAPY         67. 00       06700       OCCUPATI ONAL       THERAPY	0 0 0 0 617 0	0 0 3 0	0 0 0 0 0	0 0 40, 538 133, 737 0	0 0 0 0 0 0	60. 01 63. 00 64. 00 65. 00 66. 00 67. 00
68. 0006800SPEECH PATHOLOGY69. 0006900ELECTROCARDI OLOGY71. 0007100MEDI CAL SUPPLI ES CHARGED TO PATI ENT72. 0007200I MPL. DEV. CHARGED TO PATI ENTS73. 0007300DRUGS CHARGED TO PATI ENTS	628 0 0 0	0 30 0	0 0 0 0 0	0 15, 637 0 0 0	0 0 0 0 0	68.00 69.00 71.00 72.00 73.00
74.00       07400       RENAL DI ALYSI S         76.00       03020       OTHER ANCI LLARY         76.01       03140       CARDI AC REHAB         76.02       03070       WOMEN'S CENTER         76.03       03330       ENDOSCOPY	0 0 54 365 0	0 0 27 20 0	0 0 0 0 0	0 0 23,095 14,457 0	0 0 0 0	
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC           90.01         09001         OUTPATI ENT           90.02         09002         NEUROPSYCHOLOGY           91.00         09100         EMERGENCY           91.01         09101         SHORT STAY	99 1, 988 0 9, 877 0		0 0 0 0 0	11, 132 17, 913 4, 069 66, 315 0	0 0 66, 315 0	90. 01 90. 02 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0		0	2, 168		95.00
118.00     SUBTOTALS (SUM OF LINES 1 through 11'       NONREIMBURSABLE COST CENTERS       190.00     GIFT, FLOWER, COFFEE SHOP & CANTEEN	7) 62,045	1,008	66, 195	1, 142, 308	411, 825	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	5, 772 0 26	0 0 56	000000000000000000000000000000000000000	4, 980 0	0 0 0	192. 00 192. 01 192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFIELD SCHOOLS 192. 05 19203 PRACTICE MANAGEMENT 192. 06 19204 MOB - NOBLESVILLE SQUARE	0 0 24 0	0 0 0	0 0 0 0	0 0 0 0	0 0	192. 03 192. 04 192. 05 192. 06
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19205 RI VERVI EW MEDI CAL ARTS 192. 09 19209 BEHAVI OR CARE 193. 00 19300 NONPAI D WORKERS		0 0 0	0 0 0	0 0 0	0 0 0	192. 07 192. 08 192. 09 193. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
		_		From 01/01/2020 To 12/31/2020		pared: 51 am
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	· · · · · ·	(MEALS	(MAN HOURS)	ADMI NI STRATI O	
	(POUNDS OF	SERVIC)	SERVED)		N (DI RECT	
	LAUNDR)				NRSING HR)	
	8.00	9.00	10.00	11.00	13.00	
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0.00	0	10.00	0 0		193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0		0 0		193.02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	0		0 0	0	193.03
193.04 19304 OB/GYN SPEC GATHERS	0	0		0 0	0	193.04
193. 05 19305 OB SPECIALI STS DAVENPORT	0	0		0 0	0	193.05
193. 06 19306 OUTPATI ENT PHARMACY	0	0		0 0	0	193.06
194. 00 07950 WORKMED	0	0		0 0		194.00
194.0107951 MEALS ON WHEELS	0	0		0 6, 756	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 790, 582	2, 768, 805	2, 097, 74	3 2, 020, 085	1, 143, 423	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	26. 383692	2, 599. 816901	31.69035	4 1. 738672		
204.00 Cost to be allocated (per Wkst. B, Part II)	94, 158	87, 542	699, 14	4 18, 229	9, 630	204.00
205.00 Unit cost multiplier (Wkst. B, Part	1. 387390	82. 199061	10. 56188	5 0. 015690	0. 023384	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	RI VERVI EW H	IOSPI TAL Provi der CO	CN: 15-0059 P	In Lie	u of Form CMS-2 Worksheet B-1	
				rom 01/01/2020		pared:
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCI AL SERVI CE (TI ME SPENT)	PARAMED ED PRGM PHARMACY (ASSI GNED TI ME)	
	14.00	15.00	16.00	17.00	23.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         CAP         REL         COSTS-BLDG & FIXT           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL         7.00         00700         OPERATION OF PLANT           8.00         00800         LAUNDRY & LI NEN         SERVICE         9.00         00900         HOUSEKEEPI NG           10.00         01000         DI ETARY         11.00         01100         CAFETERI A           13.00         01300         NURSI NG         ADMI NI STRATI ON           14.00         01400         CENTRAL         SERVICES & SUPPLY           15.00         01500         PHARMACY         16.00         001600         MEDI CAL         RECORDS & LI BRARY           17.00         02300         PARAMED ED         PRGM         PHARMACY         17.00         17.00         12300         PARAMED ED         PRGM         PHARMACY	100 0 0 0 0	100 0 0 0	179 0	4, 485 0	100	$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 23.\ 00\\ \end{array}$
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	0	0	32	3, 797	0	30.00
31.00       03100       I NTENSI VE CARE UNI T         41.00       04100       SUBPROVI DER - I RF         43.00       04300       NURSERY         44.00       04400       SKI LLED NURSI NG FACI LI TY	0 0 0 0	0 0 0 0	12 0 0	3, 797 278 410 0 0	0 0 0 0	30.00 31.00 41.00 43.00 44.00
ANCI LLARY SERVICE COST CENTERS	0	0	67	0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	0 0 0	0 0 0 0 0		0 0 0 0	0 0 0 0	50.00 52.00 54.00 55.00 57.00
57. 01 03630 ULTRA SOUND	о	0	0	0	0	57.01
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	58.00 59.00
60. 00 06000 LABORATORY	0	0	1	0	0	60.00
60. 01 06001 BLOOD LABORATORY	Ő	0	0	0	0	60.01
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	25	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	Ő	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	6	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	100	0	0	0	0	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	100	0	0	100	
74.00 07400 RENAL DI ALYSI S	О	0	0	0	0	74.00
76. 00 03020 OTHER ANCI LLARY 76. 01 03140 CARDI AC REHAB	0	0	0	0	0	76.00 76.01
76. 02 03070 WOMEN' S CENTER	0	0	0	0	0	76.02
76. 03 03330 ENDOSCOPY	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					0	
90. 00 09000 CLINIC 90. 01 09001 0UTPATIENT	0	0	0	0	0	90.00 90.01
90. 02 09002 NEUROPSYCHOLOGY	Ō	0	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	11	0	0	91.00
91.01 09101 SHORT STAY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	91.01 92.00
OTHER REI MBURSABLE COST CENTERS						, ,2.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)	100	100	172	4, 485	100	118.00
NONREIMBURSABLE COST CENTERS	100	100	172	4, 400	100	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
192. 01 19201 FOUNDATI ON 192. 02 19202 CLI NI CS	0	0	0 7	0		192.01 192.02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	0	Ó	0		192.02
192.04 19207 WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192. 05 19203 PRACTI CE MANAGEMENT 192. 06 19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192.05 192.06
192. 06 19204 MOB - NOBLESVILLE SQUARE 192. 07 19208 PHYSICIANS' PRIVATE OFFICES	0	0		0		192.06 192.07
192. 08 19205 RI VERVI EW MEDI CAL ARTS	Ő	0	0	0	0	192.08
192. 09 19209 BEHAVI OR CARE	0	0	0	0		192.09
193. 00 19300 NONPAI D WORKERS	O	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 - STATISTICAL BASIS		Provider CO		Period: From 01/01/2020	Worksheet B-1	
				To 12/31/2020	Date/Time Pre 7/29/2021 10:	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	PARAMED ED	
	SERVICES &	(COSTED	RECORDS &	SERVI CE	PRGM PHARMACY	
	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
	(COSTED REQUIS.)		(TIME SPENT)		TIME)	
	14.00	15.00	16.00	17.00	23.00	
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	-	0 C	0	193.01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	(	0 C	0	193.02
193. 03 19303 OB/GYN SPEC NEMUNAI TI	0	0	(	0 C	0	193.03
193.04 19304 OB/GYN SPEC GATHERS	0	0	(	0 C		193.04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	0	(	0 0		193.05
193. 06 19306 OUTPATI ENT PHARMACY	0	0		0 0		193.06
194.00 07950 WORKMED	0	0		0 0		194.00
194.01 07951 MEALS ON WHEELS	0	0	(	0 0		194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	9, 258, 421	18, 335, 496	1, 914, 81	6 1, 124, 051	342, 335	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	92, 584. 210000	183, 354. 96000 0	10, 697. 29608	9 250. 624526	3, 423. 350000	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)	457, 107	624, 618	143, 60	в 100, 075	11, 470	204.00
205.00 Unit cost multiplier (Wkst. B, Part	4, 571. 070000	6, 246. 180000	802. 27933	22. 313266	114. 700000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0. 000000	207.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	RI VERVI EW	Provider C	CN: 15-0059	Peri od:	u of Form CMS-: Worksheet C	
				From 01/01/2020	Part I	
				To 12/31/2020	Date/Time Pre 7/29/2021 10:	51 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B, Part I,	Adj .		Di sal I owance		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDIATRICS	27, 063, 528		27, 063, 52		27, 063, 528	
31. 00 03100 INTENSIVE CARE UNIT	6, 443, 907		6, 443, 90		6, 443, 907	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	5, 686, 277		5, 686, 27	77 0 0 0	5, 686, 277	•
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	
ANCI LLARY SERVICE COST CENTERS	0			0 0	0	44.00
50. 00 05000 OPERATING ROOM	13, 088, 793		13, 088, 79	93 0	13, 088, 793	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 727, 270		4, 727, 27	70 0	4, 727, 270	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 051, 065		2, 051, 06		2, 051, 065	
57. 00 05700 CT SCAN	535, 560		535, 56		535, 560	
57. 01 03630 ULTRA SOUND	559, 534		559, 53		559, 534	
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	452, 227 1, 607, 351		452, 22		452, 227 1, 607, 351	
50. 00 06000 LABORATORY	1, 607, 351		1, 607, 35 11, 222, 18		1, 607, 351	
50. 01 06001 BLOOD LABORATORY	11, 222, 102		11,222,10	0 0	0	
53. 00 06300 BLOOD STORING, PROCESSING & TRANS	-		712, 00		712,004	
54.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
55. 00 06500 RESPI RATORY THERAPY	2, 420, 003	0	2, 420, 00	03 0	2, 420, 003	65.00
56. 00 06600 PHYSI CAL THERAPY	9, 540, 049	0	9, 540, 04	19 0	9, 540, 049	66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	-		0 0	0	
58. 00 06800 SPEECH PATHOLOGY	0	-		0 0	0	
59.00 06900 ELECTROCARDI OLOGY	1, 548, 430		1, 548, 43		1, 548, 430	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIL 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	ENT 9, 258, 421 11, 109, 808		9, 258, 42 11, 109, 80		9, 258, 421 11, 109, 808	
73. 00 07200 IMPL. DEV. CHARGED TO PATTENTS	18, 677, 831		18, 677, 83		18, 677, 831	
74.00 07400 RENAL DIALYSIS	401, 264		401, 26		401, 264	
76.00 03020 OTHER ANCI LLARY	0		101/20	0 0	0	
76. 01 03140 CARDI AC REHAB	3, 052, 075		3, 052, 07	75 0	3, 052, 075	76.0 <sup>°</sup>
76.02 03070 WOMEN'S CENTER	1, 562, 137		1, 562, 13	37 0	1, 562, 137	76.02
76. 03 03330 ENDOSCOPY	0			0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS	00/ 557	1	00/ 5		00/ 557	
20.00 09000 CLINIC 20.01 09001 0UTPATIENT	826, 557		826, 55		826, 557	
20. 01 09001 001 PATTENT 20. 02 09002 NEUROPSYCHOLOGY	1, 860, 813 553, 700		1, 860, 8 <sup>-</sup> 553, 70		1, 860, 813 553, 700	
01. 00 09100 EMERGENCY	18, 236, 240		18, 236, 24		18, 236, 240	
91.01 09101 SHORT STAY	10, 200, 240		10, 200, 2-	0 0	10, 230, 240	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P	ART 4, 177, 324		4, 177, 32	-	4, 177, 324	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	153, 366		153, 36		153, 366	
200.00 Subtotal (see instructions)	157, 527, 716				157, 527, 716	
201.00 Less Observation Beds	4, 177, 324		4, 177, 32		4, 177, 324	
202.00  Total (see instructions)	153, 350, 392	0	153, 350, 39	92 0	153, 350, 392	1202.00

COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/29/2021 10:	epared: 51 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	36, 029, 387		36, 029, 38		1	30.00
	3100 INTENSIVE CARE UNIT	11, 346, 118		11, 346, 11	8	1	31.00
	4100 SUBPROVI DER – I RF	6, 750, 836		6, 750, 83		1	41.00
	4300 NURSERY	0			C	1	43.00
	4400 SKILLED NURSING FACILITY	0			C		44.00
	NCI LLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	17, 558, 675	64, 633, 850			0.000000	
	5200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0.000000	
	5400 RADI OLOGY-DI AGNOSTI C	1, 722, 305	9, 704, 489			0.000000	
	5500 RADI OLOGY-THERAPEUTI C	126, 865	8, 392, 211	8, 519, 07		0.000000	
	5700 CT SCAN	3, 628, 216	14, 926, 775			0. 000000	
	3630 ULTRA SOUND	985, 215	6, 603, 888			0.000000	
	5800 MRI	566, 244	4, 666, 350			0.000000	
59.00 0	5900 CARDIAC CATHETERIZATION	8, 749, 611	16, 217, 979			0.000000	
	6000 LABORATORY	15, 351, 265	37, 533, 849			0.000000	
	6001 BLOOD LABORATORY	0	0		0. 000000	0.000000	
	6300 BLOOD STORING, PROCESSING & TRANS.	987, 150	416, 815	1, 403, 96		0.000000	
	6400 INTRAVENOUS THERAPY	0	0	( 000 15	0.000000	0.000000	
	6500 RESPI RATORY THERAPY	5, 439, 859	1, 493, 594			0.000000	
	6600 PHYSI CAL THERAPY	8, 716, 673	17, 918, 923			0.000000	
	6700 OCCUPATI ONAL THERAPY	0	0		0.000000	0.00000	
	6800 SPEECH PATHOLOGY	0	0		0.000000	0.000000	
	6900 ELECTROCARDI OLOGY	2,054,518	6, 569, 706	8, 624, 22		0.000000	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENT	16, 642, 684	22, 720, 740			0.000000	
72.000 73.000	7200 IMPL. DEV. CHARGED TO PATIENTS	6, 506, 723	12, 430, 539			0.000000	
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS	13, 429, 912	43, 148, 438			0.000000	
	13020 OTHER ANCI LLARY	479, 620	2, 058 0		B 0. 833054 0. 000000	0. 000000 0. 000000	
	3320 OTHER ANGTELARY 3140 CARDI AC REHAB	516, 187	11, 370, 281	11, 886, 46		0.000000	
	3140 CARDIAC REHAB 3070 WOMEN'S CENTER		7, 273, 930			0.000000	
	13330 ENDOSCOPY	6, 447			0. 214588		
	UTPATIENT SERVICE COST CENTERS	0	0		0.00000	0. 000000	76.03
	99000 CLINIC	9,000	5, 020, 118	5, 029, 11	8 0. 164354	0.000000	90.00
	9000 CLINIC 19001 OUTPATIENT	256, 472	5, 591, 628			0.000000	
	9001 00 PATTENT 9002 NEUROPSYCHOLOGY	25, 000	1, 663, 516			0.000000	
	19002 NEUROPSTCHOLOGY	4, 999, 347	34, 728, 722			0.000000	
	19101 SHORT STAY	+, 777, 347	34, 720, 722 N		0. 439027	0.000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	940, 501	4, 664, 520			0.000000	
	THER REIMBURSABLE COST CENTERS	740, 301	4,004,320	5,005,02	0.743202	0.000000	72.00
	19500 AMBULANCE SERVICES	0	0		0.000000	0. 000000	95 00
200.00	Subtotal (see instructions)	163, 824, 830	337, 692, 919			0.000000	200.00
	Less Observation Beds	105, 024, 050	557,072,717	501, 517, 74	, 	1	200.00
201.00							

leal th Financial Systems	RI VERVI EW HO			u of Form CMS-2552
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0059	Period: From 01/01/2020	Worksheet C Part I
			To 12/31/2020	Date/Time Prepare
				7/29/2021 10:51 a
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.
31. 00 03100 I NTENSI VE CARE UNI T				31.
41.00 04100 SUBPROVI DER – I RF				41.
43. 00 04300 NURSERY				43.
44.00 O4400 SKILLED NURSING FACILITY				44.
ANCI LLARY SERVI CE COST CENTERS	0.450044			
50. 00 05000 OPERATING ROOM	0. 159246			50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 413700			54.
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 240761			55.
7.00 05700 CT SCAN	0. 028863			57.
7. 01 03630 ULTRA SOUND	0. 073729			57.
8.00 05800 MRI	0. 086425			58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0.064377			59.
0. 00 06000 LABORATORY	0. 212199			60.
0.01 06001 BLOOD LABORATORY	0. 000000			60.
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 507138			63.
4.00 06400 I NTRAVENOUS THERAPY	0. 000000			64.
5. 00 06500 RESPI RATORY THERAPY	0. 349033			65.
6.00 06600 PHYSI CAL THERAPY	0. 358169			66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.
8.00 06800 SPEECH PATHOLOGY	0. 000000			68.
9.00 06900 ELECTROCARDI OLOGY	0. 179544			69.
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 235204			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 586664			72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 330123			73.
4. 00 07400 RENAL DI ALYSI S	0. 833054			74.
6. 00 03020 OTHER ANCI LLARY	0. 000000			76.
6. 01 03140 CARDI AC REHAB	0. 256769			76.
6. 02 03070 WOMEN'S CENTER	0. 214568			76.
6. 03 03330 ENDOSCOPY	0. 000000			76.
	0 1/ 425 4			
0. 00 09000 CLINIC	0. 164354			90.
0. 01 09001 0UTPATI ENT 0. 02 09002 NEUROPSYCHOLOGY	0. 318191			90.
	0. 327921			90.
1. 00 09100 EMERGENCY	0. 459027			91.
1. 01 09101 SHORT STAY	0. 000000			91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 745282			92.
	0.000000			05
5.00 09500 AMBULANCE SERVICES 00.00 Subtotal (see instructions)	0. 000000			95. 200.
01.00 Less Observation Beds				201.
02.00  Total (see instructions)				202.

Health Financial Systems	RI VERVI EW				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0059	Period: From 01/01/2020	Worksheet C Part I	
				To 12/31/2020	Date/Time Pre 7/29/2021 10:	pared:
			e XIX	Hospi tal	7/29/2021 10: Cost	51 am
		11 11		Costs	COST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	27,063,528		27, 063, 52	28 0	27, 063, 528	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 443, 907		6, 443, 90		6, 443, 907	
41.00 04100 SUBPROVIDER - IRF	5, 686, 277		5, 686, 27		5, 686, 277	
43.00 04300 NURSERY	0			0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
ANCILLARY SERVICE COST CENTERS	1	I				
50. 00 05000 OPERATING ROOM	13, 088, 793		13, 088, 79		13, 088, 793	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		4 707 0	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 727, 270 2, 051, 065		4, 727, 27 2, 051, 06		4, 727, 270 2, 051, 065	
57. 00 05700 CT SCAN	535, 560		535, 56		535, 560	
57. 01 03630 ULTRA SOUND	559, 534		559, 53		559, 534	
58. 00 05800 MRI	452, 227		452, 22		452, 227	
59.00 05900 CARDI AC CATHETERI ZATI ON	1,607,351		1, 607, 35		1, 607, 351	
60. 00 06000 LABORATORY	11, 222, 182		11, 222, 18	32 0	11, 222, 182	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	712, 004		712, 00		712, 004	
64. 00 06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	2, 420, 003				2, 420, 003	
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	9, 540, 049	0	9, 540, 04	19 0 0 0	9, 540, 049 0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0			0 0	0	•
69. 00 06900 ELECTROCARDI OLOGY	1, 548, 430	, s	1, 548, 43	°	1, 548, 430	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 258, 421		9, 258, 42		9, 258, 421	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 109, 808		11, 109, 80		11, 109, 808	
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 677, 831		18, 677, 83	31 0	18, 677, 831	73.00
74.00 07400 RENAL DIALYSIS	401, 264		401, 26	04 0	401, 264	
76.00 03020 OTHER ANCI LLARY	0			0 0	0	
76. 01 03140 CARDI AC REHAB	3, 052, 075		3, 052, 07		3, 052, 075	
76. 02 03070 WOMEN' S CENTER	1, 562, 137		1, 562, 13		1, 562, 137	
76. 03 03330 ENDOSCOPY OUTPATI ENT SERVI CE COST CENTERS	0			0 0	0	76.03
90. 00 09000 CLINIC	826, 557		826, 55	0	826, 557	90.00
90. 01 09001 OUTPATI ENT	1, 860, 813		1, 860, 81		1, 860, 813	
90. 02 09002 NEUROPSYCHOLOGY	553, 700		553, 70		553, 700	•
91.00 09100 EMERGENCY	18, 236, 240		18, 236, 24		18, 236, 240	
91. 01 09101 SHORT STAY	0			0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 177, 324		4, 177, 32	24	4, 177, 324	92.00
OTHER REIMBURSABLE COST CENTERS	450.511		450.51	-	450.511	
95. 00 09500 AMBULANCE SERVICES	153, 366		153, 36		153, 366	
200.00Subtotal (see instructions)201.00Less Observation Beds	157, 527, 716 4, 177, 324		157, 527, 71 4, 177, 32		157, 527, 716 4, 177, 324	
202.00 Total (see instructions)	153, 350, 392					
	155, 550, 592	ı 0	1 133, 330, 33	- U	100, 000, 092	1202.0U

