This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-4005 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/9/2022 2: 21 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/9/2022 2:21 pm ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVER BEND HOSPITAL (15-4005) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Ja	mie Sego	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jami e Sego			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	1, 870	0	0	19, 996	1.00
2.00 Subprovi der - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3.00
4. 00 SUBPROVI DER 1						4.00
5.00 Swing Bed - SNF	0	0	0		0	5. 00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200. 00 Total	0	1, 870	0	0	19, 996	200. 00
The above amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above compl	ex indicated.	

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

HOSPI I	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-4005			Peri od:			pared:	
	1.00		2. 00		3. 00			4	4. 00			
1. 00 2. 00	Hospital and Hospital Health Care Co Street: 2900 NORTH RIVER ROAD City: WEST LAFAYETTE		PO Box: State: IN	Zip Cod	e: 479	906-	Count	y: TI PPECAN	0E			1. 00
		Comp	oonent Name	CCN Number	CB: Num		ovi der Type	Date Certified		nt Syst 0, or XVIII	N)	
			1. 00	2. 00	3. (	00 4	1. 00	5. 00	6. 00		8.00	
3. 00	Hospital and Hospital-Based Componen Hospital		ication: ND HOSPITAL	154005	292	200	4	01/01/1966	N	P	0	3.00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Subprovi der - IPF Subprovi der - IRF Subprovi der - (Other) Swing Beds - SNF Swing Beds - NF Hospi tal -Based SNF Hospi tal -Based NF Hospi tal -Based HHA Separately Certi fi ed ASC	NI VEN BEI	NO HOSTITAL	134003	272		7	0170171700				4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC)   Hospital-Based (CORF)   Renal Dialysis											13. 00 14. 00 15. 00 16. 00 17. 00 17. 10 18. 00 19. 00
								From:		To		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)							1. 00 01/01/20 2		12/31/		20.00
	Inpatient PPS Information					1.	00	2. 00		3. (	00	
22. 00 22. 01	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.							22. 00				
22. 02	cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.  Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N				22. 02
22. 03	or "N" for no, for the portion of the cost reporting period on or after October 1.  Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for				N		N		22. 03			
22. 04	adopted by CMS in FY 2021? Enter in 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	MB delineations for statistical areas in column 1, "Y" for yes or "N" for no ing period prior to October 1. Enter in no for the portion of the cost ifter October 1. (see instructions)				N		22. 04				
23. 00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admiss of identi method us	ion, 2 if cens fying the days ed in the pric	sus days, o s in this o or cost	or 3			1 N				23. 00