Cost Center Description         Inpatien           6.00         6.00           03000 ADULTS & PEDI ATRICS         36,029,           00         03100 INTENSI VE CARE UNIT         11,346,           00         04100 SUBPROVI DER - IRF         6,750,           00         04400 SKI LLED NURSI NG FACI LI TY         40,758,           ANCI LLARY SERVI CE COST CENTERS         00,750,758,           00         05400 PELI VERY ROOM & LABOR ROOM         17,558,           00         05400 RADI OLOGY-DI AGNOSTI C         1,722,           00         05500 RADI OLOGY-THERAPEUTI C         126,           00         05500 RADI OLOGY-THERAPEUTI C         126,           00         05600 RADI OLOGY-THERAPEUTI C         15, 351,           00         05600 RADI AC CATHETERI ZATI ON         8, 749,           00         06600 LABORATORY         15, 351,           00         06000 STORI NG, PROCESSI NG & TRANS.         987,           00         06400 INTRAVENOUS THERAPY         5, 439,           00         06600 RESPI RATORY THERAPY         5, 439,           00         06600 PHYSI CAL THERAPY         8, 716,	Charges t Outpati ent 7.00 387 118	+ col. 7) 8.00	Hospi tal 6 Cost or Other Rati o 9.00	TEFRA Inpatient	
INPATIENT ROUTINE SERVICE COST CENTERS           0.00         03000         ADULTS & PEDIATRICS         36,029,           0.00         03100         INTENSIVE CARE UNIT         11,346,           0.00         04100         SUBPROVIDER - IRF         6,750,           0.00         04400         SKILLED NURSING FACILITY         40,750,           0.00         04400         SKILLED NURSING FACILITY         6,750,           0.00         05000         PERATING ROOM         17,558,           0.00         05000         DERATING ROOM         1,722,           0.00         05500         RADIOLOGY-THERAPEUTIC         126,           0.00         05500         RADI OLOGY-THERAPEUTIC         126,           0.00         05500         RADI OLOGY-THERAPEUTIC         126,           0.00         05500         RADI OLOGY-THERAPEUTIC         126,           0.00         05700         CT SCAN         3, 628,           0.01         03630         ULTRA SOUND         985,           0.00         05800         MRI         566,           0.00         05900         CARDI AC CATHETERIZATION         8, 749,           0.00         06000         LABORATORY         15, 351, <t< th=""><th>t Outpatient 7.00 387 118 836</th><th>+ col. 7) 8.00</th><th>Rati o</th><th>I npati ent</th><th></th></t<>	t Outpatient 7.00 387 118 836	+ col. 7) 8.00	Rati o	I npati ent	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           0.00         03000 ADULTS & PEDI ATRI CS         36, 029,           0.00         03100 I NTENSI VE CARE UNI T         11, 346,           0.00         04100 SUBPROVI DER - IRF         6, 750,           0.00         04300 NURSERY         6, 750,           0.00         04400 SKI LLED NURSI NG FACI LI TY         ANCI LLARY SERVI CE COST CENTERS           0.00         05000 OPERATI NG ROOM         17, 558,           0.00         05000 DELI VERY ROOM & LABOR ROOM         1, 722,           0.00         05500 RADI OLOGY-THERAPEUTI C         126,           0.00         05700 CT SCAN         3, 628,           0.01         03630 ULTRA SOUND         985,           0.00         05900 CARDI AC CATHETERI ZATI ON         8, 749,           0.00         06000 LABORATORY         15, 351,           0.01         06000 BLOOD LABORATORY         15, 351,           0.00         06400 I NTRAVENOUS THERAPY         987,           0.00         06400 I NTRAVENOUS THERAPY         5, 439,           0.00         06600 PHYSI CAL THERAPY         5, 439,	387 118 836	1	9.00	Ratio	
0.00         03000         ADULTS & PEDIATRICS         36,029,           0.00         03100         INTENSIVE CARE UNIT         11,346,           0.00         04100         SUBPROVIDER - IRF         6,750,           0.00         04300         NURSERY         6,750,           0.00         04400         SKILLED NURSING FACILITY         ANCILLARY SERVICE COST CENTERS           0.00         05000         OPERATING ROOM         17,558,           0.00         05000         DELIVERY ROOM & LABOR ROOM         1,722,           0.00         05400         RADIOLOGY-THERAPEUTIC         126,           0.00         05400         RADI OLOGY-THERAPEUTIC         126,           0.00         05500         RADI OLOGY-THERAPEUTIC         126,           0.00         05600         MRI         566,           0.00         05800         MRI         566,           0.00         05900         CARDI AC CATHETERIZATION         8, 749,           0.00         06000         LABORATORY         15, 351,           0.01         06000         LABORATORY         987,           0.00         06400         INTRAVENOUS THERAPY         5, 439,           0.00         06400         INT	118 836			10.00	
.00         03100         INTENSIVE CARE UNIT         11, 346,           .00         04100         SUBPROVIDER - IRF         6, 750,           .00         04400         SKILLED NURSING FACILITY         6, 750,           .00         04400         SKILLED NURSING FACILITY         6, 750,           .00         05000         PERATING ROOM         17, 558,           .00         05200         DELIVERY ROOM & LABOR ROOM         1, 722,           .00         05500         RADI OLOGY-THERAPEUTIC         126,           .00         05500         CT SCAN         3, 628,           .01         03630         ULTRA SOUND         985,           .00         05800         MRI         566,           .00         06000         LABORATORY         15, 351,           .01         06001         LABORATORY         15, 351,           .01         06000         LABORATORY         8, 749,           .00         06300         BLOOD LABORATORY         15, 351,           .01         06001         BLOOD LABORATORY         987,           .00         06400         NTRAVENOUS THERAPY         987,           .00         06400         NTRAVENOUS THERAPY         5, 439, <td>118 836</td> <td>0/ 000</td> <td></td> <td></td> <td></td>	118 836	0/ 000			
.00         04100         SUBPROVI DER - IRF         6,750,           .00         04300         NURSERY         6,750,           .00         04400         SKI LLED NURSI NG FACI LI TY         6,750,           ANCI LLARY SERVICE COST CENTERS         17,558,           .00         05200         DELI VERY ROOM & LABOR ROOM         17,758,           .00         05500         RADI OLOGY-DI AGNOSTI C         1,722,           .00         05500         RADI OLOGY-THERAPEUTI C         126,           .00         05800         MRI         566,           .00         05800         MRI         566,           .00         06000         LABORATORY         15, 351,           .01         06001         LABORATORY         15, 351,           .01         06000         LABORATORY         98, 749,           .00         06400         INTRAVENOUS THERAPY         98, 749,	836	36, 029, 38	7		30.0
1.00         04300         NURSERY           1.00         04400         SKI LLED         NURSI NG         FACI LI TY           ANCI LLARY         SERVI CE         COST         CENTERS           0.00         05000         OPERATI NG         ROOM         17, 558,           0.00         05200         DELI VERY         ROOM & LABOR         17, 558,           0.00         05400         RADI OLOGY-DI AGNOSTI C         1, 722,           0.00         05500         RADI OLOGY-THERAPEUTI C         126,           0.00         05700         CT         SCAN           3.00         05500         RADI OLOGY-THERAPEUTI C         126,           0.00         05700         CT         SCAN         3, 628,           0.01         03630         ULTRA         SOUND         985,           0.00         05900         CARDI AC         CATHETERI ZATI ON         8, 749,           0.00         05900         CARDI AC         CATHETERI ZATI ON         8, 749,           0.00         06000         LABORATORY         15, 351,         15, 351,           0.01         06001         BLOOD         AABORATORY         987,           0.00         06400         INTR		11, 346, 11	8		31.0
00         04400         SKI LLED NURSI NG FACI LI TY           ANCI LLARY SERVICE COST CENTERS         17,558,          00         05000         0PERATI NG ROOM         17,558,          00         05200         DELI VERY ROOM & LABOR ROOM         17,258,          00         05400         RADI OLOGY-DI AGNOSTI C         1,722,          00         05500         RADI OLOGY-THERAPEUTI C         126,          00         05700         CT SCAN         3,628,          01         03630         ULTRA SOUND         985,          00         05900         CARDI AC CATHETERI ZATI ON         8,749,          01         06001         LABORATORY         15,351,          01         06001         BLOOD LABORATORY         987,          00         06400         INTRAVENOUS THERAPY         987,          00         06400         INTRAVENOUS THERAPY         5,439,          00         06500         RESPI RATORY THERAPY         5,439,          00         06600         PHYSI CAL THERAPY         8,716,	0	6, 750, 83	6	l	41.0
ANCI LLARY SERVICE COST CENTERS           ANCI LLARY SERVICE COST CENTERS           0.00         05000           05200         DELI VERY ROOM & LABOR ROOM           17, 558,           00         05200           05200         DELI VERY ROOM & LABOR ROOM           .00         05400           0500         RADI OLOGY-DI AGNOSTI C           .00         05500           0500         CT SCAN           .00         05600           01         03630           01         03630           0500         CARDI AC CATHETERI ZATI ON           8, 749,           0.00         06000           LABORATORY           0.00         06000           LABORATORY           0.00         064001           NTRAVENOUS THERAPY           0.00         06400           0.00         06500           0.00         06500           0.00         06500           0.00         06400           NTRAVENOUS THERAPY           0.00         06500           0.00         06500           0.00         06500           0.00           0.	~1		0	1	43.0
0.00         05000         OPERATING ROOM         17,558,           0.00         05200         DELIVERY ROOM & LABOR ROOM         1,722,           0.00         05400         RADI 0L0GY-DI AGNOSTI C         1,722,           0.00         05500         RADI 0L0GY-THERAPEUTI C         126,           0.00         05700         CT SCAN         3,628,           0.01         03630         ULTRA SOUND         985,           0.00         05900         CARDI AC CATHETERI ZATI ON         8,749,           0.00         06000         LABORATORY         15,351,           0.01         06001         BLODD LABORATORY         987,           0.00         06400         INTRAVENOUS THERAPY         987,           0.00         06500         RESI RATORY THERAPY         5,439,           0.00         06600         PHYSI CAL THERAPY         5,439,	0		0	l	44.0
1.00         05200         DELIVERY ROOM & LABOR ROOM           2.00         05400         RADIOLOGY-DIAGNOSTIC         1,722,           2.00         05500         RADIOLOGY-THERAPEUTIC         126,           2.00         05700         CT SCAN         3,628,           2.01         03630         ULTRA SOUND         985,           2.00         05900         CARDIAC CATHETERIZATION         8,749,           2.00         06000         LABORATORY         15,351,           2.01         06001         BLOOD LABORATORY         987,           2.00         06400         INTRAVENOUS THERAPY         987,           2.00         06500         RESPIRATORY THERAPY         5,439,           2.00         06500         RESPIRATORY THERAPY         5,439,           2.00         06600         PHYSICAL THERAPY         8,716,		·			
00         05400         RADI OLOGY-DI AGNOSTI C         1,722,          00         05500         RADI OLOGY-THERAPEUTI C         126,          00         05700         CT SCAN         3,628,          01         03630         ULTRA SOUND         985,          00         05900         CARDI AC CATHETERI ZATI ON         8,749,          00         06000         LABORATORY         15,351,          01         06001         BLOOD LABORATORY         987,          00         06400         I STRAVENOUS THERAPY         987,          00         06400         I NTRAVENOUS THERAPY         5,439,          00         06600         PHYSI CAL THERAPY         8,716,	675 64, 633, 850	82, 192, 52	5 0. 159246	0. 000000	] 50. C
00         05400         RADI OLOGY-DI AGNOSTI C         1,722,          00         05500         RADI OLOGY-THERAPEUTI C         126,          00         05700         CT SCAN         3,628,          01         03630         ULTRA SOUND         985,          00         05900         CARDI AC CATHETERI ZATI ON         8,749,          00         06000         LABORATORY         15,351,          01         06001         BLOOD LABORATORY         987,          00         06400         I STRAVENOUS THERAPY         987,          00         06400         I NTRAVENOUS THERAPY         5,439,          00         06600         PHYSI CAL THERAPY         8,716,	0 0	D	0 0. 000000	0. 000000	52.0
3.00         05500         RADI OLOGY-THERAPEUTI C         126,           4.00         05700         CT SCAN         3, 628,           5.01         03630         ULTRA SOUND         985,           5.00         05800         MRI         566,           5.00         05900         CARDI AC CATHETERI ZATI ON         8, 749,           5.00         06000         LABORATORY         15, 351,           5.00         06300         BLOOD LABORATORY         987,           5.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         987,           5.00         06400         I NTRAVENOUS THERAPY         5, 439,           5.00         06600         PHYSI CAL THERAPY         5, 439,	305 9, 704, 489	11, 426, 79		0.00000	
2.00         05700         CT SCAN         3, 628, 985, 985, 566, 985, 566, 985, 566, 986, 985, 566, 986, 985, 566, 986, 986, 986, 566, 986, 986, 986, 986, 986, 566, 986, 986, 986, 986, 986, 986, 566, 986, 986, 986, 986, 986, 986, 986, 9		1 1 1		0.000000	
1         03630         ULTRA SOUND         985,           2.00         05800         MRI         566,           2.00         05900         CARDI AC CATHETERI ZATI ON         8, 749,           2.00         06000         LABORATORY         15, 351,           2.01         06001         BLOOD         LABORATORY         987,           2.00         06400         I NTRAVENOUS         THERAPY         987,           2.00         06400         I NTRAVENOUS         THERAPY         5, 439,           2.00         06600         PHYSI CAL         THERAPY         5, 439,				0.00000	
a. 00         05800         MRI         566,           b. 00         05900         CARDI AC CATHETERI ZATI ON         8, 749,           b. 00         06000         LABORATORY         15, 351,           b. 01         06001         BLOOD         LABORATORY         987,           c. 00         06400         I NTRAVENOUS         THERAPY         987,           c. 00         06500         RESPI RATORY         5, 439,         98, 716,				0.000000	
0.00         05900         CARDI AC CATHETERI ZATI ON         8, 749,           0.00         06000         LABORATORY         15, 351,           0.01         06001         BLOOD         LABORATORY         15, 351,           0.00         06300         BLOOD         LABORATORY         987,           0.00         06400         I NTRAVENOUS THERAPY         987,           0.00         06500         RESPI RATORY THERAPY         5, 439,           0.00         06600         PHYSI CAL THERAPY         8, 716,				0.000000	
0.00         06000         LABORATORY         15, 351,           0.01         06001         BLOOD         LABORATORY         987,           0.00         06300         BLOOD         STORI NG, PROCESSI NG & TRANS.         987,           0.00         06400         I NTRAVENOUS THERAPY         5, 439,           0.00         06500         RESPI RATORY THERAPY         5, 439,           0.00         06600         PHYSI CAL THERAPY         8, 716,				0.000000	
0.01         06001         BLOOD         LABORATORY           3.00         06300         BLOOD         STORI NG, PROCESSI NG & TRANS.         987,           4.00         06400         I NTRAVENOUS         THERAPY         5, 439,           5.00         06600         PHYSI CAL         THERAPY         5, 439,           6.00         06600         PHYSI CAL         THERAPY         8, 716,				0.000000	
3. 00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         987,           4. 00         06400         I NTRAVENOUS THERAPY         5, 439,           5. 00         06500         RESPI RATORY THERAPY         5, 439,           6. 00         06600         PHYSI CAL THERAPY         8, 716,	0 37, 555, 649		0. 212199	0.000000	
00         06400         I NTRAVENOUS THERAPY          00         06500         RESPI RATORY THERAPY         5, 439,          00         06600         PHYSI CAL THERAPY         8, 716,	s .				
5. 00         06500         RESPI RATORY THERAPY         5, 439,           5. 00         06600         PHYSI CAL THERAPY         8, 716,				0.000000	
0. 00 06600 PHYSI CAL THERAPY 8, 716,	0 (		0 0.000000	0.00000	
				0.000000	
. 00  06700  OCCUPATIONAL THERAPY				0.000000	
	0 0		0 0. 000000	0.00000	
8. 00 06800 SPEECH PATHOLOGY	0 0		0 0. 000000	0.00000	
2, 054, 2, 054,				0. 000000	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 16, 642,				0.00000	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 6, 506,				0. 000000	
8. 00 07300 DRUGS CHARGED TO PATIENTS 13, 429,	912 43, 148, 438	3 56, 578, 35	0 0. 330123	0.00000	73.
. 00 07400 RENAL DI ALYSI S 479,	620 2, 058	3 481, 67	8 0. 833054	0.000000	74.
0. 00 03020 OTHER ANCI LLARY	0 0		0 0.000000	0.000000	76.
0. 01 03140 CARDI AC REHAB 516,	187 11, 370, 281	11, 886, 46	8 0. 256769	0.00000	76.
0. 02 03070 WOMEN' S CENTER 6,	447 7, 273, 930	7, 280, 37	7 0. 214568	0. 000000	76.
0. 03 03330 ENDOSCOPY	0 0		0 0. 000000	0.00000	76.
OUTPATIENT SERVICE COST CENTERS		·			
	000 5, 020, 118	5, 029, 11	8 0. 164354	0.00000	90.
0. 01 09001 OUTPATI ENT 256,		1 1 1		0.000000	
	000 1, 663, 516			0.000000	
. 00 09100 EMERGENCY 4, 999,		1 1 1		0. 000000	
. 01 09101 SHORT STAY	0 01, 120, 122		0.000000	0.000000	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 940,	0	1		0.000000	
OTHER REIMBURSABLE COST CENTERS	4,004,020	3,003,02	0.745202	0.000000	1 12.
00 09500 AMBULANCE SERVICES	0 0		0 0. 000000	0.000000	05
				0.000000	200.
	030 337,092,919	501, 517, 74	7	1	
11.00Less Observation Beds12.00Total (see instructions)163,824,	830 337, 692, 919	501, 517, 74		1	201. 202.

alth Financial Systems	RI VERVI EW HO			u of Form CMS-255
MPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0059	Period: From 01/01/2020	Worksheet C Part I
			To 12/31/2020	Date/Time Prepar
		Title XIX	Hocni tal	7/29/2021 10:51 Cost
Cost Center Description	PPS Inpatient		Hospi tal	CUSI
cost center bescription	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11100			
. 00 03000 ADULTS & PEDIATRICS				30
. 00 03100 INTENSIVE CARE UNIT				31
. 00 04100 SUBPROVI DER – I RF				41
. 00 04300 NURSERY				43
. 00 04400 SKILLED NURSING FACILITY				44
ANCILLARY SERVICE COST CENTERS				
. 00 05000 OPERATING ROOM	0. 000000			50
. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55
. 00 05700 CT SCAN	0. 000000			57
. 01 03630 ULTRA SOUND	0. 000000			57
. 00 05800 MRI	0. 000000			58
. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59
. 00 06000 LABORATORY	0. 000000			60
. 01 06001 BLOOD LABORATORY	0. 000000			60
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63
. 00 06400 INTRAVENOUS THERAPY	0. 000000			64
. 00 06500 RESPI RATORY THERAPY	0. 000000			65
00 06600 PHYSI CAL THERAPY	0. 000000			66
. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67
. 00 06800 SPEECH PATHOLOGY	0. 000000			68
. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72
. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
. 00 07400 RENAL DI ALYSI S	0. 000000			74
00 03020 OTHER ANCI LLARY	0. 000000			76
01 03140 CARDI AC REHAB	0. 000000			76
0. 02 03070 WOMEN' S CENTER	0. 000000			76
. 03 03330 ENDOSCOPY	0. 000000			76
	0,000000			
	0. 000000			90
	0. 000000			90
	0. 000000			90
. 00 09100 EMERGENCY . 01 09101 SHORT STAY	0. 000000 0. 000000			91
	0. 000000			91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0.000000			92
. 00 09500 AMBULANCE SERVICES	0. 000000			95
0.00 Subtotal (see instructions)	0.000000			200
1.00 Less Observation Beds				200
2.00 Total (see instructions)				201

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPI TAL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 10:	epared: 51 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II, col. 26)		(col. 1 - col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER			1	-1		
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	5, 879, 963 894, 653		5, 879, 96 894, 65		264.53	31.00
41.00 SUBPROVIDER - IRF	1, 027, 438	0	1, 027, 43			
43.00 NURSERY	0			0 1, 331	0.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
200.00 Total (lines 30 through 199)	7, 802, 054		7, 802, 05	4 23, 777		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6, 00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTER		7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 200. 00 Total (lines 30 through 199)	4, 010 1, 015 3, 055 0 0 8, 080	1, 632, 752 268, 498 678, 943 0 2, 580, 193				30.00 31.00 41.00 43.00 44.00 200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0059	Period:	Worksheet D	
				From 01/01/2020	Part II Date/Time Pre	
				To 12/31/2020	7/29/2021 10:	
		Title	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)	5	· · · · ·	
	col. 26)		, , , , , , , , , , , , , , , , , , ,			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	3, 011, 425	82, 192, 525			277, 910	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000	0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	779, 880		0. 06825	650, 868	44, 422	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	415, 285	8, 519, 076			2, 825	55.00
57.00 05700 CT SCAN	4, 521	18, 554, 991	0. 00024	4 1, 195, 881	292	57.00
57.01 03630 ULTRA SOUND	4, 756	7, 589, 103	0. 00062	321, 751	202	57.01
58.00 05800 MRI	3, 893				118	
59. 00 05900 CARDI AC CATHETERI ZATI ON	169, 803	24, 967, 590				59.00
60. 00 06000 LABORATORY	883, 915	52, 885, 114			87, 582	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	-	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	117, 984	1, 403, 965			18, 997	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	80, 381	6, 933, 453			21, 334	65.00
66. 00 06600 PHYSI CAL THERAPY	356, 776	26, 635, 596			15, 868	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		-	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	385, 822	8, 624, 224	0. 04473			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	457, 107	39, 363, 424				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	85, 272				11, 346	
73.00 07300 DRUGS CHARGED TO PATIENTS	624, 618					
74.00 07400 RENAL DIALYSIS	54, 371	481, 678			14, 117	
76.00 03020 OTHER ANCI LLARY	0		0.00000		-	76.00
76. 01 03140 CARDI AC REHAB	521,064					
76.02 03070 WOMEN' S CENTER	523, 062	7, 280, 377	0. 07184			76.02
76.03 03330 ENDOSCOPY	0	0	0.00000	0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS					· · · -	
90. 00 09000 CLINIC	139, 976					90.00
90. 01 09001 OUTPATI ENT	211, 691	5, 848, 100			1, 257	90.01
90. 02 09002 NEUROPSYCHOLOGY	25, 987	1, 688, 516			286	1
91.00 09100 EMERGENCY	1, 336, 650				64, 701	91.00
91. 01 09101 SHORT STAY	0	, i i i i i i i i i i i i i i i i i i i	0,00000			91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	907, 586	5, 605, 021	0. 16192	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1			05 00
95.00 09500 AMBULANCE SERVICES	11 101 005	447 201 400		25 100 514	710 150	95.00
200.00  Total (lines 50 through 199)	11, 101, 825	447, 391, 408	I	35, 189, 514	719, 150	200.00

Health Financial Systems	RI VERVI EW			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C	CN: 15-0059	Period: From 01/01/2020	Worksheet D	
				To 12/31/2020		epared:
					7/29/2021 10:	51 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing	Nursing		h Allied Health	All Other	
	School	School	Post-Stepdow		Medi cal	
	Post-Stepdown Adjustments		Adj ustments	, ,	Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1100	271	2100	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	1 101 00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	0	<b>T</b>	0 0		200.00
Cost Center Description	Swing-Bed Adjustment	Total Costs (sum of cols.	Total Patier	nt Per Diem (col. 5 ÷	Inpatient Program Days	
	Amount (see	1 through 3,	Days	(COL 5 ÷ COL 6)	Program Days	
		minus col. 4)		COI. 0)		
	4,00	5.00	6,00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	14, 4	41 0.00	4, 010	30.00
31.00 03100 INTENSIVE CARE UNIT		0	3, 3			
41.00 04100 SUBPROVIDER - IRF	0	0	4,6		3, 055	
43.00 04300 NURSERY		0	1, 3		0	
44.00 04400 SKILLED NURSING FACILITY		0		0 0.00		
200.00 Total (lines 30 through 199)		0	23, 7	77	8, 080	200.00
Cost Center Description	Inpatient Program					
	Program Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
41. 00 O4100 SUBPROVIDER - IRF	0					41.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	-					200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0059	Period: From 01/01/2020 To 12/31/2020		pared: 51 am
			Title	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	1	0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
57.01	03630 ULTRA SOUND	0	0		0 0	0	57.01
58.00	05800 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	0	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	342, 335	73.00
74.00	07400 RENAL DIALYSIS	0	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
	OUTPATIENT SERVICE COST CENTERS	_					
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90.01	09001 OUTPATI ENT	0	0		0 0	0	90.01
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	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0		0 0	342, 335	200.00

Health Financial Systems	RI VERVI EW			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PAS	S Provider C	CN: 15-0059	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/29/2021 10:	51 am
		Title	XVIII	Hospi tal	PPS	01 011
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)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0			0 82, 192, 525	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 11, 426, 794	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 8, 519, 076	0. 000000	55.00
57.00 05700 CT SCAN	0	0		0 18, 554, 991	0. 000000	57.00
57.01 03630 ULTRA SOUND	0	0		0 7, 589, 103	0. 000000	57.01
58.00 05800 MRI	0	0		0 5, 232, 594	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 24, 967, 590	0. 000000	59.00
60. 00 06000 LABORATORY	0	0		0 52, 885, 114	0. 000000	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0. 000000	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 403, 965	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 933, 453	0. 000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 26, 635, 596	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		0 0	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 8, 624, 224	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 39, 363, 424	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 937, 262	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	342, 335	342, 33	5 56, 578, 350	0. 006051	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0 481, 678	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 11, 886, 468	0. 000000	76.01
76.02 03070 WOMEN'S CENTER	0	0		0 7, 280, 377	0. 000000	76.02
76. 03 03330 ENDOSCOPY	0	0		0 0	0. 000000	76.03
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0	0		0 5, 029, 118	0.00000	90.00
90. 01 09001 OUTPATI ENT	0	0		0 5, 848, 100	0. 000000	90.01
90. 02 09002 NEUROPSYCHOLOGY	0	0		0 1, 688, 516	0. 000000	90.02
91.00 09100 EMERGENCY	0	0		0 39, 728, 069	0. 000000	91.00
91.01 09101 SHORT STAY	0	0		0 0	0. 000000	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 5, 605, 021	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	342, 335	342, 33	5 447, 391, 408		200.00

Health Financial Systems	RI VERVI EW HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0059	Period: From 01/01/2020 To 12/31/2020		pared: 51 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	7, 585, 099		0 16, 882, 679		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	650, 868		0 2, 020, 897	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	57, 958		0 3, 015, 491	0	55.00
57.00 05700 CT SCAN	0. 000000	1, 195, 881		0 3, 787, 307	0	57.00
57.01 03630 ULTRA SOUND	0. 000000	321, 751		0 1, 680, 785	0	57.01
58.00 05800 MRI	0. 000000	158, 459		0 1,046,800	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 015, 708		0 4, 771, 107	0	59.00
60. 00 06000 LABORATORY	0. 000000	5, 240, 057		0 3, 489, 127	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	226, 057		0 72, 257	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 840, 271		0 469, 228	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 184, 592		0 164, 954	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	760, 348		0 1, 360, 344	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 909, 955		0 5, 558, 797	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 519, 607		0 3, 611, 649	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 006051	4, 286, 699	25, 93	16, 465, 287	99, 631	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	125, 061		0 0	0	74.00
76.00 03020 OTHER ANCI LLARY	0. 000000	0		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0. 000000	129, 415		0 3, 267, 175	0	76.01
76.02 03070 WOMEN'S CENTER	0. 000000	122		0 533, 360	0	76.02
76. 03 03330 ENDOSCOPY	0. 000000	0		0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	5, 268		0 1, 436, 990	0	90.00
90. 01 09001 OUTPATI ENT	0. 000000	34, 734		0 1, 597, 880	0	90.01
90. 02 09002 NEUROPSYCHOLOGY	0. 000000	18, 567		0 561, 667	0	90.02
91.00 09100 EMERGENCY	0. 000000	1, 923, 037		0 5, 010, 282	0	91.00
91.01 09101 SHORT STAY	0. 000000	0		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 982, 896	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		35, 189, 514	25, 93	39 77, 786, 959	99, 631	200.00

APPORTI ONM	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0059	Period:	Worksheet D	
				1	rom 01/01/2020	Part V	
				-	Го 12/31/2020	Date/Time Pre 7/29/2021 10:	pared: 51 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS				-		
	OO OPERATING ROOM	0. 159246			0 0	2, 688, 499	•
	DO DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
	00 RADI OLOGY-DI AGNOSTI C	0. 413700		(		836, 045	
	00 RADI OLOGY-THERAPEUTI C	0. 240761		(	-	726, 013	
	DO CT SCAN	0. 028863		(	0 0	109, 313	•
	30 ULTRA SOUND	0. 073729			°	123, 923	•
	DO MRI	0. 086425	1, 046, 800	(	0 0	90, 470	58.00
59.00 0590	OO CARDI AC CATHETERI ZATI ON	0.064377	4, 771, 107	(	0 0	307, 150	59.00
60.00 0600	DO LABORATORY	0. 212199	3, 489, 127	6, 893	3 0	740, 389	60.00
60.01 0600	1 BLOOD LABORATORY	0. 000000	0	(	0 0	0	60.01
63.00 0630	DO BLOOD STORING, PROCESSING & TRANS.	0. 507138	72, 257	(	0 0	36, 644	63.00
64.00 0640	00 INTRAVENOUS THERAPY	0. 000000	0	(	0 0	0	64.00
65.00 0650	00 RESPI RATORY THERAPY	0. 349033	469, 228	(	0 0	163, 776	65.00
66.00 0660	0 PHYSI CAL THERAPY	0. 358169	164, 954	(	0 0	59, 081	66.00
67.00 0670	O OCCUPATIONAL THERAPY	0. 000000	0	(	o o	0	67.00
	OO SPEECH PATHOLOGY	0. 000000	0	(	o o	0	68.00
	00 ELECTROCARDI OLOGY	0. 179544		(	o o	244, 242	69.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 235204	5, 558, 797		o o	1, 307, 451	71.00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 586664	3, 611, 649	(	o o	2, 118, 824	72.00
	DO DRUGS CHARGED TO PATIENTS	0. 330123			62, 629	5, 435, 570	
	DO RENAL DI ALYSI S	0.833054			0 0	0	74.00
	O OTHER ANCI LLARY	0. 000000			0	0	76.00
	O CARDI AC REHAB	0. 256769			0	838, 909	76.01
	O WOMEN' S CENTER	0. 214568			0	114, 442	
	BO ENDOSCOPY	0. 000000			0	0	
	PATIENT SERVICE COST CENTERS		-		-		
	DO CLINIC	0. 164354	1, 436, 990	(	0 0	236, 175	90.00
	01 OUTPATI ENT	0. 318191				508, 431	90.01
	02 NEUROPSYCHOLOGY	0. 327921				184, 182	
	DO EMERGENCY	0. 459027			-	2, 299, 855	
	1 SHORT STAY	0. 000000				2, 2, 7, 000	91.01
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 745282			0	732, 535	•
	R REIMBURSABLE COST CENTERS	0. , 10202	,02,070	· · · · · · · · · · · · · · · · · · ·		, 52, 555	1 2.00
	O AMBULANCE SERVICES	0. 000000		(			95.00
200.00	Subtotal (see instructions)	0.000000	77, 786, 959		-	19, 901, 919	
201.00	Less PBP Clinic Lab. Services-Program		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,07	02,02	17, 701, 717	200.00
		1	1	l ,	- U		
201100	Only Charges						

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		Provider CC	N. 15 0050	Peri od:	u of Form CMS-2552 Worksheet D	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provider CC	M. 15-0059	From 01/01/2020	Part V	
				To 12/31/2020	Date/Time Prepar 7/29/2021 10:51	
	_	Title	XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				_
50.00 05000 OPERATI NG ROOM	0	0			50	0. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52	2.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54	4.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			55	5.00
57.00 05700 CT SCAN	0	0			57	7.00
57.01 03630 ULTRA SOUND	0	0			57	7.01
58. 00 05800 MRI	0	0			58	8.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			59	9.00
60. 00 06000 LABORATORY	1, 463	0			60	0.00
60. 01 06001 BLOOD LABORATORY	0	0				0. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				3.00
64.00 06400 INTRAVENOUS THERAPY	0	0				4.00
65. 00 06500 RESPI RATORY THERAPY	0	0				5.00
66.00 06600 PHYSI CAL THERAPY	0	0				6.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				7.00
68. 00 06800 SPEECH PATHOLOGY	0	0				8.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				9.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0				1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0 20, 675				2.00 3.00
74. 00 07400 RENAL DIALYSIS	0	20, 875				4. OC
76. 00 03020 OTHER ANCI LLARY	0	0				6.00
76. 01 03140 CARDI AC REHAB	0	0				6.00
76. 02 03070 WOMEN' S CENTER	0	0				6.02
76. 03 03330 ENDOSCOPY	0	0				6.03
OUTPATI ENT SERVICE COST CENTERS						0.00
90. 00 09000 CLINIC	0	0			90	0. 00
90. 01 09001 OUTPATI ENT	0	0				0.01
90. 02 09002 NEUROPSYCHOLOGY	0	0			90	0. 02
91.00 09100 EMERGENCY	0	0			91	1.00
91.01 09101 SHORT STAY	0	o			91	1.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92	2.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					5.00
200.00 Subtotal (see instructions)	1, 463	20, 675				0.00
201.00 Less PBP Clinic Lab. Services-Program	0				201	1.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	1, 463	20, 675			202	2.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
		Commente	00N 15 TOFO	From 01/01/2020		
		component	CCN: 15-T059	To 12/31/2020	Date/Time Pre 7/29/2021 10:	
		Title	XVIII	Subprovider -	PPS	
		intre	AVI II	I RF	115	
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)	ondrigeo		
	col. 26)	001. 0)	001.2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	3, 011, 425	82, 192, 525	0, 03663	218, 885	8,020	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0,011,120	02, 172, 020	0. 00000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	779, 880	11, 426, 794				
55. 00 05500 RADI OLOGY-THERAPEUTI C	415, 285	8, 519, 076	0. 04874			55.00
57. 00 05700 CT SCAN	4, 521	18, 554, 991	0. 04872			57.00
57. 01 03630 ULTRA SOUND						57.00
58. 00 05800 MRI	4, 756	7, 589, 103				57.01
	3, 893	5, 232, 594				
59. 00 05900 CARDI AC CATHETERI ZATI ON	169, 803	24, 967, 590				59.00
60. 00 06000 LABORATORY	883, 915	52, 885, 114				•
60. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	117, 984	1, 403, 965				
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000		-	64.00
65. 00 06500 RESPI RATORY THERAPY	80, 381	6, 933, 453				
66. 00 06600 PHYSI CAL THERAPY	356, 776	26, 635, 596				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		-	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000		-	68.00
69. 00 06900 ELECTROCARDI OLOGY	385, 822	8, 624, 224	0. 04473			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	457, 107	39, 363, 424	0. 01161	2 867, 528	10, 074	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	85, 272	18, 937, 262	0.00450	03 17, 765	80	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	624, 618	56, 578, 350	0. 01104	0 779, 894	8, 610	73.00
74.00 07400 RENAL DIALYSIS	54, 371	481, 678			7, 200	74.00
76.00 03020 OTHER ANCI LLARY	0	0	01.00000		0	76.00
76. 01 03140 CARDI AC REHAB	521, 064	11, 886, 468	0. 04383	5, 993	263	76.01
76.02 03070 WOMEN' S CENTER	523, 062	7, 280, 377	0. 07184	5 17	1	76.02
76. 03 03330 ENDOSCOPY	0	0	0. 00000	0 0	0	76.03
OUTPATIENT SERVICE COST CENTERS			•		•	1
90. 00 09000 CLINIC	139, 976	5, 029, 118	0. 02783	3 1, 320	37	90.00
90. 01 09001 OUTPATI ENT	211, 691	5, 848, 100	0. 03619	18, 465	668	90.01
90. 02 09002 NEUROPSYCHOLOGY	25, 987	1, 688, 516		5, 928	91	90.02
91.00 09100 EMERGENCY	1, 336, 650	39, 728, 069				91.00
91. 01 09101 SHORT STAY	0	0				91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 605, 021	0.00000		0	92.00
OTHER REI MBURSABLE COST CENTERS		-,,021				1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	10, 194, 239	447, 391, 408		6, 807, 275	106, 151	
(		,,,	I	1, 2, 2, 2, 0		1 2 2 . 50

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provider C	CN: 15-0059	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T059	From 01/01/2020 To 12/31/2020		norod
		component	CCN: 15-1059	10 12/31/2020	7/29/2021 10:	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						1 50 00
50.00 05000 OPERATING ROOM	0	0		0 0	°  °	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
57. 00 05700 CT SCAN	0	0		0 0	0	
57. 01 03630 ULTRA SOUND	0	0		0 0	0	07.01
	0	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
	0	0		0 0	0	
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	00.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0				
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			342, 335	
74. 00 07400 RENAL DI ALYSI S	0	0			0 342, 333	1
76. 00 03020 OTHER ANCI LLARY	0	0				1
76. 01 03140 CARDI AC REHAB	0					
76. 02 03070 WOMEN' S CENTER	0					
76. 03 03330 ENDOSCOPY	0	0		0 0		
OUTPATIENT SERVICE COST CENTERS			1		<u>,                                    </u>	/0.00
90. 00 09000 CLINIC	0	0		0 (	0 0	90.00
90. 01 09001 OUTPATI ENT	0	0		0 0		
90. 02 09002 NEUROPSYCHOLOGY	0	0		0		•
91. 00 09100 EMERGENCY	0	0		0 0	ol o	
91. 01 09101 SHORT STAY	0	0		0 0	o o	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	342, 335	200.00

APPORT ID MILTOR OF LIMPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-059 Component CCN: 15-079 Title ZVIII         Provider CDN: 15-079 Total COST	Heal th	Financial Systems	RI VERVI EW	HOSF	PI TAL			In Lie	u of Form CMS-2	2552-10
Minister Gold         Component CCR: 15-1059         To         To         12/31/2020         Deter/Time Prepared: 77/22/2021         To           Cost Center Description         All Other Bedication Cost         Total Cost         Total Cost         Total Cost         Total Cost         Total Cost         Total Cost         Cost Outputient (col s, 2, 3, and a)         Total Cost         Total Cost         Cost Outputient (col s, 2, 3, and a)         Total Cost         Total Cost         Cost Outputient (col s, 2, 3, and a)         Total Cost         Cost Outputient (col s, 2, 3, and a)         Ratio of Cost (col s, 2, 3, and a)         Total Cost         Cost Outputient (col s, 2, 3, and a)         Ratio of Cost (col s, 2, 3, and a)         Total Cost         Cost Outputient (col s, 2, 3, and a)         Total Cost         Cost Outputient (col s, 2, 3, and a)         Total Cost (col s, 2, 3, and a)         Total	APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	SS	Provider C	CN: 15-0059	Ρ	eriod:	Worksheet D	
Cost Center Description         All Other Medical Education Cost         Total Cost (sup 0, and 4)         Total Cost (sup 0, and 4) <thttute< th="">         Total Cost (sup 0,</thttute<>	THROUG	GH COSTS								
Cost Center Description         All Other Medication Cost         Total Cost (sum of cols. (sum of cols. (see (col. 7) (see (see (col. 7) (see (see (col. 7) (see (see (see (see (see (see (see (se					Component (	CCN: 15-T059	T	o 12/31/2020		
Cost Center Description         All Other Medical Education Cost         Total Cost (sum of cols. 4.)         Total Cost (sum of cols. 4.)         Total Charges (see instructions)         Total Charges (see instructions)           MCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           0.00000PERATINE ROOM         0         0         0         0.0000000         50.00         50.00           0.00000C0 CT SCAN         0         0         0         0         0         0.0000000         50.00           57.00         055000 RADI LOCY-THERAPEUTI C         0         0         0         11.426,794         0.0000000         52.00           58.00         055000 RADI LOCY-THERAPEUTI C         0         0         0         11.426,794         0.0000000         52.00           59.00         055000 RADI LOCY-THERAPEUTI C         0         0         11.426,794         0.000000         57.00           59.00         059000 CARDI AC CATHETERI ZATI ON         0         0         1.433,965         0.0000000         58.00           59.00         059000 CARDI AC CATHETERI ZATI ON         0         0         0         0.0000000         59.00         0.0000000         59.00         0.0000000         59.00         0.00000000										51 am
Cost Center Description         All Other Medication Cost         Total Sum of cols. (sum of cols. (sum of cols. (sum of cols. (sum of cols. (sum of cols. (sum of cols. (sot (sum of cost (sum of cos					Title	XVIII			PPS	
Medical Education Cost         (sum of cols. 4)         Outpatient Cost (see and 4)         (from Wsst. col. 5, 2, 3, and 4)         (from Wsst. col. 5, 2, 3, and 4)         to Charges (col. 5, 2, 3, and 4)           MCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           0.00 05000 DEFRATINE ROOM         0         0         0         0         0         0.000000         50.00										
Education Cost         1, 2, 3, and Cost         Cost         Cost <t< td=""><td></td><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>		Cost Center Description								
Cost         4)         col s. 2, 3, and 4)         col . 8)         rol . 7) (see instructions)           MOLILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           52.00         05200 DELIVERY ROOM & LABOR ROOM         0         0         0.0000000 (Sec and instructions)         50.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td><b>N N N N N</b></td><td></td><td></td></t<>								<b>N N N N N</b>		
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000         OPERATING ROM         0         0         0.200000         50.00         50.00         50.00         0.000000         50.00         50.00         0.000000         50.00         50.00         0.000000         50.00         50.00         0.000000         50.00         50.00         50.00         0.000000         50.00         50.00         50.00         50.00         0.000000         50.00 </td <td></td> <td></td> <td></td> <td>  1,</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>				1,						
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           52.00         05200 DELIVERY ROM & LABOR ROM         0         0         0         0.000000         52.00           54.00         05400 RADI OLGY-DI AGNOSTIC         0         0         0         0         0.000000         52.00           55.00         05400 RADI OLGY-DI AGNOSTIC         0         0         0         0         0.000000         52.00           57.00         05700 CT SCAN         0         0         0         18.554.991         0.000000         57.00           57.00         05800 MRI         0         0         0         2.4967.570.00         0.000000         57.00           58.00         05600 MRI         0         0         0         2.4967.570.00         0.000000         57.00           59.00         05000 LABORATORY         0         0         0         0         0.000000         57.00         0.000000         57.00         0.000000         68.00         0.000000         57.00         0.000000         57.00         0.000000         50.00         0.000000         60.00         0.000000         60.00         0.000000         60.00         0.0000000         60.00			Cost		4)			col. 8)	· · ·	
Image: Contract Contracts         4.00         5.00         6.00         7.00         8.00           50.00         OSO00 (DPEATI NG ROM         0         0         0         0.000000         52.00         52.00         0.000000         52.00         0         0.000000         52.00         0         0.000000         52.00         0         0.000000         52.00         0.000000         52.00         0.000000         52.00         0.000000         52.00         0.000000         52.00         0.000000         52.00         0.000000         52.00         0.000000         52.00         0.000000         52.00         0.000000         57.00         57.00         0.57.00         0.57.00         0.57.00         0.57.00         0.57.00         0.57.00         0.57.00         0.57.00         0.000000         58.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         59.00         0.000000         LABDRATORY         0         0         0         52.85.114         0.000000         59.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50						and 4)			•	
ANCILLARY SERVICE COST CENTERS         Image: Control of Contrelati										
50. 00         05000 (DEPERATING ROM         0         0         0         82, 192, 525         0.000000         50. 00           52. 00         05200 DELLIVERY ROM & LABOR ROM         0         0         0         0.000000         52. 00           54. 00         05400 RADI 0LOGY-DI AGNOSTI C         0         0         0         0         0.000000         54. 00           55. 00         05500 (TASI 0LOGY-THERAPEUTI C         0         0         0         8, 519, 076         0.000000         57. 00           70. 00 5700 (T SCAN         0         0         0         18, 554, 991         0.000000         58. 00           50. 00 5800 (ARD I AC CATHETERI ZATI 0N         0         0         57. 00         57. 00         50. 00 <td></td> <td></td> <td>4.00</td> <td></td> <td>5.00</td> <td>6.00</td> <td></td> <td>7.00</td> <td>8.00</td> <td></td>			4.00		5.00	6.00		7.00	8.00	
52. 00         OS200         DEL VERY ROM & LABOR ROM         0        <			1							
54. 00       05400       RADI DLOGY-DIASNOSTI C       0       0       11. 426, 794       0.000000       55. 00         55. 00       05500       RADI DLOGY-THERAPEUTI C       0       0       8, 519, 076       0.000000       57. 00         57. 00       05700       CT SCAN       0       0       18. 554, 991       0.000000       57. 01         58. 00       DS500 MRI       0       0       0       7. 589, 103       0.000000       58. 00         59. 00       DS900 CARDI AC CATHETERI ZATI ON       0       0       24, 967, 590       0.000000       60. 01         60. 00       OBOOL LABORATORY       0       0       0       1.433, 965       0.000000       64. 01         63. 00       OS000 INTRAVENUS THERAPY       0       0       0       0.000000       64. 00         64. 00       OCOUP INTRAVENUS THERAPY       0       0       0       0.000000       65. 00         65. 00       OS000 INTRAVENUS THERAPY       0       0       0       0.000000       66. 00         66. 00       OGOO PHYSI CAL THERAPY       0       0       0       0.000000       67. 00         67. 00       OS00 INTRAVENUS THERAPY       0       0       0       0			0	)	0			82, 192, 525		
55.00         OS500         RADIOLOGY-THERAPEUTIC         0         0         8, 519, 076         0.000000         55.00           77.00         05700         CT SCAN         0         0         18, 554, 991         0.000000         57.00           77.01         03630         ULTRA SOUND         0         0         52.32, 594         0.000000         57.00           78.00         05800         RRI         0         0         5.232, 594         0.000000         58.00           90.00         05900         CARDIAC CATHETERIZATION         0         0         52.885, 114         0.000000         60.00           60.00         LABORATORY         0         0         0         0.000000         63.00           63.00         05000         RESPI RATORY         0         0         0         0.000000         64.00           64.00         064001         INTRAVENUS THERAPY         0         0         0         0.000000         65.00           65.00         OSCO0         RESPI RATORY THERAPY         0         0         0         0.000000         66.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         0.000000         67.00<	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	D	0		0	0	0.000000	52.00
57.00         OST00         CT SCAN         O         O         18.554.991         0.000000         57.00           57.01         03630         ULTRA SOUND         O         O         7.589,103         0.000000         57.00           57.01         03630         ULTRA SOUND         O         O         5.232,594         0.000000         59.00           59.00         OSP00         CARDIAC CATHETERIZATION         O         O         24,967,590         0.000000         59.00           0.00         OGOU         Laboratory         O         O         24,967,590         0.000000         60.00           0.01         Dedotol Laboratory         O         O         O         0.000000         64.00           0.6300         BLOOD STORING, PROCESSING & TRANS.         O         O         0.000000         64.00           0.6400         INTRAVENOUS THERAPY         O         O         0.000000         65.00           0.00000         OCOUPATI ONAL THERAPY         O         O         0.000000         67.00           0.0100         DEGO PHYSICAL THERAPY         O         O         0.000000         67.00           0.0100         DEGO PHYSICAL THERAPY         O         O         0.0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	D	0		0	11, 426, 794	0.00000	54.00
57. 01       03630       ULTRA SOUND       0       0       7, 589, 103       0.000000       57. 01         58. 00       05800       MRI       0       0       0       52, 232, 594       0.000000       58. 00         60. 00       06000       LABORATORY       0       0       0       24, 967, 559       0.000000       60. 01         60. 01       06001       BLODD LABORATORY       0       0       0       0.000000       63. 00         63. 00       06300       BLODD STORING, PROCESSING & TRANS.       0       0       0       0.000000       63. 00         64. 00       064001       INTRAVENUS THERAPY       0       0       0       0.000000       63. 00         65. 00       06500 RESPI RATORY THERAPY       0       0       0       0.000000       64. 00         66. 00       06600 PHYSI CAL THERAPY       0       0       0       0.000000       68. 00         67. 00       06700 CCUPATI ONAL THERAPY       0       0       0       0.000000       69. 00         68. 00       69000 ELECTROCARDI OLOGY       0       0       0       0.000000       69. 00         72. 00       07200 IMPL. DEV. CHARGED TO PATI ENT       0	55.00	05500 RADI OLOGY-THERAPEUTI C	0	)	0		0	8, 519, 076	0.000000	55.00
58.00         OSB00         RRI         O         O         5, 232, 594         0, 000000         58.00           59.00         OS900         CARDI AC CATHETERI ZATI ON         O         O         24, 967, 590         0, 000000         59.00           60.00         GAOOD LABORATORY         O         O         0         55.85, 114         0, 000000         60.00           64.00         CACOL ABORATORY         O         O         0         0, 000000         63.00           64.00         O6400         INTRAVENOUS THERAPY         O         O         0         0, 000000         64.00           65.00         O6500         CCUPATI ONAL THERAPY         O         O         0         0, 000000         65.00           66.00         O6000         PECH PATHORY THERAPY         O         O         0         0, 000000         67.00           67.00         OCCUPATI ONAL THERAPY         O         O         O         0, 000000         67.00         0, 000000         68.00         69.00         69.00         69.00         69.00         69.00         69.00         71.00         0, 000000         71.00         71.00         0, 000000         71.00         71.00         71.00         71.00 <td< td=""><td>57.00</td><td>05700 CT SCAN</td><td>0</td><td>)</td><td>0</td><td></td><td>0</td><td>18, 554, 991</td><td>0.000000</td><td>57.00</td></td<>	57.00	05700 CT SCAN	0	)	0		0	18, 554, 991	0.000000	57.00
58.00         OSB00         RNI         O         O         5, 232, 594         0, 000000         58.00           59.00         OS900         CARDI AC CATHETERI ZATI ON         O         O         24, 967, 590         0.000000         59.00           60.00         GAOOD LABORATORY         O         O         D         55.81, 14         0.000000         60.00           64.00         GAOOD LABORATORY         O         O         O         0.000000         63.00           64.00         GAOOD STORING, PROCESSI NG & TRANS.         O         O         0         0.000000         64.00           65.00         O64001 INTRAVENOUS THERAPY         O         O         O         0.000000         65.00           66.00         O6600 PHYSI CAL THERAPY         O         O         O         0.000000         67.00           67.00         OCCUPATI ONAL THERAPY         O         O         O         0.000000         67.00           68.00         DEECH PATHOLOGY         O         O         O         0.000000         67.00           71.00         OT400 INPL AL SUPPLIES CHARGED TO PATI ENTS         O         O         18, 937, 262         0.000000         71.00           72.00         OT3000 DRU	57.01	03630 ULTRA SOUND	0	b	0		0	7, 589, 103	0.000000	57.01
59.00         CARDI AC CATH TERI ZATI ON         O         24, 967, 590         0.000000         59.00           60.00         CABORATORY         O         O         52, 885, 114         0.000000         60.00           63.00         BLOOD LABORATORY         O         O         0         0.00000         60.00           63.00         CAGON         ILABORATORY         O         O         0.000000         61.00           63.00         CAGON         INTRAVENUS         THERAPY         O         O         0.000000         64.00           64.00         O6500         RESPI RATORY THERAPY         O         O         0         0.000000         65.00           65.00         OCCUPATI ONAL THERAPY         O         O         O         0.000000         65.00           66.00         OCCUPATI ONAL THERAPY         O         O         O         0.000000         67.00           66.00         DECTROCARDI OLOGY         O         O         O         0.000000         67.00           71.00         OTOO         RECAL 224         0.000000         71.00         0.39, 363, 424         0.000000         71.00           72.00         OTOO         HPL. DEV. CHARGED TO PATI ENTS         O <td>58.00</td> <td>05800 MRI</td> <td>0</td> <td>b</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0.000000</td> <td>58.00</td>	58.00	05800 MRI	0	b	0		0		0.000000	58.00
60. 00         loG000         LABORATORY         0         0         52, 885, 114         0.000000         60. 00           60. 01         06000         LABORATORY         0         0         0         0.000000         60. 01           60. 01         06000         DSTORI NG, PROCESSI NG & TRANS.         0         0         1, 403, 965         0.000000         64. 00           64. 00         06500         RESPI RATORY THERAPY         0         0         0         0.000000         64. 00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         0.000000         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         0.000000         67. 00           0         06700         0CCUPATI ONAL THERAPY         0         0         0         0.000000         67. 00           0         06900         ELECTROCARDI OLOGY         0         0         0         0.000000         69. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         342, 335         342, 335         56, 578, 350         0.006000         72. 00           72. 00         IPALD         <	59.00	05900 CARDI AC CATHETERI ZATI ON	0		0		0			
60.01         06001         BLOOD LABORATORY         0         0         0         0         0.000000         60.01           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         1,403,965         0.000000         63.00           64.00         06400         INTRAVENUS THERAPY         0         0         0         0.000000         64.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         0.000000         65.00           66.00         0         66.00         0         0         0         0.00000         65.00           66.00         0         0.00000         0         0         0         0         0.00000         65.00           66.00         0         0.00000         0         0         0         0.00000         66.00           68.00         06600         SPECH PATHOLOGY         0         0         0         0.00000         68.00           69.00         0         0.00000         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         73.00         74.01			0		0		0			
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       1,403,965       0.000000       63.00         64.00       1NTRAVENOUS THERAPY       0       0       0       0.000000       64.00         65.00       6500       RESPIRATORY THERAPY       0       0       0       0.000000       64.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0.000000       66.00         68.00       6800       SPEECH PATHOLOGY       0       0       0       0.000000       69.00         69.00       ELCTROCARDI OLOGY       0       0       0       0.000000       69.00         71.00       OT200       IMEL AL SUPPLIES CHARGED TO PATI ENT       0       0       18,937,262       0.000000       71.00         73.00       OT300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       74.00         74.00       OT400       RENAL DI ALYSI S       0       0       0       0.000000       76.01         76.01       03140       CARDIAC REHAB       0       0 </td <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0</td> <td>02,000,111</td> <td></td> <td>•</td>			0		0		0	02,000,111		•
64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       0.000000       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       6,933,453       0.000000       65.00         66.00       0600       PHSI CAL THERAPY       0       0       0       26,635,596       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       68.00         69.00       06900       ELECTROCARDI LOGY       0       0       0       0.000000       71.00         71.00       07100       MPL. DEV. CHARGED TO PATI ENTS       0       0       18,937,262       0.000000       72.00         73.00       07400       REMAL DI ALYSI S       0       0       0       48,035       342,335       56,578,350       0.000000       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       11,886,468       0.000000       74.00         76.01       03140       CRRDI AC REHAB       0       0       0			0	Ś	0		0	1 403 965		•
65:00       06500       RESPIRATORY THERAPY       0       0       6,933,453       0.000000       65:00         66:00       06600       PHYSI CAL THERAPY       0       0       0       26,635,596       0.000000       66:00         67:00       0CCUPATIONAL THERAPY       0       0       0       0.000000       67:00         68:00       06800       SPECH PATHOLOGY       0       0       0.000000       68:00         69:00       06900       ELECTROCARDIOLOGY       0       0       0.000000       69:00         71:00       OT200       IMPL LAK SUPPLIES CHARGED TO PATIENTS       0       0       39,363,424       0.000000       72:00         72:00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       18,937,262       0.000000       72:00         73:00       07300       RENAL DI ALYSIS       0       342,335       342,335       56,578,350       0.000000       74:00         76:01       03140       CRENAL DI ALYSIS       0       0       0       0.000000       76:01         76:02       03070       WOMEN'S CENTER       0       0       0       0       0.000000       76:01         76:03       03330					0		0	1, 403, 703		
66.00         06600         PHYSI CAL THERAPY         0         0         26,635,596         0.000000         66.00           67.00         0CCUPATI ONAL THERAPY         0         0         0         0         0.000000         67.00           68.00         0FECH PATHOLOGY         0         0         0         0         0.000000         68.00           69.00         06900         ELECTROCARDI OLOGY         0         0         0         0.000000         69.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENT         0         0         39,363,424         0.000000         71.00           72.00         07200         IMPL.         DEV. CHARGED TO PATIENTS         0         342,335         342,335         56,578,350         0.00000         72.00           74.00         07400         RENAL DI ALYSI S         0         0         0         0         0         0         0.000000         74.00           76.01         03200         OTHER ANCI LLARY         0         0         0         0         0.000000         76.01           76.02         03070         WOMEN'S CENTER         0         0         0         0         0.000000         76.02					0		0	6 933 453		•
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0.000000       67.00         68.00       06800       SPEECH       PATHOLOGY       0       0       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0.000000       69.00         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       39,363,424       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       342,335       56,578,350       0.006051       73.00         74.00       07400       RENAL DI ALYSI S       0       342,335       56,578,350       0.000000       74.00         76.00       03202       OTHER ANCI LLARY       0       0       0       0.000000       76.01         76.01       03140       CARDI AC REHAB       0       0       0       0.000000       76.02         76.02       03370       INDOSCOPY       0       0       0       0.000000       76.02         76.03       03330       ENDOSCOPY       0       0       0       0.000000       76.02         76.03       03330       ENDOSCOPY       0					0		0			•
68.00         06800         SPEECH PATHOLOGY         0         0         0         0         0.000000         68.00           69.00         06900         LECTROCARDIOLOGY         0         0         0         8, 624, 224         0.000000         69.00           71.00         OTIO         MEDICAL SUPPLIES CHARGED TO PATIENT         0         0         39, 363, 424         0.000000         72.00           72.00         O7200         IMPL.         DEV. CHARGED TO PATIENTS         0         342, 335         342, 335         56, 578, 350         0.006000         74.00           74.00         O7400         RENAL DIALYSIS         0         0         0         481, 678         0.000000         74.00           76.00         03020         OTHER ANCI LLARY         0         0         0         0         0.000000         76.00           76.01         03140         CARDIAC REHAB         0         0         0         0         0.000000         76.00           76.02         03070         WMEN'S CENTER         0         0         0         0         0         0.000000         76.02           76.02         0330         ENDSCOPY         0         0         0         0			0	Ś	0		0			•
69.00       06900       ELECTROCARDIOLOGY       0       0       8, 624, 224       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       39, 363, 424       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       18, 937, 262       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       342, 335       56, 578, 350       0.006051       73.00         74.00       07400       RENAL DI ALYSI S       0       0       481, 678       0.000000       74.00         76.00       03202       OTHER ANCI LLARY       0       0       0       0       0.000000       76.00         76.01       03140       CARDI AC REHAB       0       0       0       0       0.000000       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       0       0.000000       76.02         03330       ENDOSCOPY       0       0       0       0       0       0.000000       76.03         90.01       09001       CUTPATI ENT       0       0       0       0       0.000000 <td< td=""><td></td><td></td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>0</td><td></td><td></td></td<>			0		0		0	0		
71.00       07100       MEDI CAL       SUPPLIES CHARGED TO PATIENT       0       0       39, 363, 424       0.000000       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       0       18, 937, 262       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       342, 335       342, 335       56, 578, 350       0.006051       73.00         74.00       RENAL DIALYSIS       0       0       0       481, 678       0.000000       74.00         76.00       03020       OTHER ANCILLARY       0       0       0       0.000000       76.00         76.01       03140       CARDIAC REHAB       0       0       0       0       0.000000       76.00         76.02       03070       WOMEN'S CENTER       0       0       0       0       0.000000       76.02         76.03       03330       ENDOSCOPY       0       0       0       0.000000       76.02         70.00       09000       CLINIC       0       0       0       0.000000       76.02         70.00       09000       CLINIC       0       0       0       0.000000       90.01      <			0		0		0	0 424 224		•
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       18,937,262       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       342,335       342,335       56,578,350       0.006051       73.00         74.00       07400       RENAL DIALYSIS       0       0       0       481,678       0.000000       74.00         76.00       03020       OTHER ANCILLARY       0       0       0       0.000000       76.00         76.01       03140       CARDIAC REHAB       0       0       0       0       0.000000       76.00         76.02       03070       WOMEN'S CENTER       0       0       0       0       0.000000       76.01         76.03       03330       ENDSCOPY       0       0       0       0       0.000000       76.02         76.03       03330       ENDSCOPY       0       0       0       0       0.000000       76.02         70.00       09000       CLI NI C       0       0       0       0       0.000000       90.02         90.00       09000       UTPATI ENT       0       0       0       0.000000       90.02       90.0			0		0		0			•
73.00       07300       DRUGS CHARGED TO PATIENTS       0       342,335       342,335       56,579,350       0.006051       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       481,678       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       11,886,468       0.000000       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       7280,377       0.000000       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       0.000000       76.02         76.03       03330       ENDOSCOPY       0       0       0       0.000000       76.03         00.00       09000       CLI NI C       0       0       0       0.000000       90.01         90.00       09001       OUTPATI ENT       0       0       0       0.000000       90.02         90.01       09001       OUTPATI ENT       0       0       0       0.000000       90.02         90.02 </td <td></td> <td></td> <td>0</td> <td>1</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td> <td></td>			0	1	0		0			
74.00       07400       RENAL DI ALYSI S       0       0       481,678       0.00000       74.00         76.00       03020       OTHER ANCI LLARY       0       0       0       0.000000       76.00         76.01       03140       CARDIA C REHAB       0       0       0       11,886,468       0.000000       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       76.02       70.000000       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       0.00000       76.02         76.03       03330       ENDOSCOPY       0       0       0       0       0.00000       76.03         00TPATI ENT SERVICE COST CENTERS       0       0       0       0       0.00000       90.00         90.00       09001       UTPATI ENT       0       0       0       5,029,118       0.000000       90.01         90.01       09001       UTPATI ENT       0       0       0       1,688,516       0.000000       90.02         91.01       09002       NEUROPSYCHOLOGY       0       0       0       0.000000       91.00         91.01       09101			0	2	242.225	242.27	0 25			•
76.00       03020       OTHER ANCI LLARY       0       0       0       0.000000       76.00         76.01       03140       CARDI AC REHAB       0       0       0       11,886,468       0.000000       76.01         76.02       03070       WOMEN'S CENTER       0       0       0       76.02       76.02         03330       ENDOSCOPY       0       0       0       0       0       76.02         03330       ENDOSCOPY       0       0       0       0       0       0.000000       76.02         00UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0.000000       90.00         90.00       OUTPATI ENT       0       0       0       0.000000       90.01       90.00 </td <td></td> <td></td> <td>0</td> <td>2</td> <td>342, 335</td> <td>342, 3.</td> <td>35</td> <td></td> <td></td> <td>•</td>			0	2	342, 335	342, 3.	35			•
76.01         03140         CARDI AC REHAB         0         0         11,886,468         0.00000         76.01           76.02         03070         WOMEN'S CENTER         0         0         0         76.02         76.02           76.03         03300         ENDOSCOPY         0         0         0         0         0.000000         76.02           76.03         03300         ENDOSCOPY         0         0         0         0         0.000000         76.03           0UTPATI ENT SERVICE         COST CENTERS         0         0         0         0.000000         90.00			0	2	0		0			•
76. 02       03070       WOMEN'S CENTER       0       0       76. 02       76. 03         76. 03       03330       ENDOSCOPY       0       0       0       0       0.000000       76. 02         76. 03       03330       ENDOSCOPY       0       0       0       0.000000       76. 03         0UTPATI ENT SERVICE COST CENTERS       0       0       0       5, 029, 118       0.000000       90. 00         90. 00       09000       CLINIC       0       0       0       5, 029, 118       0.000000       90. 01         90. 01       09001       OUTPATI ENT       0       0       0       5, 848, 100       0.000000       90. 01         90. 02       PG020       NEUROPSYCHOLOGY       0       0       1, 688, 516       0.000000       90. 02         91. 00       09101       EMERGENCY       0       0       39, 728, 069       0.000000       91. 01         91. 01       09101       SHORT STAY       0       0       0       0.000000       91. 01         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       0.000000       92. 00         0THER       REI MBURSABLE COST CENTERS			0	2	0		0			
76. 03       03330       ENDOSCOPY       0       0       0       0       0.00000       76. 03         OUTPATI ENT SERVICE COST CENTERS       0       0       0       0.000000       0       0.000000       90. 00       90. 00       90. 00       0       0.000000       90. 00       90. 00       90. 00       0       5, 029, 118       0.000000       90. 00       90. 01       90. 01       90. 01       0.000000       90. 01       90. 01       90. 02       9002 NEUROPSYCHOLOGY       0       0       0       1, 688, 516       0.000000       90. 02       91. 00       90. 00       91. 00       91. 00       91. 00       91. 01       9101       SHORT STAY       0       0       0       0.000000       91. 01       91. 01       92.00       0.000000       91. 01       92.00       0.000000       91. 01       92.00       0       0       0       0.000000       91. 01       92. 00       92.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00			0	)	0		0	11, 886, 468		
OUTPATI ENT         SERVI CE         COST CENTERS           90.00         09000         CLI NI C         0         0         5, 029, 118         0. 000000         90. 00           90.01         09001         0UTPATI ENT         0         0         0         5, 848, 100         0. 000000         90. 01           90.02         09002         NEUROPSYCHOLOGY         0         0         0         1, 688, 516         0. 000000         90. 02           91.00         09100         EMERGENCY         0         0         0         39, 728, 069         0. 000000         91. 01           91.01         O9101         Start I ON         BEDS         (NON-DI STI NCT PART         0         0         0         0. 000000         91. 01           92.00         OBSERVATI ON         BEDS         (NON-DI STI NCT PART         0         0         0. 000000         92. 00           OTHER         REI MBURSABLE         COST CENTERS         95. 00         95.00         95.00         95.00			0	)	0		-			
90.00         09000         CLINIC         0         0         5,029,118         0.00000         90.00           90.01         09001         0UTPATIENT         0         0         0         5,848,100         0.000000         90.01           90.02         09002         NEUROPSYCHOLOGY         0         0         0         1,688,516         0.000000         90.02           91.00         09100         EMERGENCY         0         0         0         39,728,069         0.000000         91.00           91.01         SHORT STAY         0         0         0         0         0.000000         91.01           92.00         OB200         OBSERVATION BEDS (NON-DISTINCT PART         0         0         0         0.000000         91.01           92.00         OB200         OBSERVATION BEDS (NON-DISTINCT PART         0         0         5,605,021         0.000000         92.00           OTHER REIMBURSABLE COST CENTERS         95.00         OP500         AMBULANCE SERVICES         95.00         95.00	76.03		0	)	0		0	0	0.000000	76.03
90.01       09001       0UTPATIENT       0       0       5,848,100       0.00000       90.01         90.02       09002       NEUROPSYCHOLOGY       0       0       0       1,688,516       0.00000       90.02         91.00       09101       EMERGENCY       0       0       0       39,728,069       0.000000       91.00         91.01       09101       SHORT STAY       0       0       0       0.000000       91.01         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       0       0       0.000000       92.01         07HER       REI MBURSABLE COST CENTERS       92.00       95.00       AMBULANCE SERVICES       95.00										
90.02         09002         NEUROPSYCHOLOGY         0         0         1,688,516         0.00000         90.02         91.00         91.00         39,728,069         0.00000         91.00         91.00         91.00         00         0         0         0.00000         91.00         91.00         91.00         90.02         91.00         90.02         91.00         91.00         90.02         91.00         91.00         90.02         91.00         91.01         91.01         91.01         91.01         91.01         91.01         92.00         0         0         0         0         0         0.00000         91.01         92.00         92.00         05.605,021         0.000000         92.			-		-		0	-,,		
91.00       09100       EMERGENCY       0       0       39,728,069       0.00000       91.00         91.01       09101       SHORT STAY       0       0       0       0       0.000000       91.01         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       5,605,021       0.000000       92.00         0THER       REI MBURSABLE COST CENTERS       55.00       09500       AMBULANCE SERVICES       95.00			0	)	0		0			
91.01       09101       SHORT STAY       0       0       0       0.00000       91.01         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       5,605,021       0.000000       92.00         0THER       REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES       95.00			0	)	0		0			
92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         0         0         5,605,021         0.000000         92.00           0THER         REI MBURSABLE         COST CENTERS         95.00         9500         AMBULANCE SERVICES         95.00			0	)	0		0	39, 728, 069		
OTHER REIMBURSABLE COST CENTERS         95.00       09500 AMBULANCE SERVICES       95.00			0	D	0		0	0		
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	5, 605, 021	0.00000	92.00
200.00 Total (lines 50 through 199) 0 342,335 342,335 447,391,408 200.00	95.00	09500 AMBULANCE SERVICES								95.00
	200.00	Total (lines 50 through 199)	0	D	342, 335	342, 33	35	447, 391, 408		200.00