					To 12/3	1/2021	Date/Ti 5/9/202		
		In-State	In-State	Out-of	Out-of	Medi cai		ther	Pili
		Medi cai d	Medi cai d	State	State	HMO day		li cai d	
		paid days	eligible unpaid	Medicaid paid days	Medicaid eligible		C	lays	
			days	par a days	unpai d				
	To a contract the contract to	1.00	2. 00	3. 00	4. 00	5. 00		. 00	
24. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state	C	C	0	0		0	0	24. 00
	Medicaid eligible unpaid days in column 2,								
	out-of-state Medicaid paid days in column 3,								
	out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in								
	column 5, and other Medicaid days in column 6.								
25. 00	If this provider is an IRF, enter the in-state	C	C	0	0		0		25. 00
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,								
	out-of-state Medicaid days in column 3, out-of-state								
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
	pino para ana errgible but unpara days in cordini 5.				Urban/R	ural S	Date of	Geogr	
04.00					1. 0	00	2. (	00	04.00
26. 00	Enter your standard geographic classification (not woost reporting period. Enter "1" for urban or "2" fo		at the beq	ginning of 1	:he	1			26. 00
27. 00	Enter your standard geographic classification (not was	age) status			st	1			27. 00
	reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif			opl i cabl e,					
35. 00	If this is a sole community hospital (SCH), enter the			CH status ir	n	0			35. 00
	effect in the cost reporting period.				Dogi na	d na.	Fadi	na.	
					Begi nr		Endi 2. (		+
36. 00			script line	36 for numb	per				36. 00
37. 00	of periods in excess of one and enter subsequent date of this is a Medicare dependent hospital (MDH), ente		er of period	ds MDH statu	ıs	0			37. 00
	is in effect in the cost reporting period.		·		.5	J			
37. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for								37. 01
	instructions)	or yes or	N TOT TIO.	(366					
38. 00	If line 37 is 1, enter the beginning and ending date:								38. 00
	greater than 1, subscript this line for the number of enter subsequent dates.	r perioas i	n excess of	r one and					
					Y/		Υ/		
39. 00	Does this facility qualify for the inpatient hospita	l pavment a	ıdiustment 1	for low volu	ıme N		2. ( N		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(i	), (ii), or	(iii)? Ent	ter in colum					
	1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i				ne l				
	or "N" for no. (see instructions)	ii): Liitei	TH COLUMN 2	2 1 101 ye	7.5				
40. 00	Is this hospital subject to the HAC program reduction						N		40. 00
	"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1			yes or "N" 1	or				
					'	V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1.00	2. 00	3.00	
45. 00	Does this facility qualify and receive Capital paymen	nt for disp	roporti ona	te share in	accordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	ention for	extraordi na	arv circumst	ances	N	N	l N	46. 00
40.00	pursuant to 42 CFR §412. 348(f)? If yes, complete Wks	•		,		"	"	'`	40.00
47.00	Pt. III.				_		N		47.00
		: +-10 5	·	UNII				N	47.00
	Is this a new hospital under 42 CFR §412.300(b) PPS	•		-		N N		l N	48.00
48. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.	N	N	N	48. 00
	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in	t? Enter "	Y" for yes GME programs	or "N" for s? Enter "Y'	no. for yes or	N		N	48. 00 56. 00
48. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals	t? Enter " approved G e to columr	Y" for yes GME programs 1 1 is "Y",	or "N" for s? Enter "Y' or if this	no.  for yes or hospi tal	N		N	
48. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the responswas involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applied).	approved Ge to column rograms in cable CRs)	Y" for yes  ME programs 1 is "Y", the prior y	or "N" for s? Enter "Y' or if this year or penu	for yes or hospital ultimate	N		N	
48. 00 56. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applienter "Y" for yes; otherwise, enter "N" for no in co	approved Ge to column rograms in cable CRs)	Y" for yes  ME programs 1 is "Y", the prior y MA direct (	or "N" for s? Enter "Y' or if this year or penu GME payment	no.  for yes or hospital altimate reduction?	N		N	56. 00
48. 00 56. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the responsives involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applied Enter "Y" for yes; otherwise, enter "N" for no in column 156 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for	approved Ge to column rograms in cable CRs) lumn 2. period duri	Y" for yes  ME programs 1 is "Y", the prior y MA direct ( ng which re " for no ir	or "N" for s? Enter "Y' or if this year or pent GME payment esidents in a column 1.	no.  for yes or hospital altimate reduction?  approved If column 1	N		N	
48. 00 56. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the responswas involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applienter "Y" for yes; otherwise, enter "N" for no in collif line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fois "Y" did residents start training in the first mon	approved Ge to column rograms in cable CRs) lumn 2. period duri r yes or "N	Y" for yes  ME programs 1 is "Y", the prior y MA direct ( ng which re " for no in cost report	or "N" for s? Enter "Y' or if this year or pent GME payment esidents in n column 1. ting period?	no.  for yes or hospital altimate reduction?  approved If column 12 Enter "Y"	N		N	56. 00
48. 00 56. 00 57. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applied Enter "Y" for yes; otherwise, enter "N" for no in collif line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	approved Geto Column to column cable CRs) lumn 2. period duri r yes or "N th of this Y", complet I, if appli	Y" for yes  ME program 1 is "Y", the prior y MA direct ( ng which re " for no in cost report e Worksheet cable.	or "N" for s? Enter "Y' or if this year or penu GME payment esidents in n column 1. ting period? t E-4. If co	for yes or hospital ultimate reduction? approved If column 12 Enter "Y"	N		N	56. 00
48. 00 56. 00 57. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applienter "Y" for yes; otherwise, enter "N" for no in coll fline 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fois "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. If line 56 is yes, did this facility elect cost reim	approved Ge to column rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet I, if applibursement f	Y" for yes  ME programs 1 is "Y", the prior y MA direct (  ng which re " for no in cost report ee Workshee cable. For physicia	or "N" for s? Enter "Y' or if this year or penu GME payment esidents in n column 1. ting period? t E-4. If co	for yes or hospital ultimate reduction? approved If column 12 Enter "Y"	N		N	56. 00
48. 00 56. 00 57. 00 58. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applied Enter "Y" for yes; otherwise, enter "N" for no in collif line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	approved Ge to column rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet I, if appli bursement f complete W	Y" for yes  ME programs 1 is "Y", the prior y MA direct (  ng which re " for no in cost report e Workshee cable. for physicia //kst. D-5.	or "N" for s? Enter "Y' or if this year or penu GME payment esidents in n column 1. ting period; t E-4. If co	for yes or hospital ultimate reduction? approved If column 12 Enter "Y"	N		N	56. 00