Health Financial Systems	RI VERVI EW HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0059	Peri od:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-T059	From 01/01/2020 To 12/31/2020	Part IV Date/Time Pre 7/29/2021 10:	
		Ti tl e	XVIII	Subprovider -	PPS	
Cost Costas Description	Outrationt	I man anti- a mate	1	I RF		
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	5	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS					-	
50.00 05000 OPERATING ROOM	0. 000000	218, 885		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	67, 279		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	863		0 0	0	55.00
57.00 05700 CT SCAN	0. 000000	44, 135		0 0	0	57.00
57.01 03630 ULTRA SOUND	0. 000000	26, 467		0 0	0	57.01
58.00 05800 MRI	0. 000000	4, 433		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	24, 126		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	713, 040		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	9, 458		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0, 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0, 000000	300, 996		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 584, 297		0 0	0	66,00
67.00 06700 OCCUPATI ONAL THERAPY	0, 000000	0,000,0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	26, 583		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	867, 528		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	17, 765		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 006051	779, 894	4, 71		0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	63, 782	4,7	0 0	0	74.00
76. 00 03020 OTHER ANCI LLARY	0. 000000	03,702		0 0	0	76.00
76. 01 03140 CARDI AC REHAB	0. 000000	5, 993		0 0	0	76.01
76. 02 03070 WOMEN' S CENTER	0. 000000	5, 775		0 0	0	76.02
76. 03   03330 ENDOSCOPY	0. 000000	0		0 0	0	76.02
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	1 70.03
	0,000000	1 220		0	0	00.00
90. 00 09000 CLINIC	0. 000000	1, 320		0 0		
	0. 000000	18, 465		0 0	0	90.01
90. 02 09002 NEUROPSYCHOLOGY	0.000000	5, 928		0 0	0	90.02
91.00 09100 EMERGENCY	0. 000000	26, 021		0 1, 515	0	91.00
91.01 09101 SHORT STAY	0. 000000	0		0 0	0	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
OTHER REI MBURSABLE COST CENTERS	1					05.05
95. 00 09500 AMBULANCE SERVICES		( 007 075			-	95.00
200.00  Total (lines 50 through 199)	1	6, 807, 275	4,71	1, 515	0	200.00

	uncial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0059	Peri od:	Worksheet D	
			Component	CCN: 15-T059	From 01/01/2020 To 12/31/2020		marod
			component	CGN. 15-1057	10 12/31/2020	7/29/2021 10:	51 am
			Title	e XVIII	Subprovider -	PPS	
					' I RF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	0.450044					50.00
	O OPERATING ROOM	0. 159246	C		0 0		
	O DELIVERY ROOM & LABOR ROOM	0.000000	C		0 0	0	
	O RADI OLOGY-DI AGNOSTI C	0. 413700	C		0 0	0	
	O RADI OLOGY-THERAPEUTI C	0. 240761	C		0 0	0	
	O CT SCAN	0. 028863	C		0 0	0	
	O ULTRA SOUND	0.073729	C		0 0	0	
		0. 086425	C		0 0	0	
	O CARDI AC CATHETERI ZATI ON	0.064377	C		0 0	0	
	O LABORATORY	0. 212199	C		0 0	0	
	1 BLOOD LABORATORY	0.000000	C		0 0	0	
	O BLOOD STORING, PROCESSING & TRANS.	0. 507138	C		0 0	0	
	O I NTRAVENOUS THERAPY	0. 000000	C		0 0	0	
	O RESPIRATORY THERAPY	0. 349033	C		0 0	0	•
	O PHYSI CAL THERAPY	0. 358169	C		0 0	0	
	O OCCUPATI ONAL THERAPY	0. 000000	C		0 0	0	
	O SPEECH PATHOLOGY	0.000000	C		0 0	0	
		0. 179544	C		0 0	0	
	O MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 235204	C		0 0	0	
	O IMPL. DEV. CHARGED TO PATIENTS	0. 586664	C		0 0	0	•
	O DRUGS CHARGED TO PATIENTS	0. 330123			0 2,683	0	
	O RENAL DI ALYSI S	0. 833054 0. 000000			0 0 0 0	0	
	0 OTHER ANCI LLARY 0 CARDI AC REHAB				0 0	0	
	O WOMEN' S CENTER	0. 256769			0 0	0	
	0 ENDOSCOPY	0. 214568			0 0	0	
	ATIENT SERVICE COST CENTERS	0.00000		/	0 0	0	70.03
	O CLINIC	0. 164354	C		0 0	0	90.00
	1 OUTPATI ENT	0. 318191			0 0	0	
	2 NEUROPSYCHOLOGY	0. 327921			0 0	0	
	0 EMERGENCY	0. 459027	1, 515		0 0	695	
	1 SHORT STAY	0. 000000	i, 515		0 0	093	
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 745282			0 0	0	
	R REIMBURSABLE COST CENTERS	0.743202		<u>′</u>	0 0	0	72.00
	O AMBULANCE SERVICES	0. 000000			0		95.00
200.00	Subtotal (see instructions)	0.000000	1, 515		0 2,683	605	200.00
200.00	Less PBP Clinic Lab. Services-Program		1, 513		0 2,003	575	201.00
201.00	Only Charges				Ŭ		
202.00	Net Charges (line 200 - line 201)	1	1, 515		0 2,683	695	202.00
		1	, ,	i.	,		

Health Financial Systems	RIVERVIEW H	OSPI TAL		In Lieu	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0059	Peri od:	Worksheet D	
		Component	CCN: 15-T059	From 01/01/2020 To 12/31/2020	Part V Date/Time Pr 7/29/2021 10	
		Title	XVIII	Subprovider - IRF	PPS	
	Cost			IKF		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Services	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 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
57.00 05700 CT SCAN	0	0				57.00
57.01 03630 ULTRA SOUND	0	0				57.01
58. 00 05800 MRI	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60.01 06001 BLOOD LABORATORY	0	0				60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	886				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03020 OTHER ANCI LLARY	0	0				76.00
76. 01 03140 CARDI AC REHAB	0	0				76.01
76.02 03070 WOMEN' S CENTER	0	0				76.02
76. 03 03330 ENDOSCOPY	0	0				76.03
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 OUTPATI ENT	0	0				90.01
90. 02 09002 NEUROPSYCHOLOGY	0	0				90.02
91. 00 09100 EMERGENCY	0	0				91.00
91.01 09101 SHORT STAY	0	0				91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	886				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00  Net Charges (line 200 - line 201)	0	886				202.00

	Financial Systems RIVERVIEW HOS ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-1		
			From 01/01/2020 To 12/31/2020	Date/Time Pre	nare	
		<b>T</b>		7/29/2021 10:		
	Cost Center Description	Title XVIII	Hospi tal	PPS		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS		1			
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			14, 441 14, 441	1	
00	Private room days (excluding private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days,	14, 441	3	
	do not complete this line.		<b>J</b>	10.010		
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	12, 212 0	45	
	reporting period	<u> </u>		-		
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7	
00	reporting period Total swing-bed NF type inpatient days (including private roc	m dave) after Decomber	21 of the cost	0		
00	reporting period (if calendar year, enter 0 on this line)	Jii uays) arter becember	ST OF THE COST	0	8	
00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	4, 010	9	
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room davs)	0	10	
	through December 31 of the cost reporting period (see instruc	ctions)	5,			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12	
8. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including prive	to room dave)	0	13	
. 00	after December 31 of the cost reporting period (if calendar y			0		
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0		
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0		
	SWING BED ADJUSTMENT					
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17	
. 00	reporting period 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost					
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	f the cost	0.00	19	
	reporting period		++	0.00	0	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter becember 31 01	the cost	0.00	20	
	Total general inpatient routine service cost (see instruction			27, 063, 528		
2.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22	
8.00	Swing-bed cost applicable to SNF type services after December	<sup>-</sup> 31 of the cost reporti	ng period (line 6	0	23	
I. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 31 of the cost report	ing period (line	0	24	
	7 x line 19)	·	0 1 1	-		
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25	
6.00	Total swing-bed cost (see instructions)			0	26	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		27, 063, 528	27	
8.00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28	
9.00	Private room charges (excluding swing-bed charges)		-	0	29	
	Semi-private room charges (excluding swing-bed charges)	1.1.7.20)		0		
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TTNE 28)		0.000000		
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00		
	Average per diem private room cost differential (line 34 x li			0.00		
	Private room cost differential adjustment (line 3 x line 35)	- /		0	36	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line			
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			-	
3. 00	Adjusted general inpatient routine service cost per diem (see			1, 874. 08	38	
9.00	Program general inpatient routine service cost (line 9 x line	e 38)		7, 515, 061	39	
), 00	Medically necessary private room cost applicable to the Progr	. ,		0		
	Total Program general inpatient routine service cost (line 39			7, 515, 061		

Health Financial Systems	RI VERVI EW F				u of Form CMS-	
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2020	Worksheet D-1	1
				To 12/31/2020	Date/Time Pre 7/29/2021 10:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Total Inpati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	42.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43. 00 I NTENSI VE CARE UNI T	6, 443, 907	3, 382	1, 905. 3	5 1, 015	1, 933, 930	43.00
44. 00 CORONARY CARE UNIT						44.00
45. 00 BURN I NTENSI VE CARE UNI T 46. 00 SURGI CAL I NTENSI VE CARE UNI T						45.00
47. 00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wk	st. D-3. col. 3	. line 200)			1.00 9,208,820	48.00
49.00 Total Program inpatient costs (sum of lines			ons)		18, 657, 811	
PASS THROUGH COST ADJUSTMENTS			What D are	f Danta I and	1 001 050	1 50 00
50.00 Pass through costs applicable to Program inp.	atient routine	Services (Troi	n wkst. D, sur	n of Parts I and	1, 901, 250	50.00
51.00 Pass through costs applicable to Program inpa	atient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II	745, 089	51.00
and IV)	FO and F1				0 / / / 000	E0.00
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost exclu	,	lated non-ph	vsician anesti	netist and	2, 646, 339 16, 011, 472	
medical education costs (line 49 minus line		natea, non pr		lotrot, and	10,011,172	00.00
TARGET AMOUNT AND LIMIT COMPUTATION						1 54 00
<ul><li>54.00 Program discharges</li><li>55.00 Target amount per discharge</li></ul>					0 0.00	
56.00 Target amount (line 54 x line 55)					0.00	
57.00 Difference between adjusted inpatient operat	ing cost and ta	rget amount (	ine 56 minus	line 53)	0	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost re	porting poriod	onding 1006	undated and c	ampounded by the	0.00	
market basket	por tring period	enuring 1990, i		silipourided by the	. UU	39.00
60.00 Lesser of lines 53/54 or 55 from prior year					0.00	
61.00 If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
amount (line 56), otherwise enter zero (see		S (TTHES 54 X	60), 01 1% 01	the target		
62.00 Relief payment (see instructions)					0	
63.00 Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64.00 Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.00
instructions)(title XVIII only)					_	
65.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reportinț	j period (See	0	65.00
66.00 Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	55)(title XVI)	I only). For	0	66.00
CAH (see instructions)						
67.00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67.00
68.00 Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	o	68.00
(line 13 x line 20)			- (0)			
69.00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00 Skilled nursing facility/other nursing facil				)		70.00
71.00 Adjusted general inpatient routine service of 72.00 Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
72.00 Program routine service cost (line 9 x line 73.00 Medically necessary private room cost applic		(line 14 x li	ne 35)			72.00
74.00 Total Program general inpatient routine serv	0	•	,			74.00
75.00 Capital-related cost allocated to inpatient	routine service	costs (from )	Norksheet B, F	Part II, column		75.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00 Program capital-related costs (line 9 x line						77.00
78.00 Inpatient routine service cost (line 74 minu:	,	novi don	dc)		l	78.00
79.00 Aggregate charges to beneficiaries for excess 80.00 Total Program routine service costs for comp				nus line 79)		79.00
81.00 Inpatient routine service cost per diem limi			(		l	81.00
82.00 Inpatient routine service cost limitation (I						82.00
83.00 Reasonable inpatient routine service costs ( 84.00 Program inpatient ancillary services (see in:		s)				83.00
85.00 Utilization review - physician compensation		ins)				84.00
86.00 Total Program inpatient operating costs (sum	of lines 83 th				l	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS						
	)			1	1 2 2 2 2 0	
87.00 Total observation bed days (see instructions 88.00 Adjusted general inpatient routine cost per		line 2)			2, 229 1, 874. 08	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	5, 879, 963	27,063,528	0. 21726	5 4, 177, 324	907, 586	90.00
91.00 Nursing School cost	0	27, 063, 528	0.00000	0 4, 177, 324	0	91.00
92.00 Allied health cost	0	27,063,528	0.00000	0 4, 177, 324	0	92.00
93.00 All other Medical Education	0	27, 063, 528	0.00000	4, 177, 324	0	93.00

)MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Pre 7/29/2021 10:	pare
	Cost Capton Decomintion	Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		4, 623	1.
00	Inpatient days (including private room days, excluding swing-			4, 623	2.
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ad dave)		1 4 2 2	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	4, 623 0	4. 5.
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	r 31 of the cost	0	7.
00	reporting period	in days) thi dugh becember	i si oi the cost	0	/ ·
00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable 1	a the Dreaman (aveluding	a cwing bod and	3, 055	9.
00	newborn days) (see instructions)	the Program (excruding	y swilly-bed allo	3,000	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10.
	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period				
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.
1.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	davs)	0	14.
	Total nursery days (title V or XIX only)			0	15.
5.00	Nursery days (title V or XIX only)			0	16.
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (	of the cost	0.00	17.
	reporting period	ů – – – – – – – – – – – – – – – – – – –			
3. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.
	reporting period			0.00	
0. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20.
I. 00	Total general inpatient routine service cost (see instruction	ns)		5, 686, 277	21.
2.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22.
	5 x line 17) Swing had east appliable to SNE type complete often December	21 of the east reporting	ng ported (line (	0	22
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	SI OF THE COST TEPOLT	ng period (inne o	0	23.
1.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25.
	x line 20)			0	20.
	Total swing-bed cost (see instructions)			0	26.
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 686, 277	27.
3. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
9.00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TThe 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	34
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 5, 686, 277	36. 37.
	27 minus line 36)			5,000,277	J/.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		I	1 220 00	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 230. 00 3, 757, 650	
	Medically necessary private room cost applicable to the Progr	-		0,707,000	40.
. 00		9 + line 40)		3, 757, 650	

alth Financial Systems DMPUTATION OF INPATIENT OPERATING COST	RI VERVI EW		CN: 15-0059	Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-T059	From 01/01/2020 To 12/31/2020	Date/Time Pre	epared
		Title	e XVIII	Subprovider -	7/29/2021 10: PPS	51 am
Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	I npati ent Cost	I npati ent Days	Diem (col. ÷ col. 2)	5	(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	0 ts	C	0.0	00 0	0	42.0
3.00 INTENSIVE CARE UNIT	0	C	0.0	0 0	0	
4. 00 CORONARY CARE UNIT 5. 00 BURN INTENSIVE CARE UNIT						44.0
5. 00 SURGI CAL I NTENSI VE CARE UNI T						46.0
7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
					1.00	
B.00 Program inpatient ancillary service cost (					2, 164, 363	
P. 00 Total Program inpatient costs (sum of line: PASS THROUGH COST ADJUSTMENTS	s 41 through 48)	see instructi	ons)		5, 922, 013	49.0
0.00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	678, 943	50.0
1.11) 1.00 Pass through costs applicable to Program i	npatient ancilla	rv services (f	rom Wkst. D.	sum of Parts II	110, 870	51.0
and IV)	•	j con 11 coc (1				
2.00  Total Program excludable cost (sum of line: 3.00  Total Program inpatient operating cost exc		alated non-nh	veician anest	batist and	789, 813 5, 132, 200	
medical education costs (line 49 minus line	5 1	erated, non-pri	ysi ci an anest		5, 152, 200	55.
TARGET AMOUNT AND LIMIT COMPUTATION 4.00 Program discharges					0	54.
5.00 Target amount per discharge					0.00	
5.00 Target amount (line 54 x line 55)					0	
7.00 Difference between adjusted inpatient oper 3.00 Bonus payment (see instructions)	ating cost and ta	arget amount (	line 56 minus	line 53)	0	
P. 00 Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and c	ompounded by the	-	59.
market basket D.00 Lesser of lines 53/54 or 55 from prior yea	r cost roport u	dated by the	markat backat		0.00	60.
1.00 If line 53/54 is less than the lower of line					0.00	
which operating costs (line 53) are less t		ts (lines 54 x	60), or 1% o	f the target		
amount (line 56), otherwise enter zero (se 2.00 Relief payment (see instructions)	e instructions)				0	62.
3.00 Allowable Inpatient cost plus incentive pa	yment (see instru	uctions)			0	63.
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine c	osts through Dece	ember 31 of th	e cost report	ing period (See	0	64.
instructions)(title XVIII only)	Ū.			0.		
5.00 Medicare swing-bed SNF inpatient routine control instructions) (title XVIII only)	osts after Decemb	per 31 of the	cost reportin	g period (See	0	65.
5.00 Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVI	II only). For	0	66.
CAH (see instructions) 7.00  Title V or XIX swing-bed NF inpatient rout	ine costs through	n December 31	of the cost r	eporting period	0	67.
(line 12 x line 19) 3.00 Title V or XIX swing-bed NF inpatient rout	ina casta aftar (	)acambar 21 of	the cost ron	orting poriod	0	68.0
(line 13 x line 20)		becember 31 01	the cost rep	or tring period		00.
7.00 Total title V or XIX swing-bed NF inpatien					0	69.
PART III - SKILLED NURSING FACILITY, OTHER D. 00 Skilled nursing facility/other nursing fac				)		70.
1.00 Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.
2.00 Program routine service cost (line 9 x line 3.00 Medically necessary private room cost appl	,	n (line 14 x l	ine 35)			72.
4.00 Total Program general inpatient routine se	rvice costs (line	e 72 + line 73	)			74.
5.00 Capital-related cost allocated to inpatien 26, line 45)	t routine service	e costs (from	Worksheet B,	Part II, column		75.
6.00 Per diem capital-related costs (line 75 ÷						76.
7.00 Program capital-related costs (line 9 x li 3.00 Inpatient routine service cost (line 74 mi						77.
9.00 Aggregate charges to beneficiaries for exc		provider recor	ds)			78.
0.00 Total Program routine service costs for co	•	cost limitatio	n (line 78 mi	nus line 79)		80.
1.00  Inpatient routine service cost per diem li 2.00  Inpatient routine service cost limitation		1)				81. 82.
3.00 Reasonable inpatient routine service costs	•	· .				83.
4.00 Program inpatient ancillary services (see						84.
5.00  Utilization review – physician compensation 6.00  Total Program inpatient operating costs (s						85. 86.
PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROUGH COST	/			1	
7.00 Total observation bed days (see instruction 3.00 Adjusted general inpatient routine cost pe		line 2)			0 00	87. 88.
					0.00	1 00.

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (	CCN: 15-T059	From 01/01/2020 To 12/31/2020		pared: 51 am
		Title	XVIII	Subprovider -	PPS	
				IRF		
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	1,027,438	5, 686, 277	0. 18068	37 0	0	90.00
91.00 Nursing School cost	0	5, 686, 277	0.0000	0 00	0	91.00
92.00 Allied health cost	0	5, 686, 277	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	5, 686, 277	0.0000	0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period: From 01/01/2020	Worksheet D-1	
		THE	To 12/31/2020	7/29/2021 10:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		14, 441	1 1
00	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			14, 441	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	iys). If you have only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b	ed days)		12, 212	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excludin	a swing-bed and	463	9
	newborn days) (see instructions)	0	0 0		
00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period		•	0	
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
00	Total nursery days (title V or XIX only)		-	1, 331	15
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	t the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	is)		27, 063, 528	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line A	0	23
	x line 18)			0	
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		27, 063, 528	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had a	hanges)	0	1.20
	Private room charges (excluding swing-bed charges)		nai ges)	0	28
	Semi-private room charges (excluding swing-bed charges)			0	30
00 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0. 000000 0. 00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		ctions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	10 01/		0.00	36
00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	27, 063, 528	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
o -	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 874. 08 867, 699	
	Medically necessary private room cost applicable to the Progr	-		0	40
. 00	Total Program general inpatient routine service cost (line 39	9 + line 40)		867,699	41

	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW H	Provider C	CN: 15-0059	Period:	u of Form CMS- Worksheet D-1	
					From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/29/2021 10:	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)	0	1, 331	0.0	0 0	C	) 42.
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	6, 443, 907	3, 382	1, 905. 3	5 0	C	43.
	CORONARY CARE UNIT	0,443,707	5, 502	1, 903. 5	5	C	44.
	BURN INTENSIVE CARE UNIT						45.
	SURGI CAL I NTENSI VE CARE UNI T						46.
7.00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	+
3.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			450, 256	48.
	Total Program inpatient costs (sum of lines	41 through 48)(	see instructi	ons)		1, 317, 955	49.
	PASS THROUGH COST ADJUSTMENTS		1		C During Land		1 50
0. 00	Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, su	m of Parts I and	C	50.
1.00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	C	51.
	and IV)					c c	
	Total Program excludable cost (sum of lines					C	
3.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	5 1	lated, non-ph	ysician anest	hetist, and	C	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					C	54.
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					C	
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (	ine 56 minus	line 53)	C	
	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996.	updated and c	ompounded by the		
	market basket	per 11.3 per 12.					
	Lesser of lines 53/54 or 55 from prior year					0.00	
1.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					C	) 61.
	amount (line 56), otherwise enter zero (see		5 (ITHES 54 X	00), 01 1% 0	i the target		
2.00	Relief payment (see instructions)	,				C	62.
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			C	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	te through Doco	mbor 21 of th	a cost roport	ing pariod (Saa	C	64.
4.00	instructions)(title XVIII only)	tis through bece		e cost report	ing period (see	C	04.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	C	65.
	instructions)(title XVIII only)					_	
6.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	55)(title XVI	ll only). For	C	66.
7.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	C	67.
	(line 12 x line 19)						
8.00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	C	68.
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino coste (	lino 67 i lin	5 69)		C	69.
	PART III - SKILLED NURSING FACILITY, OTHER N						07.
0.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37	)		70.
	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.
	Program routine service cost (line 9 x line Medically pecessary private room cost applic		(line 14 v l	no 35)			72.
	Medically necessary private room cost applic Total Program general inpatient routine serv						73.
	Capital -related cost allocated to inpatient				Part II, column		75.
	26, line 45)		-				
	Per diem capital -related costs (line 75 ÷ li						76.
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.
	Aggregate charges to beneficiaries for exces	,	rovi der recor	ds)			79.
. 00	Total Program routine service costs for comp	arison to the c			nus line 79)		80.
	Inpatient routine service cost per diem limi		<b>`</b>				81.
	Inpatient routine service cost limitation (I						82.
	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		3)				84.
	Utilization review - physician compensation		ns)				85.
5.00	Total Program inpatient operating costs (sum	of lines 83 th					86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS					0.000	0.7
7.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		lino 2)			2, 229 1, 874. 08	
8.00	Aurusteu uererar moarrent romme cost de					1 0/4 1/2	

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		pared: 51 am
		Titl	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	5, 879, 963	27,063,528	0. 21726	5 4, 177, 324	907, 586	90.00
91.00 Nursing School cost	0	27,063,528	0.00000	4, 177, 324	0	91.00
92.00 Allied health cost	0	27,063,528	0.00000	4, 177, 324	0	92.00
93.00 All other Medical Education	0	27, 063, 528	0.00000	4, 177, 324	0	93.00

OMPUT	Financial Systems RIVERVIEW H ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T059	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 10:	
		Title XIX	Subprovider - IRF	Cost	01 0
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS		4		
	INPATIENT DAYS				
. 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			4,623	
00	Private room days (excluding private room days, excluding swing Private room days (excluding swing-bed and observation bed o	5	rivate room davs	4, 623	
00	do not complete this line.	days). It you have only p	rvate room days,	0	J J.
00	Semi-private room days (excluding swing-bed and observation	bed days)		4, 623	4.
00	Total swing-bed SNF type inpatient days (including private n	room days) through Decemb	er 31 of the cost	0	5.
~~	reporting period		21 - 6 + 6 +	0	
00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	7
	reporting period			-	
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)			20	
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	g swing-bed and	30	9
D. 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 instru		com days)	0	'`
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,				
2.00	Swing-bed NF type inpatient days applicable to titles V or >	XIX only (including priva	te room days)	0	12
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	XIX only (including priva	te room dave)	0	13
. 00	after December 31 of the cost reporting period (if calendar			0	13
. 00	Medically necessary private room days applicable to the Prog			0	14
5.00	Total nursery days (title V or XIX only)		5 /	1, 331	15
5.00	Nursery days (title V or XIX only)			0	16
7 00	SWING BED ADJUSTMENT	i and through December 21	af the east	0.00	1 1 7
7.00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ices through December 31	or the cost	0.00	''
3. 00	Medicare rate for swing-bed SNF services applicable to servi	ices after December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	ces through December 31 o	f the cost	0.00	19
D. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	oos aftar Dacambar 21 of	the cost	0.00	20
J. 00	reporting period	ces arter becenber 31 01	the cost	0.00	20
1.00	Total general inpatient routine service cost (see instruction	ons)		5, 686, 277	21
2.00	Swing-bed cost applicable to SNF type services through Decer	mber 31 of the cost repor	ting period (line	0	22
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost reporti	ng period (line 6	0	23
I. 00	x line 18) Swing-bed cost applicable to NF type services through Decemb	her 31 of the cost report	na period (line	0	24
1.00	7 x line 19)		ng period (inic	0	27
5.00	Swing-bed cost applicable to NF type services after December	r 31 of the cost reportin	g period (line 8	0	25
	x line 20)			_	
6.00	Total swing-bed cost (see instructions)	+ (line 21 minus line 24)		0	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	t (The 21 minus The 26)		5, 686, 277	27
3. 00	General inpatient routine service charges (excluding swing-b	bed and observation bed c	narges)	0	28
9.00	Private room charges (excluding swing-bed charges)		5,	0	
0. 00	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)	\ \		0.00	
8.00 .00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		ctions)	0.00	
5.00	Average per diem private room cost differential (line 32 r			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost		fferential (line	5, 686, 277	37
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
3. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL Adjusted general inpatient routine service cost per diem (se			1, 230. 00	38
	Program general inpatient routine service cost per drem (se			36, 900	
		-		00,700	
0.00	Medically necessary private room cost applicable to the Prog			0	140

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	RI VERVI EW I		CN: 15-0059	In Lie Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-T059	From 01/01/2020 To 12/31/2020	Date/Time Pre	epare
		Ti ti	e XIX	Subprovider -	7/29/2021 10: Cost	51 8
Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
Intensive Care Type Inpatient Hospital Uni	ts		<u> </u>	0	0	7 72.
3. 00 INTENSIVE CARE UNIT 4. 00 CORONARY CARE UNIT	0	(	0.0	0 00	0	43.
5. 00 BURN INTENSIVE CARE UNIT						44.
5.00 SURGI CAL I NTENSI VE CARE UNI T					-	46.
7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
3.00 Program inpatient ancillary service cost	(Wkst D-3 col 3	Line 200)			1.00 52,872	48
<ul> <li>Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS</li> </ul>			ons)		89, 772	
0.00 Pass through costs applicable to Program i	inpatient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.
III) .00 Pass through costs applicable to Program i	inpatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.
and IV) 2.00 Total Program excludable cost (sum of line	es 50 and 51)				о	52.
3.00 Total Program inpatient operating cost exo medical education costs (line 49 minus lin	cluding capital re	elated, non-ph	iysi ci an anest	hetist, and	0	
TARGET AMOUNT AND LIMIT COMPUTATION					0	54.
.00 Target amount per discharge					0.00	55
<ul> <li>.00 Target amount (line 54 x line 55)</li> <li>.00 Difference between adjusted inpatient oper</li> </ul>	cating cost and ta	urgot amount (	lino 56 minus	lino 52)	0	
. 00 Bonus payment (see instructions)	ating cost and ta	inger amount (		s THE 55)	0	
.00 Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and c	compounded by the	0.00	
market basket 0.00 Lesser of lines 53/54 or 55 from prior yea	ar cost report un	dated by the	markat baskat		0.00	60
.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less	ines 55, 59 or 60 than expected cost	enter the les	ser of 50% of	the amount by	0	
amount (line 56), otherwise enter zero (se 2.00 Relief payment (see instructions)	ee instructions)				0	62.
3.00 Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	ayment (see instru	icti ons)			0	63.
4.00 Medicare swing-bed SNF inpatient routine of instructions) (title XVIII only)	costs through Dece	ember 31 of th	ne cost report	ing period (See	0	64
5.00 Medicare swing-bed SNF inpatient routine of	costs after Decemb	er 31 of the	cost reportir	ng period (See	0	65
instructions)(title XVIII only) 0.00 Total Medicare swing-bed SNF inpatient rou	utine costs (line	64 plus line	65)(title XVI	II only). For	0	66.
CAH (see instructions) 2.00  Title V or XIX swing-bed NF inpatient rout	tine costs through	December 31	of the cost r	eporting period	0	67.
(line 12 x line 19) 3.00 Title V or XIX swing-bed NF inpatient rout	tine costs after D	ecember 31 of	the cost rep	orting period	0	68.
(line 13 x line 20) 7.00 Total title V or XIX swing-bed NF inpatier					0	69.
PART III - SKILLED NURSING FACILITY, OTHER 0.00 Skilled nursing facility/other nursing fac				·)		70
.00 Adjusted general inpatient routine service				)		71
00 Program routine service cost (line 9 x lin						72
.00 Medically necessary private room cost appl .00 Total Program general inpatient routine se	0					73
.00 Capital-related cost allocated to inpatier 26, line 45)	•			Part II, column		75
00 Per diem capital -related costs (line 75 ÷						76
.00 Program capital-related costs (line 9 x li .00 Inpatient routine service cost (line 74 mi	· · ·					77
0.00 Aggregate charges to beneficiaries for exc	cess costs (from p					79
<ul> <li>00 Total Program routine service costs for construction</li> <li>00 Inpatient routine service cost per diem li</li> </ul>	•	ost limitatio	on (line 78 mi	nus line 79)		80
2.00 Inpatient routine service cost per drem in		)				82
8.00 Reasonable inpatient routine service costs	s (see instruction	· .				83
4.00  Program inpatient ancillary services (see 5.00  Utilization review - physician compensatio		uns)				84.
5.00 Total Program inpatient operating costs (s						86
PART IV - COMPUTATION OF OBSERVATION BED F	PASS THROUGH COST					
7.00  Total observation bed days (see instruction 3.00  Adjusted general inpatient routine cost pe		line 2)			0 0.00	
9.00 Observation bed cost (line 87 x line 88) (						89.

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (	CCN: 15-T059	From 01/01/2020 To 12/31/2020		pared: 51 am
		Ti tl	e XIX	Subprovider -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	_	_			
90.00 Capital-related cost	1,027,438	5, 686, 277	0. 18068	37 0	0	90.00
91.00 Nursing School cost	0	5, 686, 277	0.0000	0 00	0	91.00
92.00 Allied health cost	0	5, 686, 277	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	5, 686, 277	0.0000	0 00	0	93.00

Cost Center Description	Title			Date/Time Pre	par
Cost Center Description	II the	XVIII	Hospi tal	7/29/2021 10: PPS	51
		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x	
		1.00	2.00	col . 2) 3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
. 00 03000 ADULTS & PEDI ATRI CS			9, 506, 273		30
. 00 03100 I NTENSI VE CARE UNI T			3, 157, 257		31
. 00 04100 SUBPROVI DER – I RF			0		41
. 00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
. OO OFERATING ROOM		0. 15924		1, 207, 897	50
00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 41370			
00 05500 RADI OLOGY-THERAPEUTI C		0. 24076			
00 05700 CT SCAN		0. 02886			
01 03630 ULTRA SOUND		0. 07372			
00 05800 MRI		0. 08642			
00 05900 CARDI AC CATHETERI ZATI ON		0.06437			
00 06000 LABORATORY		0. 21219			
01 06001 BLOOD LABORATORY		0.0000			
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.50713			
00 06400 I NTRAVENOUS THERAPY		0.00000		0	
		0. 34903			
00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY		0. 35816			
00 06800 SPEECH PATHOLOGY		0.00000			
00 06900 ELECTROCARDI OLOGY		0. 17954			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 23520			
00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 58666			
00 07300 DRUGS CHARGED TO PATIENTS		0. 33012			
00 07400 RENAL DI ALYSI S		0. 83305			
00 03020 OTHER ANCI LLARY		0.00000			
01 03140 CARDI AC REHAB		0. 25676			
02 03070 WOMEN' S CENTER		0. 21456			
03 03330 ENDOSCOPY		0.00000	0 0	0	7
OUTPATIENT SERVICE COST CENTERS					
00 09000 CLINIC		0. 16435	5, 268	866	90
01 09001 OUTPATI ENT		0. 31819			
02 09002 NEUROPSYCHOLOGY		0. 32792			
00 09100 EMERGENCY		0. 45902			
01 09101 SHORT STAY		0.0000			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 74528	32 0	0	92
OTHER REIMBURSABLE COST CENTERS		1			4.
00 09500 AMBULANCE SERVICES			05 400 51		95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			35, 189, 514		
1.00Less PBP Clinic Laboratory Services-Program only charge2.00Net charges (line 200 minus line 201)	ges (line 61)		0 35, 189, 514		20 <sup>2</sup>

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0059	Peri od:	Worksheet D-3	3
			From 01/01/2020		
	Component	CCN: 15-T059	To 12/31/2020	Date/Time Pre 7/29/2021 10:	epare 51 a
	Titl€	× XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		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					
0. 00 03000 ADULTS & PEDIATRICS			0		30
. 00 03100 INTENSIVE CARE UNIT			0		31
. 00 04100 SUBPROVI DER – I RF			4, 442, 983		41
6. 00 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS		1			
. 00 05000 OPERATING ROOM		0. 1592		34, 857	
. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4137		27, 833	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2407		208	
. 00 05700 CT SCAN		0. 0288		1, 274	
01 03630 ULTRA SOUND		0. 07372		1, 951	
. 00 05800 MRI		0. 08642		383	
00 05900 CARDI AC CATHETERI ZATI ON		0.0643		1, 553	
. 00 06000 LABORATORY		0. 2121		151, 306	
. 01 06001 BLOOD LABORATORY		0.0000		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 50713		4, 797	
. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
. 00 06500 RESPI RATORY THERAPY		0. 3490		105, 058	
. 00 06600 PHYSI CAL THERAPY		0. 3581		1, 283, 784	
00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
		0.0000		0	
00 06900 ELECTROCARDI OLOGY		0. 1795		4, 773	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT		0. 23520		204, 046	
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5866		10, 422	
. 00 07300 DRUGS CHARGED TO PATI ENTS		0. 33012		257, 461	
00 07400 RENAL DI ALYSI S		0.8330		53, 134	
00 03020 OTHER ANCI LLARY		0.0000		0	
. 01 03140 CARDI AC REHAB		0. 2567		1, 539	
. 02 03070 WOMEN' S CENTER		0. 2145		4	
. 03 03330 ENDOSCOPY		0.0000	0 00	0	76
OUTPATI ENT SERVICE COST CENTERS		0. 1643	54 1, 320	217	90
. 00   09000  CLINIC . 01   09001  OUTPATI ENT		0. 1843		5, 875	
02 09002 NEUROPSYCHOLOGY		0. 3181		1, 944	
. 00  09100 EMERGENCY		0. 32792		1, 944	
. 01  09101 SHORT STAY		0. 00000		0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7452		0	
OTHER REIMBURSABLE COST CENTERS		0.74520	0	0	4 72
. 00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			6, 807, 275	2, 164, 363	
1.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0,007,279	2, 101, 000	201
12.00 Net charges (line 200 minus line 201)		1	6, 807, 275		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0059	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Pre	epar
	T: +1	e XIX	llooni tol	7/29/2021 10: Cost	51
Cost Center Description	11 (1	Ratio of Cos	Hospital t Inpatient	Inpati ent	
Cost center bescription		To Charges	Program	Program Costs	
		l lo shargos	Charges	(col. 1 x	
			5.121 922	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1		
00 03000 ADULTS & PEDIATRICS			1, 257, 462		3
00 03100 INTENSIVE CARE UNIT			0		3
00 04100 SUBPROVI DER – I RF			0		4
00 04300 NURSERY			0		4
ANCI LLARY SERVI CE COST CENTERS		1			
00 05000 OPERATING ROOM		0. 15924		47, 728	
00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 41370		7, 243	
00 05500 RADI OLOGY-THERAPEUTI C		0. 24076		0	-
00 05700 CT SCAN		0. 02886		1, 542	
01 03630 ULTRA SOUND		0.07372		740	
00 05800 MRI		0. 08642			
00 05900 CARDI AC CATHETERI ZATI ON		0.06437			
00 06000 LABORATORY		0. 21219		77, 717	
01 06001 BLOOD LABORATORY		0.00000		0	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.50713			
		0.00000		0	
		0.34903		22, 476	
00 06600 PHYSI CAL THERAPY		0.35816			
00 06700 OCCUPATI ONAL THERAPY		0.00000		0	
00  06800  SPEECH PATHOLOGY 00  06900  ELECTROCARDI OLOGY		0. 00000		0	-
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 17952			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 23520		28, 202	
00 07300 DRUGS CHARGED TO PATIENTS		0. 33012		97, 182	
00 07400 RENAL DI ALYSI S		0. 83305		8, 861	
00 03020 OTHER ANCI LLARY		0. 00000		0,001	
01 03140 CARDI AC REHAB		0. 25676		561	
02 03070 WOMEN' S CENTER		0. 23070		0	
03 03330 ENDOSCOPY		0. 21430			
OUTPATIENT SERVICE COST CENTERS		0.00000		0	1 '
00 09000 CLINIC		0. 16435	230	38	9
01 09001 0UTPATI ENT		0. 31819		0	
02 09002 NEUROPSYCHOLOGY		0. 32792		0	
00 09100 EMERGENCY		0. 45902			
01 09101 SHORT STAY		0. 00000		0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 74528		0	
OTHER REIMBURSABLE COST CENTERS					1 1
00 09500 AMBULANCE SERVICES					9
0.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 769, 769	450, 256	20
Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		20
2.00 Net charges (line 200 minus line 201)			1, 769, 769		20

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0059	Period:	Worksheet D-3	3
		001 45 7050	From 01/01/2020		
	Component	CCN: 15-T059	To 12/31/2020	Date/Time Pre 7/29/2021 10:	
	Ti tl	e XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			Ŭ	col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
D. 00 03000 ADULTS & PEDIATRICS			0		30.
I. 00 03100 I NTENSI VE CARE UNI T			0		31.
I. 00 04100 SUBPROVI DER – I RF			140, 725		41.
3. 00 04300 NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS					
0. 00 O5000 OPERATING ROOM		0. 15924		-	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		-	
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 41370			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 24076	51 0	0	55
2. 00 05700 CT SCAN		0. 02886	53 1, 669	48	57
7. 01 03630 ULTRA SOUND		0.07372	29 0	0	57
. 00 05800 MRI		0. 08642	25 0	0	58
. 00 05900 CARDI AC CATHETERI ZATI ON		0.0643	77 0	0	59
0. 00 06000 LABORATORY		0. 21219	99 4, 970	1, 055	60
0. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 50713	38 0	0	63
I. 00 06400 I NTRAVENOUS THERAPY		0.0000	0 00	0	64
5. 00 06500 RESPI RATORY THERAPY		0. 34903	33 150	52	65
0. 00 06600 PHYSI CAL THERAPY		0. 35816	59 118, 993	42, 620	66
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000	0 00	0	67
3. 00 06800 SPEECH PATHOLOGY		0.00000	0 00	0	68
9. 00 06900 ELECTROCARDI OLOGY		0. 17954	14 5, 953	1, 069	69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 23520	17, 999	4, 233	71
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 58666	64 0	0	72
00 07300 DRUGS CHARGED TO PATIENTS		0. 33012	10, 990	3, 628	73
. 00 07400 RENAL DIALYSI S		0.83305	54 0	0	74
0. 00 03020 OTHER ANCI LLARY		0.0000	0 00	0	76
. 01 03140 CARDI AC REHAB		0. 25676	59 0	0	76
. 02 03070 WOMEN' S CENTER		0. 21456	58 0	0	76
0. 03 03330 ENDOSCOPY		0.0000		0	76
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC		0. 16435	54 0	0	90
01 09001 OUTPATI ENT		0. 31819	91 524	167	90
. 02 09002 NEUROPSYCHOLOGY		0. 32792	21 0	0	90
. 00 09100 EMERGENCY		0. 45902	27 0	0	91
. 01 09101 SHORT STAY		0.0000		0	91
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 74528		0	92
OTHER REIMBURSABLE COST CENTERS					1
. 00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			161, 248	52, 872	200
1.00 Less PBP Clinic Laboratory Services-Program only charges	6 (line 61)		0		201
02.00 Net charges (line 200 minus line 201)			161, 248		202