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

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/9/2022 2:21 pm Ratio (col. 3/ Program Code Unwei ghted Unwei ghted Program Name (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

leal th Financial Systems RIVER BEND HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	wof Form CMS Worksheet S- Part I Date/Time Pr 5/9/2022 2:2	2 epared:			
		1.00				
Long Term Care Hospital PPS  10.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  11.00 Is this a LTCH co-located within another hospital for part or all of the cost report "Y" for yes and "N" for no.	ng period? Enter	N N	80. 00 81. 00			
TEFRA Providers  15.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for your good of this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i) 23. Enter "Y" for your and "N" for your and "N" for your good		N	85. 00 86. 00			
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  1s this hospital an extended neoplastic disease care hospital classified under section (1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	on	N	87. 00			
1000(U)(1)(D)(VI): Litter 1 Tor yes or N Tor Ho.	V 1. 00	XI X 2. 00	+			
Title V and XIX Services	~ N	Y	90.00			
00.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.						
P1.00 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.	N	Y	91.00			
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00			
instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ente	- N	N	93. 00			
"Y" for yes or "N" for no in the applicable column. 24.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94.00			
applicable column.						
P5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. P6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95. 00 96. 00			
applicable column. 07.00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97. 00			
28.00 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 column 1 for title V, and in column 2 for title XIX.	Y	98. 00				
Descritle V or XIX follow Medicare (title XVIII) for the reporting of charges on Wk: C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	Y	98. 0				
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	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1					
for title V, and in column 2 for title XIX.  18.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAI reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column		N	98. 03			
for title V, and in column 2 for title XIX.  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 nd	N	98. 04			
Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance (Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and		Y	98. 05			
28.06 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.	Y	Y	98. 06			
Rural Providers  105.00 Does this hospital qualify as a CAH?	N		105. 00			
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of paym	ent		106. 00			
for outpatient services? (see instructions)  107.00 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)	N		107. 00			
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) 108.00 is this a rural hospital qualifying for an exception to the CRNA fee schedule? See	12 N		108. 00			
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.						
Physical         Occupation           1.00         2.00	nal Speech 3.00	Respi ratory 4.00				
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	109. 00			
		1.00				
   110.00 Did this hospital participate in the Rural Community Hospital Demonstration project	(§410A	1.00 N	110. 00			

Health Financial Systems RIVER BEND HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4005 Peri od: Worksheet S-2 From 01/01/2021 Part I То 12/31/2021 Date/Time Prepared: 5/9/2022 2: 21 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 N Ν 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 161. 10 CORF Ν Ν Ν 161. 10 1.00 Mul ti campus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zi p Code CBSA Name County State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, 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

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act		
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		N	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the		168. 00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	ı hardshi p		168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	0.	00169.00	
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in 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. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0 171. 00

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/9/2022 2:2	epared:
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Ente			
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	corumn 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.00
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providences, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A	04/21/2022	4.00
00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	1
	Approved Educational Activities			1.00	2.00	
	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provide	n N		6.00
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructi ons.		N		7. 00
00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		· ·			8. 00
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9.00
. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in 1	the current	N		10.00
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N	
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If yes	s see instruct	tions		Υ	12. 0
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N	13. 0
	1	ents waived? If	yes, see ins	structi ons.	N	14. 0
	Did total beds available change from the prior cost reporti		yes, see inst		N t B	15. 0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data  Was the cost report prepared using the PS&R Report only?  If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	02/11/2022	Y	02/11/2022	16. 00
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 0
. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
. 00	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for corrections of other PS&R Report  information? If yes, see instructions.	N		N		19. 0