To         12/31/2020         Display         Title XVIII         Heapt Int         Type 2021           Initia XVIII         Heapt Int         Heapt Int         Type 2021	NT	TTLEMENT	NT			RI VERVI E		Provider CCN: 15	-0059	Period:	worksheet E		1002-10
Title XVIII         Hospital         PP           0000         Rear A LINPATIENT HOSPITAL SERVICES (MDER 19PS:         1.00           1000         DEG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)         7.407.           1.01         DEG amounts other than outlier payments for discharges occurring on or after Detober 1 (see instructions)         3.311.           1.02         DEG amounts other than outlier payments for Model 4 BPCI for discharges occurring on or after Detober 1 (see instructions)         3.311.           1.03         DEG amounts other than outlier payment for Model 4 BPCI for discharges occurring on or after Detober 1 (see instructions)         125.           1.04         DEG amounts other than outlier payment for Model 4 BPCI (see instructions)         125.           1.04         Dettier payments for discharges occurring prior to October 1 (see instructions)         125.           2.05         Dutlier payments for discharges occurring prior to October 1 (see instructions)         126.           2.04         Dutlier payments for discharges occurring prior to the most recort cost reporting period ending or or before 12/31/96. (see instructions)         127.           2.04         Dutlier payments for discharges occurring on a fire rol oparting period ending or or before 12/31/96. (see instructions)         128.           2.05         Difficient for all opathie and osteopathic prooprass that meet the criteria for an add-no to the cap f										From 01/01/2020 To 12/31/2020	Date/Time F		
PART A INPATEENT HOSPITAL SERVICES UNDER IPPS         1.00           100         DRE Amounts Other Than Outlier Payments         7,407,           101         Instructions)         Than outlier payments for discharges occurring prior to October 1 (see instructions)         7,407,           102         DRE for Tederal specific operating payment for Wodel 4 BPCI for discharges occurring on or after October 1 (see instructions)         3,311,           104         DRE for Tederal specific operating payment for Wodel 4 BPCI for discharges occurring on or after October 1 (see instructions)         3,00           105         Outlier payments for discharges for Model 4 BPCI (see instructions)         125,           104         DRE for Tederal specific operating payment for Bother October 1 (see instructions)         125,           104         Outlier payments for discharges cocurring on or after October 1 (see instructions)         125,           104         DRE for Tederal specific operating payment for Bother October 1 (see instructions)         125,           104         DRE for Tederal specific operating payment for Bother October 1 (see instructions)         125,           104         DRE for Tederal specific operating payment for Bother October 1 (see instructions)         126,           105         Outlier payments for discharges cocurring on or after October 1 (see instructions)         126,           106         DRE for Tederal specific operating payment for								Title XVII	1	Hospi tal	7/29/2021 1 PPS		51 am
Det A         INPAT Let INSPITAL SERVICES UNDER LIPPS           1.00         DRG amounts other than outlier payments for discharges occurring prior to October 1 (see Instructions)         7,407.           1.10         DRG fear and ther than outlier payments for discharges occurring prior to October 1 (see Instructions)         7,407.           1.20         Def federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see Instructions)         3,311.           1.30         DRG for federal specific operating payment for Model 4 BPCI (see instructions)         125.           1.40         DR for federal specific operating payment for Uotober 1 (see instructions)         125.           2.30         Duttier payment for discharges cocurring prior to October 1 (see instructions)         125.           2.40         Duttier payments for discharges cocurring prior to October 1 (see instructions)         125.           3.40         Dittier dayments and subseque cocurring prior to October 1 (see instructions)         127.           1.40         Def days available divided by number of days in the cost reporting period (see instructions)         127.           1.40         Def days available divided by number of aps specified under 42 CFR §412.105(r)(1)(iv)(S)(1)         128.           1.40         Def days available divided by number of aps aps specified under 42 CFR §412.105(r)(1)(iv)(S)(1)         129.           1.40         Def days availab													
1.01       DRC amounts other than outlier payments for discharges occurring prior to Dectoer 1 (see       7,407.         1.02       DRG amounts other than outlier payments for discharges occurring prior to Dectoer 1 (see       3,311.         1.02       DRG amounts other than outlier payment for Model 4 BPCI for discharges occurring prior to Dectoer 1 (see instructions)       3,311.         1.04       DRG for decral specific operating payment for Model 4 BPCI (see instructions)       0,0000         2.00       Dutlier payments for discharges. (see instructions)       10000         2.01       Dutlier payments for discharges occurring prior to Dectober 1 (see instructions)       102000         2.01       Dutlier payments for discharges occurring prior to Dectober 1 (see instructions)       10200000000000000000000000000000000000	۲V	AL SERV	VICES (	UNDER	I PPS						1.00		
1.02       DBC ansults other than outline payments for discharges occurring on or after October 1 (see instructions)       3.311.         1.03       DBC for federal specific operating payment for Model 4 BPCI for discharges occurring on or after       1.64         1.04       DBC for federal specific operating payment for Model 4 BPCI for discharges occurring on or after       1.65         1.04       DBC for federal specific operating payment for Model 4 BPCI (see instructions)       1.05         2.00       Outlier payments for discharges for Model 4 BPCI (see instructions)       105.         2.01       Outlier payments for discharges for Model 4 BPCI (see instructions)       103.         3.00       Managed Care Simulated Payments       100 (see instructions)       103.         3.00       Managed Care Simulated Payments       100 (see instructions)       102.         5.00       FE count for allopathic and osteopathic programs for the most recent cost reporting period ending of or beer 12/31/996. (see instructions)       122.         7.00       MAA Section 422 reduction amount to the IME cap as specified under 42 CFR 9412.05(f)(1)(i)(i)(B)(1)       (Cost report straddles July 1, 2011 then see instructions.       (cost report straddles July 1, 2001. then see instructions.         8.00       Adjuiteer (increase if the hosys in law as awarded FE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions.)       (cost report straddles July 1, 2001. then see instructions.)       (c			2		r di sc	charges o	occurri	ng prior to Octo	ober 1	(see	7, 407, 3	0 358	1. 00 1. 01
1.03       DRC for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)         1.04       DRC for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)         2.00       Duttler payments for discharges for Model 4 BPCI (see instructions)         2.01       Duttler payments for discharges occurring on or after October 1 (see instructions)       125.         2.02       Duttler payments for discharges occurring on or after October 1 (see instructions)       125.         2.03       Duttler payments for discharges occurring on after October 1 (see instructions)       125.         3.00       Managed Care Simulated Payments       126.         4.00       File count for allogathic and ostropathic programs for the most recent cost reporting period ending of read regrams in accordance with 42 CFR 413.75(C)       127.         7.00       MA Section 422 reduction amount to the IME cap as specified under 42 CFR 412.05(C)(1)(1)(4)(B)(1)       (1         7.01       AAA Sido Sido reduction amount to the IME cap as specified under 42 CFR 412.05(C)(1)(4)(4)(B)(2) If the cost report straddles July 1, 2011 then see instructions.       128.         0.02       Ad ustment (increase if the hospital was awarded FTE cap slots from aclosed teaching hospital under § 5050 of ACA. (see instructions)       (2         0.01       The amount of increase if the hospital was awarded FTE cap slots from sour records       (	ра	utlier p	paymen	nts fo	r di sc	charges o	occurri	ng on or after (	October	1 (see	3, 311, 2	298	1. 02
1.04       DRS for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)       000000000000000000000000000000000000	tin	operati	ing pa	yment	for N	<i>l</i> odel 4 B	BPCI fo	r di scharges occ	curri ng	prior to October	Ť	0	1.03
2.00       Outlier payments for discharges. (see instructions)       0         2.01       Outlier payments for discharges cocurring prior to October 1 (see instructions)       125, 0         2.02       Outlier payments for discharges occurring on or after October 1 (see instructions)       103, 0         3.03       Managed Care Simulated Payments       128, 0         4.00       Bed days available divided by number of days in the cost reporting period (see instructions)       129, 1         5.00       FTE count for all opathic and osteopathic programs for the nest recent cost reporting period ending of or before 12/3/1796 (see instructions)       120, 1         6.00       FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for east in action and to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(1)       100, 0         7.01       FTE count for all opathic and osteopathic programs in accordance with 42 CFR \$413.75(c), 0(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 5069 (August 1, 2002).       100, 0         8.00       Adjustment (increase of decrease) to the FTE count for residents in structions)       0       0         9.01       Ines 5 506 of ACA. (see instructions)       0       0       0       0         9.02       Inter admont of increase if the hops tall awas awarded FTE cap slots from a closed teaching hospital       0       0         9.03       Ines 5 plus the matos from programs in the cu	ti n		ing pa	yment	for N	<i>l</i> odel 4 B	BPCI fo	r di scharges occ	curri ng	on or after		0	1.04
2 02       Outlier payment for discharges for Model 4 BPC1 (see instructions)       125         2 03       Outlier payments for discharges occurring on or after October 1 (see instructions)       125         2 04       Outlier payments for discharges occurring on or after October 1 (see instructions)       126         3 05       Bed days available divided by number of days in the cost reporting period (see instructions)       127         5 06       FTE count for allopathic and osteopathic programs for the most recent cost reporting neriod (see instructions)       126         6 07       Defore 12/31/1996 (see instructions)       126         7 08       MAA Section 422 reduction amount to the LME cap as specified under 42 CFR \$412.105(f)(1)(1)(9)(8)(2) if the Correst or affiliated programs in accordance with 42 CFR 413.76(b), 413.79(c)(2)(1)(1), 46       127         7 06       MAA Section 422 reduction amount to the LME cap as specified under 42 CFR \$412.105(f)(1)(1)(9)(8)(2) if the Correst or affiliated programs in accordance with 42 CFR 413.76(b), 413.79(c)(2)(1)(1), 46       127         1 708       MAA Section 422 reduction as warded FTE cap slots under \$503 of the ACA. If the cost or affiliated programs in accordance with 42 CFR 413.76(b), 413.79(c)(2)(1)(1), 46       128         1 708       Ma Section 400.7 FK 50069 (August 1, 2002).       128       129         0 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5050 of ACA. (see instructions)       120	3.	charges.	. (see	e inst	ructic	ons)						_	2.00
2.03       Outlier psyments for discharges occurring prior to October 1 (see instructions)       125.         2.04       Outlier psyments for discharges occurring on or after October 1 (see instructions)       103.         3.00       Managed Care SImulated Payments       126.         4.00       Bed days available divided by number of days in the cost reporting period (see instructions)       127.         1.01       recurring the divided by number of days in the cost reporting period ending on or before 12/31/1996. (see instructions)       127.         0.01       OFTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)       (cont for allopathic and osteopathic programs to instructions)       (cont for allopathic and osteopathic programs for affiliated programs for affiliated programs in accordance with 42 CFR 413.75(b) (31.379(c) (21)(v).       (dot file cost report straddie s) ult 1, 2011 then see instructions.       (cont for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b) (31.379(c) (21)(v).       (dot file cost report straddie s) ult 1, 2011, see instructions.       (cont for allopathic and osteopathic programs.       (cont for allopathic and steopathic and for allopathic and steopathi	fc		for Mo	odel 4	BPCI	(see ins	structi	ons)				0	2.01 2.02
3.00       Managed Care Simulated Payments       124         0.00       Bed days available divided by number of days in the cost reporting period (see instructions)       124         1.01       rect Madical Education Adjustment       124         0.01       File count for allopathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/1996. (see instructions)       126         0.01       File count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)       106         0.01       MMA Saction 422 reduction amount to the IWE cap as specified under 42 CFR 5412.105(f)(1)(i)(B)(2) If the cost report straddles July 1, 2011 then see instructions.       107         0.02       Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b) (A13.79(c)(2)(i)). 44 FR 26340 (May 12, 1998), and 6 FR 5000 (May 12, 2012)       108         0.03       FIE count for allopathic and osteopathic programs.       108       109       110.100 FIE count for the pospital was awarded FIE cap slots from a closed teaching hospital under \$5500 of AA. (see instructions)       100       108       100       100       100       100       100       100       100       100       100       100       100       100       100       100       100       100       100       100       100		0				•			s)		125, 5	- 1	2.02
4.00       Bed days available divided by number of days in the cost reporting period (see instructions)       122         1.00       FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/1996. (see instructions)       (6)         6.00       FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)       (6)         7.00       MAX Section 422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(8)(2) If the cost report straddles July 1, 2011 then see instructions.       (2)         0.04       Justment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2630 (twp 12, 1998), and 67 FR 50069 (August 1, 2002).       (2)         8.01       The amount of increase If the hospital was awarded FTE cap slots under § 5030 of the ACA. If the cost report straddles July 1, 2011, see instructions.       (2)         9.00       Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions)       (2)         10.00       FTE count for relidents in dental and poliatric programs.       (2)         11.00       Current year all ouble FTE (see instructions)       (2)         10.00       FTE count for residents in initial was awarded by line 4).       (2)         10.00       FTE count for residents in dental and poliatric programs.				ring	on or	after Oc	tober	1 (see instructi	i ons)		103, 0		2.04
Indirect Medical Education Adjustment       Indirect Medical Education Adjustment         100       FEE count for allopathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/1996. (see instructions)       (6)         0.00       FEE count for allopathic and osteopathic programs for the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)       (6)         0.00       MAS Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)       (7)         1.01       Acd 5 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.       (7)         8.00       Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for anount of increase If the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       (7)         0.01       FTE count for residents in dental and podiatric programs.       (7)         0.02       FTE count for residents in dental and podiatric programs.       (7)         0.03       GT in amount of increase of the prior year.       (7)         1.00       FTE count for residents in initial years of the program       (8)         1.00       FTE count for residents in initial years of the program       (7)         1.00       Tra allowable FTE count for the prol year.       (7)		2		of do		the east		ting pariod (and	. inctru	uations)	100	0	3.00
5.00       FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending of one programs in accordance with 42 CFR 413.79(e)       (1)         6.00       FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)       (2)         7.00       MMA Section 422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.       (2)         8.00       Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).       (2)         8.01       The amount of increase If the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddle July 1, 2011, see instructions.       (2)         8.02       The amount of increase If the hospital was awarded FTE cap slots from a closed teaching hospital under \$5506 of ACA. (see instructions)       (2)         9.00       Sum of Lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions)       (2)         10.00       FTE count for the prony report.       (2)         11.00       FTE count for the prony report.       (2)         10.00       Trail allowable FTE count for the prony report.       (2)         10.00       FTE count for the prony report.       (2) <td></td> <td></td> <td></td> <td></td> <td><u>ys in</u></td> <td>the cost</td> <td>. repor</td> <td>ting period (see</td> <td>einstru</td> <td>uctions)</td> <td>120.</td> <td>44</td> <td>4.00</td>					<u>ys in</u>	the cost	. repor	ting period (see	einstru	uctions)	120.	44	4.00
6.00       FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)       (1)         7.00       MMA Section 422 reduction amount to the IME cap as specified under 42 CFR 5412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.       (2)         8.00       Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1. 2002).       (3)         8.01       The amount of increase if the hospital was awarded FTE cap slots under 5 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       (2)         8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under 5 5506 of ACA. (see instructions)       (2)         9.00       Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)       (2)         10.00       FTE count for residents in dental and podiatric programs.       (2)       (2)         11.00       FTE count for the prony tear.       (2)         12.00       Current year allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.       (2)         13.00       Total allowable FTE count for the prony tear.       (2)       (3)         14.00       Druent for residen	ste	and ost	teopat	hic p	rogram	ns for th	ne most	recent cost rep	porting	period ending or	0.	00	5.00
7.00       IMMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.       0         8.00       Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).       0         8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0         8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions).       0         9.00       Sum Of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions).       0         10.00       FTE count for residents in dental and podiatric programs.       0         12.00       Current year allowable FTE (see instructions).       0         13.00       Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997. Otherwise enter zero.       0         15.00       Sum Of lines 19 or 20 (see instructions).       0       0         14.00       Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997. Otherwise enter zero.       0         15.00       Sum Of lines 19 or 20 (see instructions).       0       0 </td <td>ste</td> <td>and ost</td> <td>teopat</td> <td>hic p</td> <td></td> <td></td> <td>neet th</td> <td>e criteria for a</td> <td>an add-o</td> <td>on to the cap for</td> <td>0.</td> <td>00</td> <td>6.00</td>	ste	and ost	teopat	hic p			neet th	e criteria for a	an add-o	on to the cap for	0.	00	6.00
cost report straddles July 1, 2011 then see instructions.       Control of the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50669 (August 1, 2002).         8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       Control of the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5503 of ACA. (see instructions)         9.00       Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)       Control of the amount of residents in dental and podiatric programs.         12.00       Current year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997. Contervity sear allowable FTE count for the penultimate year if that year ended on or after September 30, 1997. Contervity sear allowable FTE count for the penultimate year if that year ended on or after September 30, 1997. Contervity sear resident to bed ratio (line 18 divided by line 4).       0.0000         0.00       Prior year resident to bed ratio (see instructions)       0.0000         10.00       Enter the lesser of lines 19 or 20 (see instructions)       0.0000         10.00       Enter the lesser of lines 19 or 20 (see instructions)       0.0000         10.00       Sum of lines 19 or 20 (see instructions)       0.0000         10.00       Enter the lesser of lines 19 or 20 (see instructions)       0.0000 <td>٦t</td> <td>n amount</td> <td>t to t</td> <td>he IM</td> <td>E cap</td> <td>as speci</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>00</td> <td>7.00</td>	٦t	n amount	t to t	he IM	E cap	as speci						00	7.00
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1999), and 67 FR 50069 (Mugust 1, 2002).         8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       (0)         8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)       (0)         9.00       Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)       (0)         10.00       FTE count for allopathic and osteopathic programs in the current year from your records       (0)         11.00       FTE count for residents in dental and podiatric programs.       (0)         12.00       Current year allowable FTE count for the prior year.       (0)         13.00       Total allowable FTE count for the pongram       (0)         14.00       Total allowable FTE count for the prior year.       (0)         15.00       Sum of lines 12 through 14 divided by 3.       (1)       (2)         16.00       Adjustment for residents in initial years of the program       (2)       (2)         17.00       Adjustment for residents in initial years of the program       (2)       (2)         18.00       Adjustment for residents in initial years of the program       (2)       (2)	201	y 1, 20	011 th	nen se	e inst	tructions	5.	-		, , , , , ,		00	7.01
8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions.       (1)         8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)       (2)         9.00       Sum of lines 5 plus 6 minus lines (7) and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)       (2)         10.00       FTE count for allopathic and osteopathic programs in the current year from your records       (2)         11.00       FTE count for residents in dental and podiatric programs.       (2)         12.00       Current year allowable FTE (see instructions)       (2)         13.00       Total allowable FTE count for the prior year.       (2)         14.00       Total allowable FTE count for the prior year.       (2)         15.00       Sum of lines 12 through 14 divided by 3.       (2)         16.00       Adjustment for residents in initial years of the program       (2)         17.00       Adjustment for residents of artio (see instructions)       (2)         18.00       Adjusted rolling avarage FTE count       (2)         19.00       Current year allowable FTE count for the Add-on for 5 422 of the MMA       (2)         10.00       Adjusted rolling avarage fTE count       (2)         10.00       <	nce	ccordanc	ice wit	h 42 (							0.	00	8.00
8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)       Image: Comparison of the	nos	° the ho	ospi ta	nÍwas			ap slo	ts under § 5503	of the	ACA. If the cost	0.	00	8. 01
instructions)instructions)10.00FTE count for allopathic and osteopathic programs in the current year from your records011.00FTE count for residents in dental and podiatric programs.012.00Current year allowable FTE (see instructions)013.00Total allowable FTE count for the prior year.014.00Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.015.00Sum of lines 12 through 14 divided by 3.016.00Adjustment for residents in initial years of the program017.00Adjusted rolling average FTE count018.00Adjusted rolling average FTE count019.00Current year resident to bed ratio (see instructions)0.00010.00Enter the lesser of lines 19 or 20 (see instructions)0.00010.01Enter the lesser of lines 19 or 20 (see instructions)0.00010.01IME payment adjustment for the Addo-on for § 422 of the MMA0.00023.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050(f)(1)(iv)(C).000024.00IME FTE Resident Count Over Cap (see instructions)0.00025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)0.00026.00Resident to bed ratio (divide line 25 by line 4)0.00027.00IME add-on adjustment factor. (see instructions)0.00028.00IME add-on adjus	nos	° the ho	iospi ta	nl was			ap slo	ts from a closed	d teachi	ing hospital	0.	00	8. 02
11.00       FTE count for residents in dental and podiatric programs.       0         12.00       Current year allowable FTE (see instructions)       0         13.00       Total allowable FTE count for the prior year.       0         14.00       Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997.       0         0       Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997.       0         0       Adjustment for residents in initial years of the program       0         15.00       Sum of lines 12 through 14 divided by 3.       0         16.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjusted rolling average FTE count       0         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000         10.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000         21.01       IME payment adjustment for the Add-on for § 422 of the MMA       0.000         22.00       IMe payment adjustment for the Add-on for § 422 of the MMA       0.000         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0         24.01       IME FTE Resident Count Over Cap (see instructions)       0.000 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td><td></td><td></td><td></td><td>00</td><td>9.00</td></t<>								•				00	9.00
12.00       Current year allowable FTE (see instructions)       0         13.00       Total allowable FTE count for the prior year.       0         14.00       Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.       0         15.00       Sum of lines 12 through 14 divided by 3.       0         16.00       Adjustment for residents in initial years of the program       0         17.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjustment for resident to bed ratio (line 18 divided by line 4).       0.000         01.00       Prior year resident to bed ratio (see instructions)       0.000         02.00       IME payment adjustment (see instructions)       0.000         03.00       IME payment adjustment (see instructions)       0.000         10.01       IME payment adjustment - Managed Care (see instructions)       0.000         11.01       FTE Resident Count Over Cap (see instructions)       0.000         12.00       IME payment adjustment factor. (see instructions)       0.000         11.01       FTE Resident Count Over Cap (see instructions)       0.000         12.00       IME FTE Resident Count Over Cap (see instructions)       0.000         25.00       If the amount on line 24 is greater than -0-			•	•	0			nt year from you	ur recoi	rds		00	
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otherwise enter zero.015.00Sum of lines 12 through 14 divided by 3.16.00Adj ustment for residents in initial years of the program17.00Adj ustment for residents displaced by program or hospital closure18.00Adj ustment for residents displaced by program or hospital closure19.00Current year resident to bed ratio (line 18 divided by line 4).19.00Current year resident to bed ratio (see instructions)20.00Prior year resident to bed ratio (see instructions)21.00Enter the lesser of lines 19 or 20 (see instructions)22.01IME payment adj ustment - Managed Care (see instructions)23.00IME payment adj ustment for the Add-on for § 422 of the MMA23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105(f)(1)(iv)(C).(f)(1)(iv)(C).24.00IME FTE Resident Count Over Cap (see instructions)25.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see26.00Resident to bed ratio (divide line 25 by line 4)27.00IME payment factor. (see instructions)28.01IME add-on adj ustment factor. (see instructions)28.01IME add-on adj ustment factor. (see instructions)29.01ID all ME payment ( sum of lines 22 and 28)29.01Total IME payment ( sum of lines 22 and 28)29.01Disproportionate Share Adj ustment30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)31.00Percentage of Medicaid patient days (see i												00	
16.00       Adjustment for residents in initial years of the program       0         17.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjustment for residents displaced by program or hospital closure       0         18.00       Adjustment for residents displaced by program or hospital closure       0         19.00       Current year resident to bed ratio (see instructions)       0.000         21.00       IME payment adjustment (see instructions)       0         22.01       IME payment adjustment for the Add-on for § 422 of the MMA       0         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0         24.00       IMe FTE Resident Count Over Cap (see instructions)       0       0         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0       0         26.00       Resident to bed rat			•		ate ye	arifth∶	nat yea	r ended on or af	fter Sep	ptember 30, 1997,		00	
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18.00       Adjusted rolling average FTE count       0         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000         20.00       Prior year resident to bed ratio (see instructions)       0.000         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000         22.01       IME payment adjustment (see instructions)       0.000         22.01       IME payment adjustment (see instructions)       0.000         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0         (f)(1)(iv)(C).       .       .       .         24.00       IME FTE Resident Count Over Cap (see instructions)       .       .         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       .         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000         27.00       IME payments adjustment amount (see instructions)       .       0.000         28.01       IME add-on adjustment amount - Managed Care (see instructions)       .       0.000         28.01       IME add-on adjustment amount - Managed Care (see instructions)       .       0.000         29.01       Total IME payment - Managed Care (see instructions)       .       . <t< td=""><td></td><td></td><td>2</td><td></td><td></td><td></td><td></td><td>ure</td><td></td><td></td><td></td><td></td><td>17.00</td></t<>			2					ure					17.00
20.00Prior year resident to bed ratio (see instructions)0.00021.00Enter the lesser of lines 19 or 20 (see instructions)0.00022.00IME payment adjustment (see instructions)0.00022.01IME payment adjustment - Managed Care (see instructions)0.00023.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.000(f) (1) (iv) (C)24.00IME FTE Resident Count Over Cap (see instructions)25.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see<	oun	FTE cou	unt	. 0									18.00
21.00Enter the lesser of lines 19 or 20 (see instructions)0.00022.00IME payment adjustment (see instructions)0.00022.01IME payment adjustment (see instructions)0.0001 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA0.00023.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.000(f) (1) (iv) (C).0.0000.00024.00IME FTE Resident Count Over Cap (see instructions)0.00025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.00026.00Resident to bed ratio (divide line 25 by line 4)0.00027.00IME payments adjustment factor. (see instructions)0.00028.00IME add-on adjustment factor. (see instructions)0.00029.00Total IME payment (sum of lines 22 and 28)0.00029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)0.000Disproportionate Share Adjustment0.0010.0000.000Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)0.00131.00Percentage of Medicaid patient days (see instructions)0.00032.00Sum of lines 30 and 3118							ine 4)				0.0000		
22.00       IME payment adjustment (see instructions)         1ME payment adjustment - Managed Care (see instructions)         1ndirect Medical Education Adjustment for the Add-on for § 422 of the MMA         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105         (f) (1) (iv) (C).       (f) (1) (iv) (C).         24.00       IME FTE Resident Count Over Cap (see instructions)         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000         27.00       IME payments adjustment factor. (see instructions)       0.000         28.00       IME add-on adjustment amount (see instructions)       0.000         28.01       IME payment - Managed Care (see instructions)       0.000         29.00       Total IME payment - Managed Care (see instructions)       0.000         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.000         Disproportionate Share Adjustment       0.001 adds.01       0.000         31.00       Percentage of Medicaid patient days to Medicare Part A patient days (see instructions)       0.002         32.00       Sum of lines 30 and 31       18			•								0.0000		
22. 01       IME payment adjustment - Managed Care (see instructions)         1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA         23. 00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 (f) (1) (iv) (C).         24. 00       IME FTE Resident Count Over Cap (see instructions)         25. 00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)         26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000         27. 00       IME payments adjustment factor. (see instructions)       0.000         28. 00       IME add-on adjustment amount (see instructions)       0.000         28. 01       IME payment (sum of lines 22 and 28)       0.000         29. 01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.001         01       Disproportionate Share Adjustment       30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       23.00         31. 00       Percentage of Medicaid patient days (see instructions)       31.00       31.00         22. 00       Sum of lines 30 and 31       18					struct	.ions)					0.0000	000	21.00 22.00
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).24.00IME FTE Resident Count Over Cap (see instructions)25.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)26.00Resident to bed ratio (divide line 25 by line 4)27.00IME payments adjustment factor. (see instructions)28.00IME add-on adjustment amount (see instructions)28.01IME add-on adjustment amount - Managed Care (see instructions)29.00Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)29.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)31.00Percentage of Medicaid patient days (see instructions)32.00Sum of lines 30 and 31					instr	ructions)	1					0	
24.00IME FTE Resident Count Over Cap (see instructions)025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)026.00Resident to bed ratio (divide line 25 by line 4)0.00027.00IME payments adjustment factor. (see instructions)0.00028.00IME add-on adjustment amount (see instructions)0.00028.01IME add-on adjustment amount - Managed Care (see instructions)0.00029.00Total IME payment ( sum of lines 22 and 28)129.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)1Disproportionate Share Adjustment130.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)131.00Sum of lines 30 and 3118	ısti	n Adjus	stment	for	the Ad	d-on for	§ 422		der 42 (	CFR 412.105	0.	00	23.00
instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 18	-		•									00	24.00
27.00       IME payments adjustment factor. (see instructions)       0.000         28.00       IME add-on adjustment amount (see instructions)       0.000         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.000         29.00       Total IME payment ( sum of lines 22 and 28)       0.001         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.001         Disproportionate Share Adjustment       30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       2.01         31.00       Percentage of Medicaid patient days (see instructions)       16         32.00       Sum of lines 30 and 31       18		0					the I	ower of line 23	orline	e 24 (see		00	
28.00       IME add-on adjustment amount (see instructions)         28.01       IME add-on adjustment amount - Managed Care (see instructions)         29.00       Total IME payment (sum of lines 22 and 28)         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)         Disproportionate Share Adjustment         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)         31.00       Percentage of Medicaid patient days (see instructions)         32.00       Sum of lines 30 and 31													26.00 27.00
28.01       IME add-on adjustment amount - Managed Care (see instructions)         29.00       Total IME payment (sum of lines 22 and 28)         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)         Disproportionate Share Adjustment         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)         31.00       Percentage of Medicaid patient days (see instructions)         32.00       Sum of lines 30 and 31			•			13)					0.0000	0	28.00
29.00       Total IME payment ( sum of lines 22 and 28)         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)         Disproportionate Share Adjustment         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)         31.00       Percentage of Medicaid patient days (see instructions)         32.00       Sum of lines 30 and 31						instruc	ctions)					Ő	28.01
Disproportionate Share Adjustment         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       22         31.00       Percentage of Medicaid patient days (see instructions)       16         32.00       Sum of lines 30 and 31       18	es	oflines	s 22 a	and 28	)							0	29.00
30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2231.00Percentage of Medicaid patient days (see instructions)1632.00Sum of lines 30 and 3118				nofli	ines 2	2.01 and	28.01	)				0	29.01
31.00Percentage of Medicaid patient days (see instructions)1632.00Sum of lines 30 and 3118				lays to	o Medi	care Par	t A pa	tient days (see	instru	ctions)	2.	42	30.00
							. 10			/	16.		
												98	
			•	0	•		ctions)					09	33.00 34.00