Heal th	Financial Systems RIVER BEND	HOSPI TAL		In Lie	eu of Form CM:	S-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time P 5/9/2022 2:	repared:	
			iption	Y/N	Y/N		
00.00	1011 11 1000		0	1. 00	3.00	00.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00	
	incoort data for other. Beserred the other day astiments.	Y/N	Date	Y/N	Date		
		1.00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	FPT CHILDRENS I	HOSPI TALS)		1.00		
	Capital Related Cost						
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 00	
23.00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost		23. 00	
	reporting period? If yes, see instructions.						
24. 00	Were new leases and/or amendments to existing leases enter	ed into during	this cost re	eporting period?		24. 00	
25 00	If yes, see instructions	the cost re	cting posts-1	Olfwas and		25.00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	ung period:	r ii yes, see		25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost renorti	na period? I	f ves see		26. 00	
20.00	instructions.	ne cost reporti	ing period: i	1 yes, see		20.00	
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit		27. 00	
	copy.	·					
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or letters of credit el	ntered into du	ring the cost	reporting		28. 00	
20.00	period? If yes, see instructions.	band funda (D	ab+ Camilaa I	Doggeria Fund)		20.00	
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see insti		ebt Service i	Reserve Fund)		29. 00	
30. 00	Has existing debt been replaced prior to its scheduled mate		deht? If ves	200		30.00	
30.00	instructions.	arrey wren new	debt: 11 yes	5, 300		30.00	
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see		31. 00	
00.00	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		ea through co	ntractual		32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		na to competi	tive bidding? If		33. 00	
00.00	no, see instructions.	pri ca per tarini	ig to competi	tive brading. II		00.00	
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facility under an a	rrangement witl	n provi der-ba	sed physi ci ans?		34. 00	
	If yes, see instructions.						
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. 00	
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Do+o		
				1. 00	2.00		
	Home Office Costs			1.00	2.00		
36. 00	Were home office costs claimed on the cost report?					36.00	
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	>		37. 00	
	If yes, see instructions.						
38. 00	If line 36 is yes , was the fiscal year end of the home of			=		38. 00	
20.00	the provider? If yes, enter in column 2 the fiscal year end					20.00	
39. 00	If line 36 is yes, did the provider render services to other	er chain compoi	nents? If yes	5,		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If was soo			40. 00	
40.00	instructions.	nome office:	ii yes, see			40.00	
	1						
		1.	. 00	2.	00		
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	TI NA		SEVERS		41. 00	
	held by the cost report preparer in columns 1, 2, and 3,						
40.00	respectively.	DI HE & CO	6			40.00	
42. 00	Enter the employer/company name of the cost report	BLUE & CO., LI	_6			42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7946		TSEVERS@BLUEAN	DCO COM	43.00	
73.00	report preparer in columns 1 and 2, respectively.	017 713-7740		ISEVENSEDECEAN	DOO. GOW	43.00	

Heal th	Financial Systems RIVER BEND	) HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-4005	Peri od: From 01/01/2021	Worksheet S-2 Part II		
			To 12/31/2021	Date/Time Pre 5/9/2022 2:21	pared: _pm	
		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,					
	respecti vel y.					
42.00	Enter the employer/company name of the cost report				42.00	
	preparer.					
43.00	Enter the telephone number and email address of the cost				43.00	
	report preparer in columns 1 and 2, respectively.					

 
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-4005

					T	12/31/2021	Date/Time Prep	
							5/9/2022 2: 21 I/P Days / 0/P	pili
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		16	5, 840	0.00	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			16	5, 840	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			16	5, 840	0.00	0	14.00
15. 00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF	41. 00		0	0		0	17.00
18. 00	SUBPROVI DER	42. 00		0	0		0	18.00
19. 00	SKILLED NURSING FACILITY							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
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			16				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

Provider CCN: 15-4005

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/9/2022 2:21 pm

						5/9/2022 2: 21	pm	
		I/P Days	s / O/P Visits	/ Trips	Full Time Equivalents			
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
		6. 00	7. 00	8.00	9. 00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	320	177				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)	0	510				2. 00	
3.00	HMO IPF Subprovider	0	0				3. 00	
4.00	HMO IRF Subprovider	0	0				4. 00	
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00	
6.00	Hospital Adults & Peds. Swing Bed NF		0				6. 00	
7.00	Total Adults and Peds. (exclude observation	320	177	2, 905			7. 00	
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT						8. 00	
9.00	CORONARY CARE UNIT						9. 00	
10. 00	BURN INTENSIVE CARE UNIT						10. 00	
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00	
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00	
13. 00	NURSERY						13. 00	
14. 00	Total (see instructions)	320	177		0.00	47. 79	•	
15. 00	CAH visits	0	0	0			15. 00	
16. 00	SUBPROVI DER - I PF						16. 00	
17. 00	SUBPROVI DER - I RF	0	0	0				
18. 00	SUBPROVI DER		0	0	0.00	0.00	1	
19. 00	SKILLED NURSING FACILITY						19. 00	
20. 00	NURSING FACILITY						20. 00	
21. 00	OTHER LONG TERM CARE						21. 00	
22. 00	HOME HEALTH AGENCY						22. 00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00	
24. 00	HOSPI CE						24. 00	
24. 10	HOSPICE (non-distinct part)			0			24. 10	
25. 00	CMHC - CMHC						25. 00	
25. 10	CMHC - CORF	0	0	-				
26. 00	RURAL HEALTH CLINIC	0	0	-			ł	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			1	
27. 00	Total (sum of lines 14-26)				0.00	47. 79	l	
28. 00	Observation Bed Days		0	1			28. 00	
29. 00	Ambul ance Tri ps	0					29. 00	
30. 00	Employee discount days (see instruction)			0			30.00	
31. 00	Employee discount days - IRF			0			31. 00	
32. 00	Labor & delivery days (see instructions)	0	0	0			32. 00	
32. 01	Total ancillary labor & delivery room			0			32. 01	
	outpatient days (see instructions)	_						
33. 00	LTCH non-covered days	0					33.00	
33. 01	LTCH site neutral days and discharges	이		l			33. 01	