Heal th	Financial Systems RI VERVI EW HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Pre 7/29/2021 10:	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment		-		
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ente	or zoro on this line) (so	0. 00000000 e 1, 307, 420	0. 00000000 1, 682, 889	35. 01 35. 02
33. UZ	instructions)	er zero on this rine) (se	1, 307, 420	1, 002, 009	30. UZ
35.03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	978, 779	424, 181	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0	. ,	1, 402, 960		36.00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 through	gh 46)		
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6	684 and 685. (see	0		40.00
41 00	instructions)				41 00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, ( instructions)	583, 684 an 685. (See	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-	-DRGs 652 682 683 684	0		41.01
	an 685. (see instructions)	51100 002, 002, 000, 001	0		
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	82, 683, 684 an 685. (see	0		43.00
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions	5)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 4		0		46.00
47.00	Subtotal (see instructions)		12, 486, 646		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.00
	only. (see instructions)			A	
				Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructions	5)		12, 486, 646	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			863, 726	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ine 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment			28, 582	53.00
54.00	Special add-on payments for new technologies			112, 337	54.00
54.01 55.00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line (	60)		0	54.01 55.00
56.00	Cost of physicians' services in a teaching hospital (see inti	-		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. 1	III, column 9, lines 30 t	hrough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		5	25, 939	58.00
59.00	Total (sum of amounts on lines 49 through 58)			13, 517, 230	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		13, 517, 230	
62.00	Deductibles billed to program beneficiaries			1, 162, 304	
63.00 64.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			7, 040 25, 419	
65.00	Adjusted reimbursable bad debts (see instructions)			16, 522	
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		25, 419	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		12, 364, 408	67.00
68.00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	ınstructions)	0	70.50
70. 87 70. 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0 0	70. 87 70. 88
70.88		tructions)		0	70.88
70.90					70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0 0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-29, 554	
70.94	HRR adjustment amount (see instructions)			-4, 208	70.94
70.95	Recovery of accel erated depreciation			0	70.95

	Financial Systems RIVERVIEW HC	Provider C	CN: 15-0059	Peri od:	u of Form CMS- Worksheet E	2002
ALCOL			CN. 13-0037	From 01/01/2020 To 12/31/2020	Part A Date/Time Pre	epare
		Title	XVIII	Hospi tal	7/29/2021 10: PPS	51 2
				(уууу)	Amount	
				0	1.00	<u> </u>
D. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		0		70.
	the corresponding federal year for the period prior to 10/1)					
). 97	Low volume adjustment for federal fiscal year (yyyy) (Enter			0	0	70.
	the corresponding federal year for the period ending on or a	fter 10/1)			0	70
). 98 ). 99	Low Volume Payment-3				0 51 210	
	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines	× 40 % 70)			51, 319 12, 279, 327	
. 00	Sequestration adjustment (see instructions)	5 09 & 70)			81, 044	
	Demonstration payment adjustment amount after sequestration				01, 044	
. 03	Sequestration adjustment-PARHM pass-throughs				0	71
. 00	Interim payments				11, 914, 248	
. 01	Interim payments-PARHM					72
. 00	Tentative settlement (for contractor use only)				0	73
. 01	Tentative settlement-PARHM (for contractor use only)					73
. 00	Balance due provider/program (line 71 minus lines 71.01, 71.	02, 72, and			284, 035	74
	73)					
. 01 5. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accord	lanca with			244 224	74
. 00	CMS Pub. 15-2, chapter 1, §115.2	ance with			246, 326	/5
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					1
. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	n of 2.03			0	90
	plus 2.04 (see instructions)					
00	Capital outlier from Wkst. L, Pt. I, line 2				0	91
00	Operating outlier reconciliation adjustment amount (see inst				0	
00	Capital outlier reconciliation adjustment amount (see instru				0	
. 00	The rate used to calculate the time value of money (see inst				0.00	
. 00	Time value of money for operating expenses (see instructions				0	
. 00	Time value of money for capital related expenses (see instru			Prior to 10/1		90
				1.00	2.00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	0	100
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 000000000	
2.00	HVBP adjustment amount for HSP bonus payment (see instruction	ons)		0	0	102
2 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000	0. 0000	1102
	HRR adjustment amount for HSP bonus payment (see instruction	le)		0.0000		103
+. 00	Rural Community Hospital Demonstration Project (§410A Demons		ustment	0	0	
0. 00	Is this the first year of the current 5-year demonstration p					200
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, li	ne 49)				201
	Medicare discharges (see instructions)					202
3.00	Case-mix adjustment factor (see instructions)		-6 +6		•	203
	Computation of Demonstration Target Amount Limitation (N/A i period)	n inst year	or the curre	nt 5-year demons	tration	
4.00	Medicare target amount					204
	Case-mix adjusted target amount (line 203 times line 204)					205
	Medicare inpatient routine cost cap (line 202 times line 205	5)				206
	Adjustment to Medicare Part A Inpatient Reimbursement					
	Program reimbursement under the §410A Demonstration (see ins					207
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A	A, line 59)				208
	Adjustment to Medicare IPPS payments (see instructions)					209
	Reserved for future use	•				210
ı. UU	Total adjustment to Medicare IPPS payments (see instructions	>)				211
2 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	211)				212
		, <u>z</u> ıı)				212
	low-volume adjustment (see instructions)					
3.00	Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS	and cost rei	mbursement)			218

OW VC	LUME CALCULATION EXHIBIT 4			Provider C	F	Period: From 01/01/2020 Fo 12/31/2020		pared
		l i ne	Amounts (from E, Part A)	Pre/Post Entitlement	VVIII Period Prior to 10/01	0n/After 10/01	PPS Total (Col 2 through 4)	
00	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00 0	1.0
00	payments	1.00	0	0		0	0	1.0
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7, 407, 358	0	7, 407, 358	3	7, 407, 358	1.0
02	DRG amounts other than outlier payments for discharges occurring on or after October	1.02	3, 311, 298	0		3, 311, 298	3, 311, 298	1. C
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	Ο	0	(	כ כ	0	1. C
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.(
00	Outlier payments for discharges (see instructions)	2.00						2.0
01	Outlier payments for	2.02	0	0	(	0 0	0	2.0
02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2.03	125, 580	0	125, 580	D	125, 580	2.0
03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103, 055	0		103, 055	103, 055	2. (
00	Operating outlier reconciliation	2. 01	0	0	(	o o	0	3.
00	Managed care simulated payments	3.00	0	0	(	0 0	0	4.(
00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0.00000	0. 000000		5.0
00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.
00	IME payment adjustment (see instructions)	22.00	0	0	(	0 0	0	6.
01	IME payment adjustment for managed care (see instructions)	22.01	0	0	(	0 0	0	6.
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ection 422 of	the MMA			
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7.
00	IME adjustment (see instructions)	28.00	0	0	(	0 0	0	8.
01	IME payment adjustment add on for managed care (see	28.01	0	0	(	0 0	0	8.
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	(	o o	0	9.
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	(	0 0	0	9.
	Disproportionate Share Adjustme				1			
. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0509	0. 0509	0. 0509	9 0. 0509		10.
. 00	Disproportionate share adjustment (see instructions)	34.00	136, 395	0	94, 259	9 42, 136	136, 395	11.
. 01	Uncompensated care payments Additional payment for high per	36.00	1, 402, 960		978, 779	9 424, 181	1, 402, 960	11.
. 00	Total ESRD additional payment	46.00	0	0	(	0 0	0	12.
. 00 . 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	12, 486, 646 0	0	8, 605, 976	5 3, 880, 670 0 0	12, 486, 646 0	
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
. 00	Total payment for inpatient operating costs (see instructions)	49.00	12, 486, 646	0	8, 605, 976	3, 880, 670	12, 486, 646	15.

LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO	CN: 15-0059	Period: From 01/01/2020	Worksheet E	+ 1
						To 12/31/2020		pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	<ul> <li>Peri od</li> <li>On/After</li> <li>10/01</li> </ul>	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	863, 726	0	-291, 67	75 1, 155, 401	863, 726	16.00
17.00	Special add-on payments for new technologies	54.00	112, 337	0	20, 15	53 92, 184	112, 337	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.0 <sup>°</sup> 17.02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		Ο	0		0 0	0	18.00
19.00	SUBTOTAL			0	8, 334, 45	54 5, 128, 255	13, 462, 709	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	831, 225 0	0	-246, 98	36 1, 078, 211 0 0	831, 225 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2.00 2.01	0 0	-	-35, 03	32 35, 032 0 0		
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0. 000	0. 0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0			0 0		
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0391	0. 0391	0. 039	0. 0391		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	32, 501	0	-9, 65	57 42, 158	32, 501	25.00
26.00	Total prospective capital payments (see instructions)	12.00	863, 726	0	-291, 67	75 1, 155, 401	863, 726	26.00
		W/S E, Part A	(Amounts to					
		line 0	E, Part A)	2.00	2.00	1.00	F 00	
27.00	Low volume adjustment factor	0	1.00	2.00	3.00	4.00	5.00	27.0
28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.0000	0	0	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

SPI 1	FAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 10:	parec
			Title		Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00					1. (
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7, 407, 358	7, 407, 35	8	7, 407, 358	1.0
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 311, 298		3, 311, 298	3, 311, 298	1.
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00					2.
01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	125, 580	125, 58	0	125, 580	2.
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103, 055		103, 055	103, 055	2.
00	Operating outlier reconciliation	2.01	0		0 0	0	3.
00	Managed care simulated payments	3.00	0		0 0	0	4.
	Indirect Medical Education Adjustment						
0	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000			5.
)0 )1	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0		0 0 0 0	0	6. 6.
	instructions) Indirect Medical Education Adjustment for the	Add on for S	oction 422 of th	bo MMA			
0	IME payment adjustment factor (see	27.00	0. 000000	0.00000	0.000000		7.
.0	i nstructi ons)	27.00	0.000000	0.00000	0.000000		/ ·
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8.
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
)1	Total IME payment for managed care (sum of	29.01	0		0 0	0	9.
	lines 6.01 and 8.01)						
~~	Disproportionate Share Adjustment	22.00	0.0500	0.050			10
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0509	0. 050	0. 0509		10.
00	Disproportionate share adjustment (see instructions)	34.00	136, 395	94, 25	9 42, 136	136, 395	11.
01	Uncompensated care payments	36.00	1, 402, 960	978, 77	9 424, 181	1, 402, 960	11.
00	Additional payment for high percentage of ESI Total ESRD additional payment (see	46.00	di scharges 0		0 0	0	12.
00	instructions) Subtotal (see instructions)	47.00	12, 486, 646	8, 605, 97	6 3, 880, 670	12, 486, 646	13.
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0,000,77	0 0	0	14.
00	Total payment for inpatient operating costs (see instructions)	49.00	12, 486, 646	8, 605, 97	6 3, 880, 670	12, 486, 646	15.
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	863, 726	-291, 67	5 1, 155, 401	863, 726	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	112, 337	20, 15	92, 184	112, 337	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
00	Capital outlier reconciliation adjustment	93.00	0		0 0	0	18.
00	amount (see instructions)						

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CO		Period: From 01/01/2020 To 12/31/2020		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	831, 225	-246, 98	6 1, 078, 211	831, 225	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	0	-35, 03	2 35, 032	0	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0 0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0391	0. 039			24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	32, 501	-9, 65	7 42, 158	32, 501	25.00
26.00 Total prospective capital payments (see instructions)	12.00	863, 726	-291, 67	5 1, 155, 401	863, 726	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	0		0	0	28.00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	-29, 554	-35, 90	4 6, 350	-29, 554	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30.01
31.00 HRR adjustment (see instructions)	70. 94	-4, 208	-1, 48	5 -2, 723	-4, 208	31.00
B1.01   HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 51, 319	51, 319	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

	N HOSPITAL		u of Form CMS-2	2552-1
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2020 To 12/31/2020		narod.
	Title XVIII	Hospi tal	7/29/2021 10: PPS	
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 Medical and other services (see instructions)			22, 138	
2.00 Medical and other services reimbursed under OPPS (see ins 3.00 OPPS payments	structions)		19, 802, 288 15, 842, 462	
4.00 Outlier payment (see instructions)			162, 781	
4.01 Outlier reconciliation amount (see instructions)			0	
5.00 Enter the hospital specific payment to cost ratio (see in 6.00 Line 2 times line 5	istructions)		0. 000 0	
7.00 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 Transitional corridor payment (see instructions)			0	
9.00 Ancillary service other pass through costs from Wkst. D, 10.00 Organ acquisitions	Pt. IV, col. 13, line 200		99, 631 0	
11.00 Total cost (sum of lines 1 and 10) (see instructions)			22, 138	
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges 12.00 Ancillary service charges			69, 522	12.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col.	4, line 69)		07,022	
14.00 Total reasonable charges (sum of lines 12 and 13)			69, 522	14.00
Customary charges 15.00 Aggregate amount actually collected from patients liable	for navment for services or	a charge basis	0	15.00
16.00 Amounts that would have been realized from patients liable			0	
had such payment been made in accordance with 42 CFR §413	3. 13(e)	-		
17.00Ratio of line 15 to line 16 (not to exceed 1.000000)18.00Total customary charges (see instructions)			0. 000000 69, 522	
19.00 Excess of customary charges over reasonable cost (complet	e only if line 18 exceeds l	ine 11) (see	47, 384	
instructions)				
20.00 Excess of reasonable cost over customary charges (complet instructions)	e only if line 11 exceeds I	ine 18) (see	0	20.00
21.00 Lesser of cost or charges (see instructions)			22, 138	21.00
22.00 Interns and residents (see instructions)			0	
23.00 Cost of physicians' services in a teaching hospital (see 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and			0 16, 104, 874	
COMPUTATION OF REIMBURSEMENT SETTLEMENT	,,,		10, 104, 074	24.00
25.00 Deductibles and coinsurance amounts (for CAH, see instruc			0	
26.00 Deductibles and Coinsurance amounts relating to amount on 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and			2, 824, 285 13, 302, 727	
instructions)	20) prus the sum of Tries 2		13, 302, 727	27.00
28.00 Direct graduate medical education payments (from Wkst. E-			0	
29.00 ESRD direct medical education costs (from Wkst. E-4, line 30.00 Subtotal (sum of lines 27 through 29)	2 36)		0 13, 302, 727	
31.00 Primary payer payments			1, 382	
32.00 Subtotal (line 30 minus line 31)			13, 301, 345	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL S 33.00 Composite rate ESRD (from Wkst. I-5, line 11)	ERVICES)		0	33.00
34.00 Allowable bad debts (see instructions)			99, 213	
35.00 Adjusted reimbursable bad debts (see instructions)			64, 488	
36.00 Allowable bad debts for dual eligible beneficiaries (see 37.00 Subtotal (see instructions)	Instructions)		99, 213 13, 365, 833	
38.00 MSP-LCC reconciliation amount from PS&R			110	1
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
<ul> <li>39. 50 Pioneer ACO demonstration payment adjustment (see instruc</li> <li>39. 97 Demonstration payment adjustment amount before sequestrat</li> </ul>			0	39.5
39. 98 Partial or full credits received from manufacturers for r		uctions)	0	
39.99 RECOVERY OF ACCELERATED DEPRECIATION		·	0	
<ul><li>40.00 Subtotal (see instructions)</li><li>40.01 Sequestration adjustment (see instructions)</li></ul>			13, 365, 723 88, 214	
40.02 Demonstration payment adjustment amount after sequestrati	on		00,214	1
40.03 Sequestration adjustment-PARHM pass-throughs				40.0
41.00 Interim payments 41.01 Interim payments-PARHM			13, 431, 992	41.0
41.01  Interim payments-PARHM 42.00  Tentative settlement (for contractors use only)			0	
42.01 Tentative settlement-PARHM (for contractor use only)				42.0
<ul> <li>43.00 Balance due provider/program (see instructions)</li> <li>43.01 Balance due provider/program-PARHM (see instructions)</li> </ul>			-154, 483	43.0
44.00 Protested amounts (nonallowable cost report items) in acc §115.2	cordance with CMS Pub. 15-2,	chapter 1,	0	
TO BE COMPLETED BY CONTRACTOR			-	
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructio	nns)		0	
92.00 The rate used to calculate the Time Value of Money				92.0
93.00 Time Value of Money (see instructions)			0	93.0
94.00 Total (sum of lines 91 and 93)			ı 0	94.0

	Financial Systems RIVER\ ATION OF REIMBURSEMENT SETTLEMENT	/I EW HOSPI TAL Provi der CCN: 15-0059	Period:	u of Form CMS-2 Worksheet E	2552-10
		Component CCN: 15-T059	From 01/01/2020 To 12/31/2020	Part B Date/Time Pre	
		Title XVIII	Subprovider -	7/29/2021 10: PPS	51 am
			I RF		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			886	
2.00 3.00	Medical and other services reimbursed under OPPS (see OPPS payments	instructions)		695 499	
4.00	Outlier payment (see instructions)			477	
4.01	Outlier reconciliation amount (see instructions)			0	4.0
5.00 6.00	Enter the hospital specific payment to cost ratio (see Line 2 times line 5	instructions)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. Organ acquisitions	D, Pt. IV, col. 13, line 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			886	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			2, 683	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, co	I. 4, line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			2, 683	14.00
15.00	Aggregate amount actually collected from patients liab			0	
16.00	Amounts that would have been realized from patients li had such payment been made in accordance with 42 CFR §	1 5	on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	413. 13(e)		0.000000	17.00
18.00	Total customary charges (see instructions)			2,683	
19.00	Excess of customary charges over reasonable cost (comp instructions)	lete only if line 18 exceeds I	ine 11) (see	1, 797	19.00
20.00	Excess of reasonable cost over customary charges (comp	lete only if line 11 exceeds l	ine 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			886	21.00
	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (s			0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 COMPUTATION OF REIMBURSEMENT SETTLEMENT	and 9)		499	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see inst			0	25.00
26.00 27.00	Deductibles and Coinsurance amounts relating to amount Subtotal [(lines 21 and 24 minus the sum of lines 25 a			0 1, 385	
271.00	instructions)		2 and 20] (000	.,	2/10
28.00	Direct graduate medical education payments (from Wkst. ESRD direct medical education costs (from Wkst. E-4, I	· · · · · ·		0	
30.00	Subtotal (sum of lines 27 through 29)	The 30)		1, 385	
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONA	L SERVICES)		1, 385	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)			0	33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
36.00	Allowable bad debts for dual eligible beneficiaries (s	ee instructions)		0	36.0
	Subtotal (see instructions)			1, 385	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see inst	ructions)		0	39.5
39.97	Demonstration payment adjustment amount before sequest			0	
39. 98 39. 99	Partial or full credits received from manufacturers fo RECOVERY OF ACCELERATED DEPRECIATION	r replaced devices (see instru	ctions)	0	
40.00	Subtotal (see instructions)			1, 385	
40.01	Sequestration adjustment (see instructions)	ati an		9	
40.02	Demonstration payment adjustment amount after sequestr Sequestration adjustment-PARHM pass-throughs	ation		0	40.0
41.00	Interim payments			1, 533	
	Interim payments-PARHM			0	41.0
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.0 42.0
43.00	Balance due provider/program (see instructions)			-157	43.0
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in §115.2	accordance with CMS Pub. 15-2,	chapter 1,	0	43.0 <sup>°</sup> 44.00
00.00	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instruc	tions)		0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
94.UU	Total (sum of lines 91 and 93)			0	94.0

NALY	Financial Systems         RIVERVIEW           SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED         RENDERED	Provider C	CN: 15-0059	Peri od:	eu of Form CMS-2 Worksheet E-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	parec
		Titlo	XVIII	Hospi tal	7/29/2021 10: PPS	51 an
			t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		11, 709, 6		13, 106, 476	1.(
. 00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
. 00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
. 01	ADJUSTMENTS TO PROVIDER	12/31/2020	135, 5	03 12/31/2020	215, 216	3.
02		07/08/2020	69, 1		110, 300	
. 03				0	0	3.
04				0	0	
. 05	Duran di alara dan Durananan			0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	3.
53				0	0	3.
. 54				0	0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		204, 6	03	325, 516	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99)		11, 914, 2	48	13, 431, 992	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as				10/101/772	
	appropri ate)					
00	TO BE COMPLETED BY CONTRACTOR		[			1 -
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	
03	Provider to Program			0	0	5.
50	TENTATI VE TO PROGRAM			0	0	5.
51				0	0	
52				0	0	-
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.
00	5.50-5.98) Determined net settlement amount (balance due) based on					6.
00	the cost report. (1)					0.
01	SETTLEMENT TO PROVIDER		284, 0	35	0	6.
02	SETTLEMENT TO PROGRAM			0	154, 483	
. 00	Total Medicare program liability (see instructions)		12, 198, 2		13, 277, 509	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1.00	2.00	
. 00	Name of Contractor			1.00	2.00	8.

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0059 CCN: 15-T059	Period: From 01/01/2020 To 12/31/2020	Date/Time Prep	pare
		Title	e XVIII	Subprovider -	7/29/2021 10: 5 PPS	51 ar
		Innotion	+ Dort A	I RF	rt B	
		Inpatien	nt Part A	Pa	ТВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
. 00	Tatal interim neuments paid to provider	1.00	2.00 5,651,3	3.00	4.00	1.
. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5, 051, 3	0	0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER		1	0	0	3.
02 03 04				0 0 0	0 0 0	3. 3. 3.
05				0	0	3.
50	Provider to Program		1	0		3
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0 0	0 0 0 0	3 3 3 3 3 3
0	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		5, 651, 3	-	0 1, 533	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
00	TO BE COMPLETED BY CONTRACTOR 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					5
)1	TENTATI VE TO PROVIDER			0	0	5
)2 )3				0 0	0	5 5
50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5
51 52				0 0	0	5 5
99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on			0	0	5
)1	the cost report. (1) SETTLEMENT TO PROVIDER		2, 8	77	0	6
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		5, 654, 2	36 Contractor	157 1,376 NPR Date	6 7
			0	Number 1.00	(Mo/Day/Yr) 2.00	

Heal th	Financial Systems RIVERVIEW	/ HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0059	Period: From 01/01/2020 To 12/31/2020		epared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				
1.00	Total hospital discharges as defined in AARA §4102 from W		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.				6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HII technology	WKST. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruction	s)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestrat	ion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	nd line 31) (see instructio	ns)		32.00

PART III - 1 00 Net Federal 00 Medicare SS 00 Inpatient R	MBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059 Title XVIII	Period: From 01/01/2020 To 12/31/2020		_
00 Net Federal 00 Medicare SS 00 Inpatient R		Title XVIII			pare
00 Net Federal 00 Medicare SS 00 Inpatient R			Subprovider -	7/29/2021 10: PPS	<u>51 a</u>
00 Net Federal 00 Medicare SS 00 Inpatient R		· · ·	I RF		
00 Net Federal 00 Medicare SS 00 Inpatient R	IEDI CARE PART A SERVI CES - I RF PPS			1.00	
00 Medicare SS 00 Inpatient R	PPS Payment (see instructions)			5, 558, 772	1 1.
00  Inpatient R	ratio (IRF PPS only) (see instructions	)		0. 0163	
	ehabilitation LIP Payments (see instruct			106, 173	3
00  Outlier Pay	nents			99, 627	4
	ntern and resident FTE count in the mos 15, 2004 (see instructions)	t recent cost reporting period e	nding on or prior	0.00	5
program or	es for the unweighted intern and residen nospital closure, that would not be coun	ted without a temporary cap adjus		0.00	í
	4(d)(1)(iii)(F)(1) or (2) (see instruct				
	g program adjustment. (see instructions)		nonlod of - "	0.00	
2	's unweighted FTE count of I&R excluding	y FIES IN THE NEW program growth	period of a "new	0.00	
00 Current yea	ogram" (see instructions) c's unweighted I&R FTE count for residen ogram" (see instructions)	ts within the new program growth	period of a "new	0.00	1
	resident count for IRF PPS medical educa	tion adjustment (see instructions	)	0.00	
	y Census (see instructions)		,	12.631148	
9	ustment Factor (see instructions)			0.000000	
5	ustment (see instructions)			0	
00 Total PPS P	ayment (see instructions)			5, 764, 572	1
00 Nursing and	Allied Health Managed Care payments (se	e instruction)		0	1
.00 Organ acqui	sition (DO NOT USE THIS LINE)				1
00 Cost of phy	sicians' services in a teaching hospital	(see instructions)		0	1
	ee instructions)			5, 764, 572	
00 Primary pay				19, 189	
	ne 17 less line 18).			5, 745, 383	
00 Deductibles	10 minut Line (0)			40, 700	
	ne 19 minus line 20)			5, 704, 683	
	ne 21 minus line 22)			17, 600 5, 687, 083	
	ad debts (exclude bad debts for profession	onal services) (see instructions)		5,007,003	
	mbursable bad debts (see instructions)			0	2
	ad debts for dual eligible beneficiaries	(see instructions)		0	
	um of lines 23 and 25)			5, 687, 083	
	uate medical education payments (from Wk	st. E-4, line 49)		0	
	through costs (see instructions)	. ,		4, 719	2
.00 Outlier pay	nents reconciliation			0	3
00 OTHER ADJUS	TMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
. 50 Pioneer ACO	demonstration payment adjustment (see i	nstructions)		0	3
	on payment adjustment amount before sequ			0	
	t payable to the provider (see instructi	ons)		5, 691, 802	
	on adjustment (see instructions)			37, 566	
	on payment adjustment amount after seque	stration		0	
.00 Interim pay				5, 651, 359	
	ettlement (for contractor use only) provider/program (line 32 minus lines 3	2 01 22 02 22 and 24		0 2, 877	
.00 Protested a	nounts (nonallowable cost report items)		chapter 1,	2,877	
§115.2 TO BE COMPL	TED BY CONTRACTOR				
	tlier amount from Wkst. E-3, Pt. III, li	ne 4		99, 627	50
	onciliation adjustment amount (see instr	uctions)		0	
	ed to calculate the Time Value of Money of Money (see instructions)			0.00	52 53

	Financial Systems RIVERVIEW HC			u of Form CMS-2	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Pre 7/29/2021 10:	pare
		Title XIX	Hospi tal	Cost	51 2
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	ERVICES FOR TITLES V OR	XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient hospital/SNF/NF services		1, 317, 955		1.
	Medical and other services			0	2.
	Organ acquisition (certified transplant centers only)		0		3.
	Subtotal (sum of lines 1, 2 and 3)		1, 317, 955	0	4.
	Inpatient primary payer payments		0		5.
	Outpatient primary payer payments			0	6.
	Subtotal (line 4 less sum of lines 5 and 6)		1, 317, 955	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable Charges		1 257 442		
	Routine service charges Ancillary service charges		1, 257, 462	0	8.
	Organ acquisition charges, net of revenue		1, 769, 769 0	0	10
	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		3, 027, 231	0	
	CUSTOMARY CHARGES		0,027,201		1.5
	Amount actually collected from patients liable for payment f	or services on a charge	0	0	13
	basis	3		-	_
. 00	Amounts that would have been realized from patients liable f	or payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	15
	Total customary charges (see instructions)		3, 027, 231	0	16
	Excess of customary charges over reasonable cost (complete o	nly if line 16 exceeds	1, 709, 276	0	17
	line 4) (see instructions)				
	Excess of reasonable cost over customary charges (complete o	nly if line 4 exceeds li	ne 0	0	18
	16) (see instructions)		0	0	10
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	19   20
	Cost of covered services (enter the lesser of line 4 or line		1, 317, 955	0	20
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b			0	21
	Other than outlier payments		0	0	22
	Outlier payments		0	0	23
	Program capital payments		0	0	24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	27
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		1, 317, 955	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	1, 317, 955	0	31
	Deducti bl es		0	0	32
	Coinsurance		0	0	33
	Allowable bad debts (see instructions)		0	0	34
	Utilization review		0	-	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	na 33)	1, 317, 955	0	36
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37
	Subtotal (line 36 ± line 37)		1, 317, 955	0	38
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39	<u>۱</u>	1, 317, 955	0	39 40
	Interim payments	)	1, 239, 954	0	40
	Balance due provider/program (line 40 minus line 41)		78, 001	0	41
	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub 15-2	/0,001	0	42
	chapter 1, §115.2	a	0	0	1 73

	Financial Systems RIVERVIEW H ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-T059	From 01/01/2020 To 12/31/2020	Part VII Date/Time Pre 7/29/2021 10:	
		Title XIX	Subprovider - IRF	Cost	
			I npati ent	Outpati ent	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S COMPUTATION OF NET COST OF COVERED SERVICES	SERVICES FOR TITLES V OR	AIA SERVICES		
00	Inpatient hospital/SNF/NF services		89, 772		1 1
00	Medical and other services		0,7,7,2	0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		89, 772	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		89, 772	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges		140, 725		
00 00	Routine service charges Ancillary service charges		140, 725	0	
00	Organ acquisition charges, net of revenue		101, 248	0	10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		301, 973	0	
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment	for services on a charge	0	0	13
	basi s	Ũ			
. 00	Amounts that would have been realized from patients liable		on 0	0	14
	a charge basis had such payment been made in accordance with	h 42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
. 00	Total customary charges (see instructions)		301, 973	0	
. 00	Excess of customary charges over reasonable cost (complete o	only IT line 16 exceeds	212, 201	0	1
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete o	only if line 1 exceeds li	ne 0	0	18
. 00	16) (see instructions)	on y i i ine 4 exceeds ii	0	0	
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line	e 16)	89, 772	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b	be completed for PPS prov	iders.		
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	1
. 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	
. 00 . 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only	<b>N</b>	0	0	27
. 00	Titles V or XIX (sum of lines 21 and 27)	)	89, 772	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		07,112	0	23
0. 00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	89, 772	0	
	Deducti bl es	- /	0,,,,2	0	
. 00	Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	and 33)	89, 772	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		89, 772	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
. 00	Total amount payable to the provider (sum of lines 38 and 39	9)	89, 772	0	
. 00	Interim payments		107, 520	0	
2.00	Balance due provider/program (line 40 minus line 41)		-17, 748	0	
3.00	Protested amounts (nonallowable cost report items) in accord	uance with CMS Pub 15-2,	0	0	43

	Financial         Systems         RIVERVIEW         HOS           GRADUATE         MEDICAL         EDUCATION         (GME)         & ESRD         OUTPATIENT         DIRECT	Provi der C		Period:	u of Form CMS-2 Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 10:	
		Title	XVIII	Hospi tal	PPS	
					1.00	
. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs fo	r cost reporti	na periods	0.00	1.00
2. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF			0 1	0.00	2.00
. 00	Amount of reduction to Direct GME cap under section 422 of MM				0.00	3.00
. 01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					3.01
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0.00	4.00
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		r cost reporti	ng periods	0.00	4.0
. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see ins	tructions for	cost reporting	0.00	4.02
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus	ines 4.01 and	0.00	5.00
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs fo	r the current	year from your	0.00	6.00
. 00	Enter the lesser of line 5 or line 6				0.00	7.00
			Primary Care 1.00	0ther 2.00	Total 3.00	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	0.0		0.00	8.00
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.0	0 0.00	0.00	9.0
0.00	6. Weighted dental and podiatric resident FTE count for the curr	ent vear		0.00		10.0
0. 01	Unweighted dental and podiatric resident FTE count for the cu			0.00		10.0
1.00 2.00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	ıg year (see	0.0			11.00 12.00
3.00	instructions) Total weighted resident FTE count for the penultimate cost re	eporti ng	0.0	0 0.00		13.0
4.00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	0.0	0 0.00		14.0
5.00	Adjustment for residents in initial years of new programs		0.0			15.0
5.01 6.00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0.0			15.0 16.0
6. 01	Unweighted adjustment for residents displaced by program of hospital of a closure		0.0			16.0
7.00	Adjusted rolling average FTE count		0.0			17.0
8.00	Per resident amount Approved amount for resident costs		0.0	0 0.00 0 0	0	18.0 19.0
7100			I	<u> </u>		
0.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots re	ceived under 42	1.00	20.0
1 00	Sec. 413.79(c)(4)				0.00	01.0
1.00 2.00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr				0. 00 0. 00	
3.00	Enter the locality adjustment national average per resident a		instructions)			23.0
	Multiply line 22 time line 23				0	
5.00	Total direct GME amount (sum of lines 19 and 24)		I npati ent	Managed Care	0 Total	25.0
			Part A	0		
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
6. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	8, 08	0 4, 970		26.00
7.00	Total Inpatient Days (see instructions)		20, 45			27.0
8.00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 39509	1 0. 243020 0 0	0	28.00 29.00
9.00 9.01	Percent reduction for MA DGME			0	0	29.0
30.00	Reduction for direct GME payments for Medicare Advantage			0	0	30.00
1.00	Net Program direct GME amount				0	31.0

Heal th	Financial Systems RIVERVIEW H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0059	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2020 To 12/31/2020	Date/Time Pre	norod.
			10 12/31/2020	7/29/2021 10:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TI	FLE XVIII ONLY (NURSING S	CHOOL AND PARAMED	ICAL	
	EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B and $94$ )	, Pt. I, SUM OF COI. 20 a	nd 23, TINES 74	0	32.00
	Renal dialysis and home dialysis total charges (Wkst. C, Pt		74 and 94)	481, 678	33.00
	Ratio of direct medical education costs to total charges (I	ine 32 ÷ line 33)		0.00000	34.00
	Medicare outpatient ESRD charges (see instructions)			0	
36.00	Medicare outpatient ESRD direct medical education costs (li			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVI	I ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			24, 579, 824	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 6			0	38.00
	Cost of physicians' services in a teaching hospital (see in:	structions)		0	39.00
	Primary payer payments (see instructions)	ava lina (0)		19, 189	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 mi) Part B Reasonable Cost	lus ITTle 40)		24, 560, 635	41.00
42.00	Reasonable cost (see instructions)			19, 925, 638	42 00
	Primary payer payments (see instructions)			1, 382	
	Total Part B reasonable cost (line 42 minus line 43)			19, 924, 256	
	Total reasonable cost (sum of lines 41 and 44)			44, 484, 891	
	Ratio of Part A reasonable cost to total reasonable cost (I	ine 41 ÷ line 45)		0.552112	
47.00	Ratio of Part B reasonable cost to total reasonable cost (I	ine 44 ÷ line 45)		0. 447888	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND I	PART B			
	Total program GME payment (line 31)			0	48.00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only	,, , , , , , , , , , , , , , , , , , ,		0	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII onl	y) (see instructions)		0	50.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	Fr	eriod: com 01/01/2020	Worksheet G	
nl y)			Тс	12/31/2020	Date/Time Pre 7/29/2021 10:	pareo 51 ar
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	12, 427, 385	0	0	0	1.
. 00	Temporary investments	0	0	0	0	2.
. 00	Notes receivable	0	0	0	0	3.
. 00	Accounts receivable	75, 604, 873		0	0	4.
. 00 . 00	Other receivable	14, 399, 241 -38, 078, 261	0	0	0	5. 6.
00	Allowances for uncollectible notes and accounts receivable Inventory	6, 484, 458	, i i i i i i i i i i i i i i i i i i i	0	0	0.
. 00	Prepai d expenses	2, 454, 855		0	0	8.
00	Other current assets	0	0	0	0	9
D. 00	Due from other funds	0	0	0	0	10.
1.00	Total current assets (sum of lines 1-10)	73, 292, 551	0	0	0	11.
	FIXED ASSETS	45 0(4 004				1 4 0
2.00	Land improvements	15, 961, 384		0	0	12. 13.
3.00 4.00	Land improvements Accumulated depreciation	3, 160, 234 -4, 039, 297		0	0	13.
	Buildings	165, 529, 203		0	0	15
6.00	Accumulated depreciation	-76, 112, 814		0	0	16
	Leasehold improvements	1, 399, 855		0	0	17
B. 00	Accumulated depreciation	0	0	0	0	18
9.00	Fixed equipment	51, 814, 379	0	0	0	19
	Accumulated depreciation	-34, 970, 182		0	0	20
	Automobiles and trucks	0	0	0	0	21
	Accumulated depreciation	0	0	0	0	22
	Major movable equipment	117, 243, 801	0	0	0	23
	Accumulated depreciation Minor equipment depreciable	-81, 863, 809	0	0	0	24 25
	Accumulated depreciation		0	0	0	20
	HIT designated Assets		0	0	0	20
	Accumulated depreciation	0	0	Ő	0	28
	Mi nor equi pment-nondepreci abl e	0	0	0	0	29
	Total fixed assets (sum of lines 12-29)	158, 122, 754	0	0	0	30
	OTHER ASSETS					
	Investments	75, 545, 892	0	0	0	31
	Deposits on Leases	0	0	0	0	32
3.00 1.00	Due from owners/officers Other assets	79, 827	Ŭ	0	0	33 34
	Total other assets (sum of lines 31-34)	75, 625, 719		0	0	34
5.00	Total assets (sum of lines 11, 30, and 35)	307,041,024		0	0	36
0.00	CURRENT LI ABI LI TI ES	007/011/021				1
7.00	Accounts payable	8, 653, 793	0	0	0	37
3.00	Salaries, wages, and fees payable	12, 600, 226	0	0	0	38
9.00	Payroll taxes payable	0	0	0	0	39
	Notes and Loans payable (short term)	28, 896, 843		0	0	
	Deferred income	0	0	0	0	
	Accelerated payments		0	0	0	42
	Due to other funds Other current liabilities	95, 571, 986 1, 468, 856		0	0	
	Total current liabilities (sum of lines 37 thru 44)	147, 191, 704		0	0	
	LONG TERM LI ABI LI TI ES	117,171,701				
5.00	Mortgage payable	0	0	0	0	46
7.00	Notes payable	54, 965, 000	0	0	0	47
3.00	Unsecured Loans	0	0	0	0	48
	Other long term liabilities	4, 107, 526		0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	59,072,526		0	0	50
. 00	Total liabilities (sum of lines 45 and 50)	206, 264, 230	0	0	0	51
00	CAPITAL ACCOUNTS	100 774 704		1		1 5 2
2.00 3.00	General fund balance Specific purpose fund	100, 776, 794	0			52 53
4.00	Donor created - endowment fund balance - restricted			o		54
+. 00 5. 00	Donor created - endowment fund balance - restricted			0		55
5.00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	
B. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	100, 776, 794	0	0	0	59
D. 00	Total liabilities and fund balances (sum of lines 51 and	307, 041, 024			0	60

Health Financial Systems	RIVERVIEW H	OSPI TAL		In Li	eu of Form CMS	-2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-0059	Period: From 01/01/202 To 12/31/202	Worksheet G-	1 epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.00Additions (credit adjustments) (specify)6.008.009.0010.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0016.0017.0018.0018.00Total deductions (sum of lines 12-17)19.00Fund balance at end of period per balance	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	129, 273, 974 -28, 497, 180 100, 776, 794 0 100, 776, 794 0 100, 776, 794			0	$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 0.4.00\\ 0.5.00\\ 0.6.00\\ 0.6.00\\ 0.7.00\\ 0.8.00\\ 0.7.00\\ 10.00\\ 11.00\\ 12.00\\ 0.13.00\\ 0.14.00\\ 0.15.00\\ 0.15.00\\ 0.16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array} $
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1.00 Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
<ul> <li>10.00 Total additions (sum of line 4-9)</li> <li>11.00 Subtotal (line 3 plus line 10)</li> <li>12.00 Deductions (debit adjustments) (specify)</li> <li>13.00</li> <li>14.00</li> <li>15.00</li> <li>16.00</li> <li>17.00</li> <li>18.00 Total deductions (sum of lines 12-17)</li> <li>19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)</li> </ul>	0 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

Heal th	Financial Systems RIVERVIEW HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATI ENT REVENUES AND OPERATI NG EXPENSES	Provider CC	N: 15-0059	Period: From 01/01/2020 To 12/31/2020	Worksheet G-2 Parts I & II Date/Time Pre 7/29/2021 10:	pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					1
1.00	Hospi tal		39, 104, 70	74	39, 104, 704	1.00
2.00	SUBPROVIDER - IPF		07710177		07,101,701	2.00
3.00	SUBPROVIDER - IRF		7, 831, 7	56	7, 831, 756	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	
8.00	NURSING FACILITY OTHER LONG TERM CARE					8.00 9.00
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		46, 936, 40	50	46, 936, 460	
10.00	Intensive Care Type Inpatient Hospital Services	I	40, 930, 40		40, 930, 400	10.00
11.00	I NTENSI VE CARE UNI T		13, 740, 50	02	13, 740, 502	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	13, 740, 50	02	13, 740, 502	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16	b)	60, 676, 9		60, 676, 962	
18.00	Ancillary services		101, 723, 64		499, 526, 660	1
19.00 20.00	Outpatient services RURAL HEALTH CLINIC			0 0	0	19.00 20.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		
21.00	HOME HEALTH AGENCY			0 0	0	21.00
23.00	AMBULANCE SERVICES			0 0	0	
24.00	CMHC			0	Ŭ	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	162, 400, 60	06 397, 803, 016	560, 203, 622	28.00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)			240, 602, 817		29.00
29.00 30.00	ADD (SPECIFY)			240, 802, 817		30.00
30.00	ADD (SFECTIT)			0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00	Total deductions (sum of lines 27 41)			0		41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 4	12) (transfor		0 240, 602, 817		42.00 43.00
43.00	to Wkst. G-3, line 4)			240,002,017		43.00
		I		I	1	

	Financial Systems	RI VERVI EW HOSPI TAL		ieu of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-	From 01/01/20		
			To 12/31/20	Date/Time Pre 7/29/2021 10:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Pa			560, 203, 622	
2.00	Less contractual allowances and discounts	on patients' accounts		370, 034, 480	
3.00	Net patient revenues (line 1 minus line 2)			190, 169, 142	
4.00	Less total operating expenses (from Wkst.			240, 602, 817	
5.00	Net income from service to patients (line	3 minus line 4)		-50, 433, 675	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			7, 680, 692	7.00
8.00	Revenues from telephone and other miscella	neous communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and g	uests		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 p	atients		0	17.00
18.00	Revenue from sale of medical records and a	bstracts		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 INCOME			-1, 114, 287	24.00
24.01	OTHER OPERATING REVENUE			10, 981, 333	
24.50	COVID-19 PHE Funding			4, 388, 757	
25.00	Total other income (sum of lines 6-24)			21, 936, 495	
26.00	Total (line 5 plus line 25)			-28, 497, 180	
	OTHER EXPENSES (SPECIFY)			0	
28.00	Total other expenses (sum of line 27 and s	ubscripts)		0	
	Net income (or loss) for the period (line i			-28, 497, 180	

ealth Financial Systems RIV ALCULATION OF CAPITAL PAYMENT	/ERVIEW HOSPITAL Provider CCN: 15-0059	Period:	u of Form CMS-2 Worksheet L	2002
		From 01/01/2020 To 12/31/2020	Parts I-III	
	Title XVIII	Hospi tal	PPS	JIA
			1.00	
PART I - FULLY PROSPECTIVE METHOD				-
CAPITAL FEDERAL AMOUNT			001 005	
00 Capital DRG other than outlier			831, 225	
01 Model 4 BPCI Capital DRG other than outlier			0	
00 Capital DRG outlier payments			0	
01 Model 4 BPCI Capital DRG outlier payments	be east reporting period (and inst	wati ana)	-	
00 Total inpatient days divided by number of days in th 00 Number of interns & residents (see instructions)	he cost reporting period (see instr	ructions)	43.25 0.00	
00 Number of interns & residents (see instructions) 00 Indirect medical education percentage (see instruct	i onc)		0.00	
00 Indirect medical education percentage (see histiduct) 00 Indirect medical education adjustment (multiply line	· · · · · · · · · · · · · · · · · · ·	columns 1 and	0.00	
1.01) (see instructions)	5		-	
00 Percentage of SSI recipient patient days to Medicard 30) (see instructions)	e Part A patient days (Worksheet E,	part A line	2.42	7.
00 Percentage of Medicaid patient days to total days (	see instructions)		16. 56	8
00 Sum of lines 7 and 8			18. 98	9
.00 Allowable disproportionate share percentage (see in:	structions)		3. 91	10
.00 Disproportionate share adjustment (see instructions	)		32, 501	11
.00 Total prospective capital payments (see instruction	s)		863, 726	12
			1.00	
PART II - PAYMENT UNDER REASONABLE COST	+!>		0	1 1
00 Program inpatient routine capital cost (see instruc			0	
00 Program inpatient ancillary capital cost (see instru			0	
00 Total inpatient program capital cost (line 1 plus 1 00 Capital cost payment factor (see instructions)	The 2)		0	-
00 Total inpatient program capital cost (line 3 x line	4)		0	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
Program inpatient capital costs (see instructions)			0	1 1
00 Program inpatient capital costs for extraordinary c	ircumstances (see instructions)		0	
00 Net program inpatient capital costs (line 1 minus l			0	
00 Applicable exception percentage (see instructions)	,		0.00	4
00 Capital cost for comparison to payments (line 3 x li	ine 4)		0	5
00 Percentage adjustment for extraordinary circumstance			0.00	6
00 Adjustment to capital minimum payment level for ext		line 6)	0	7
00 Capital minimum payment level (line 5 plus line 7)			0	8
00 Current year capital payments (from Part I, line 12	, as applicable)		0	9
	level to capital payments (line 8 l	ess line 9)	0	10.
.00 Current year comparison of capital minimum payment	vel over capital payment (from pric	or year	0	11.
.00 Carryover of accumulated capital minimum payment le				112
.00 Carryover of accumulated capital minimum payment le Worksheet L, Part III, line 14)	capital payments (line 10 plus line	e 11)	0	12.
<ul> <li>.00 Carryover of accumulated capital minimum payment lew Worksheet L, Part III, line 14)</li> <li>.00 Net comparison of capital minimum payment level to m</li></ul>			0	
<ul> <li>.00 Carryover of accumulated capital minimum payment lew Worksheet L, Part III, line 14)</li> <li>2.00 Net comparison of capital minimum payment level to 0</li> <li>3.00 Current year exception payment (if line 12 is position)</li> </ul>	ive, enter the amount on this line)	)	-	13.
.00 Carryover of accumulated capital minimum payment le Worksheet L, Part III, line 14) 2.00 Net comparison of capital minimum payment level to b	ive, enter the amount on this line) vel over capital payment for the fo	)	0	13
<ul> <li>.00 Carryover of accumulated capital minimum payment lew Worksheet L, Part III, line 14)</li> <li>.00 Net comparison of capital minimum payment level to 0 Current year exception payment (if line 12 is position)</li> <li>.00 Carryover of accumulated capital minimum payment lew</li> </ul>	ive, enter the amount on this line, vel over capital payment for the fo ine)	)	0	13 14
<ul> <li>.00 Carryover of accumulated capital minimum payment lew Worksheet L, Part III, line 14)</li> <li>.00 Net comparison of capital minimum payment level to 0 Current year exception payment (if line 12 is position Carryover of accumulated capital minimum payment lew (if line 12 is negative, enter the amount on this line)</li> </ul>	ive, enter the amount on this line) vel over capital payment for the fo ine) t (see instructions)	)	0 0	13 14 15