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-4005

Full Time   Component   Full Time   Course   C					To	12/31/2021	Date/Time Pre 5/9/2022 2:21	
Component			Full Time	_	Di sch	arges	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Normal   Hospital   Adult s & Peds. (columns 5			Equi val ents					
Nospital 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 LOP room available beds)   Nospital Adults & Peds. Swing Bed Swing		Component		Title V	Title XVIII	Title XIX		
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 HM0 lapf Subprovider 0 0 3.00 3.00 HM0 lPF Subprovider 0 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed SNF 0 6.00 7.00 Total Adults and Peds. (exclude observation beds) (see Instructions) 8.00 INTENSIVE CARE UNIT 0 9.00 10.00 BURN INTENSIVE CARE UNIT 1 9.00 10.00 BURN INTENSIVE CARE UNIT 1 10.00 11.00 SUBRICAL INTENSIVE CARE UNIT 1 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 13.00 NURSER? 13.00 15.00 CAH visits 1 18.00 15.00 CAH visits 1 18.00 15.00 CAH visits 1 18.00 16.00 SUBRROVIDER - IPF 0.00 17.00 SUBRROVIDER - IPF 0.00 18.00 SUBRROVIDER - IPF 0.00 19.00 SUBRROVIDER - IRF 0.00 19.00 SING ILED NURSING FACILITY 0.00 19.00 SING INFORM CARE 0.			11. 00					
Hospice days) (see instructions for col. 2   for the portion of ILDP room avail able beds)	1. 00			0	40	45	594	1.00
For the portion of LDP room available beds)   2 00   3 00   3 00   3 00   3 00   3 00   4 0								
2.00								
3.00   HMO IPF Subprovider	0.00	•				405		0.00
4. 00   MMO IRF Subprovider   5. 00   6. 00   1. 00		1			0			1
5.00   Hospit tal Adult ts & Peds. Swing Bed NF   6.00   6.00   Hospit tal Adult ts and Peds. (exclude observation beds) (see instructions)   8.00   Intensive Care unit   9.00   10.00   Buds) (see instructions)   8.00   Intensive Care unit   9.00   10.00   Buds intensive Care unit   9.00   10.00   Buds intensive Care unit   10.00   10.00   Buds intensive Care unit   10.00   10.						0		
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 7.00 Total Adults and Peds (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 11.00 SURRICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 14.00 Total (see instructions) 16.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 O O O O O O O O O O O O O O O O O O						O O		
7. 00   Total Adults and Peds (exclude observation beds) (see instructions)   8. 00   1NTENSIVE CARE UNIT   9. 00   10. 00   1NTENSIVE CARE UNIT   10. 00   11. 00		, ,						
beds) (see instructions)   8. 00   1								
8. 00   INTENSIVE CARE UNIT	7.00							7.00
9. 00   COROMARY CARE UNIT	0.00							0 00
10.00   BURN INTENSIVE CARE UNIT   10.00   11.00   SURGICAL INTENSIVE CARE UNIT   11.00   11								
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 31. 00								1
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBLILED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days								
13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 15. 00 CAH visits 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 O								
14.00 Total (see instructions)								
15. 00 CAH visits			0.00	0	40	4.5	EO.4	
16. 00   SUBPROVIDER - IPF			0.00	U	40	45	594	
17. 00 SUBPROVIDER - IRF								
18. 00 SUBPROVI DER			0.00	0	0	0	0	
19. 00 20. 00 19				-	-	-1		
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   22.00   HOME HEALTH AGENCY   23.00   AMBULATORY SURGICAL CENTER (D. P. )   23.00   24.00   HOSPICE   24.10   25.00   24.10   HOSPICE   25.10   25.10   25.10   25.10   26.00   26.00   RURAL HEALTH CLINIC   25.10   26.00   26.25   FEDERALLY QUALIFIED HEALTH CENTER   0.00   26.25   FEDERALLY QUALIFIED HEALTH CENTER   0.00   27.00   28.00   Observation Bed Days   29.00   Ambulance Trips   28.00   29.00   Ambulance Trips   29.00			0.00	U		٩	U	
21.00 OTHER LONG TERM CARE  22.00 HOME HEALTH AGENCY  23.00 AMBULATORY SURGICAL CENTER (D.P.)  24.00 HOSPICE  24.10 HOSPICE (non-distinct part)  25.00 CMHC - CMHC  25.00 CMHC - CORF  26.00 RURAL HEALTH CLINIC  26.25 FEDERALLY QUALIFIED HEALTH CENTER  26.00 Observation Bed Days  27.00 Observation Bed Days  29.00 Ambul ance Trips  30.00 Employee discount days (see instruction)  31.00 Employee discount days (see instructions)  32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  21.00  22.00  22.00  22.00  23.00  24.10  25.00  25.10  0.00  0								
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CORF 25.10 CMHC - CORF 25.10 CMHC - CORF 25.10 CMHC - LINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 TO Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  22.00 23.00 24.00 24.00 24.00 25.10 26.00 25.10 26.00 26.25 27.00 26.25 27.00 27.00 28.00 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days								
23. 00 24. 00 14. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19								
24. 00 40. HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 25. 10 CMHC - CORF 25. 10 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 28. 00 Doservation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  24. 00 24. 10 25. 00 26. 00 27. 00 0.								
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  24. 10 25. 00 25. 00 25. 10 26. 00 26. 25 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 30. 0								
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  25. 00 25. 10 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 10 26. 00 26. 00 27. 00 28. 00 29.								
25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  25. 10 0. 00 26. 00 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 30. 00 31. 00 31. 00 32. 01 32. 01 33. 00 33. 00 33. 00								
26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days Ambul ance Tri ps 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF Labor & delivery days (see instructions) 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  26. 00 26. 25 0. 00 27. 00 28. 00 29. 00 31. 00 32. 00 33. 00 30. 00 31. 00 31. 00 32. 01 32. 01 33. 00 33. 00			0.00					
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 28. 00 Observation Bed Days 28. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0. 00 33. 00 33. 00								
27.00   Total (sum of lines 14-26)   0.00   27.00   28.00   0bservation Bed Days   28.00   29.00   Ambulance Trips   29.00   30.00   Employee discount days (see instruction)   31.00   Employee discount days - IRF   31.00   32.00   Labor & delivery days (see instructions)   32.01   Total ancillary labor & delivery room   0utpatient days (see instructions)   33.00   LTCH non-covered days   0   33.00   33.00								
28. 00   Observation Bed Days   28. 00   29. 00   Ambulance Trips   29. 00   30. 00   Employee discount days (see instruction)   30. 00   Employee discount days - IRF   31. 00   32. 00   Labor & delivery days (see instructions)   32. 01   Total ancillary labor & delivery room   0utpatient days (see instructions)   33. 00   LTCH non-covered days   0   33. 00   33. 00								
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  29.00 30.00 31.00 32.00 32.00								
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  30.00 31.00 32.00 32.00 32.01								
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  31.00 32.00 32.01								
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.00 32.01								1
32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  32.01								
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00								
33. 00 LTCH non-covered days 0 33. 00								
33.01 LTCH site neutral days and discharges 0 33.01	33.00				0			33.00
	33. 01	LTCH site neutral days and discharges			0			33. 01

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3, 606, 461

3, 606, 461

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4, 309, 450

5, 902, 709

10, 212, 159

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7, 915, 911

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13, 818, 620

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0 113.00

7, 915, 911 118. 00

5, 902, 709 194. 00

13, 818, 620 200. 00

110.00 11000 INTESTINAL ACQUISITION

NONREI MBURSABLE COST CENTERS

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (SUM OF LINES 118 through 199)

111.00 11100 I SLET ACQUISITION

113.00 11300 INTEREST EXPENSE

194.00 07950 OP AND RC

118.00

200.00

| Peri od: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

				То	12/31/2021	Date/Time Prepared: 5/9/2022 2:21 pm
Cost Center Descrip	tion	Adjustments	Net Expenses			97 77 ESEE E. E. F
·		(See A-8)	For Allocation			
		6.00	7. 00			
GENERAL SERVICE COST CENT						
1.00 O0100 NEW CAP REL COSTS-B	LDG & FIXT	0	800, 312			1. 00
5.00 O0500 ADMINISTRATIVE & GE		-197, 188	1, 399, 321			5. 00
INPATIENT ROUTINE SERVICE						
30. 00 03000 ADULTS & PEDIATRICS		-619, 807	4, 899, 283			30.00
41. 00   04100   SUBPROVI DER - I RF		0	0			41.00
42. 00 04200 SUBPROVI DER		0	0			42. 00
ANCILLARY SERVICE COST CE	NTERS					
57. 00 05700 CT SCAN		0	0			57. 00
58. 00 05800 MAGNETIC RESONANCE		0	0			58. 00
59. 00   05900   CARDI AC CATHETERI ZA	TION	0	0			59. 00
60. 00  06000   LABORATORY		0	0			60.00
60. 01   06001   BLOOD LABORATORY		0	0			60. 01
72. 00   07200   I MPL. DEV. CHARGED	-	0	0			72. 00
73. 00 07300 DRUGS CHARGED TO PA		0	0			73. 00
OUTPATIENT SERVICE COST C						
88.00   08800   RURAL HEALTH CLINIC		0	0			88. 00
89.00 08900 FEDERALLY QUALIFIED	HEALTH CENTER	0	0			89. 00
90. 00  09000  CLI NI C		0	0			90.00
90. 01  09001 DAY TREATMENT		0	0			90. 01
92. 00 09200 OBSERVATION BEDS (N						92. 00
OTHER REIMBURSABLE COST C	ENTERS					
99. 10 09910 CORF		0	0			99. 10
SPECIAL PURPOSE COST CENT						
109.00 10900 PANCREAS ACQUISITIO	l l	0	0			109. 00
110.00 11000 INTESTINAL ACQUISIT	I ON	O	0			110. 00
111.00 11100 I SLET ACQUI SI TI ON		0	0			111. 00
113.00 11300 I NTEREST EXPENSE		0	0			113. 00
118.00 SUBTOTALS (SUM OF L		-816, 995	7, 098, 916			118. 00
NONREI MBURSABLE COST CENT	ERS	1				
194. 00 07950 OP AND RC		0	5, 902, 709			194. 00
200.00 TOTAL (SUM OF LINES	118 through 199)	-816, 995	13, 001, 625			200. 00

Health Financial Systems RECLASSIFICATIONS RIVER BEND HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-4005 Peri od: From 01/01/2021 To 12/31/2021 Worksheet A-6 Date/Time Prepared: 5/9/2022 2:21 pm Increases Cost Center Li ne # Sal ary 0ther 5.00 2. 00 3.00 4.00 A - DEFAULT 1.00 0.00 1.00 500.00 Grand Total: Increases 500.00

Health Financial Systems RECLASSIFICATIONS RIVER BEND HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-4005 Peri od: From 01/01/2021 To 12/31/2021 Worksheet A-6 Date/Time Prepared: 5/9/2022 2:21 pm Decreases Wkst. A-7 Ref. 10.00 Cost Center Li ne # Sal ary 0ther 9. 00 6. 00 7.00 8.00 A - DEFAULT 1.00 0.00 1.00 500.00 Grand Total: Decreases 500.00

					Fro To	om 01/01/2021 12/31/2021	Part I Date/Time Pre 5/9/2022 2:21	pm
				Acqui si ti ons	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	4, 760, 955	0		0	O	0	1. 00
2.00	Land Improvements	0	0		0	0	0	2. 00
3.00	Buildings and Fixtures	0	1, 750		0	1, 750	0	3.00
4.00	Building Improvements	13, 310, 235	1, 237, 882		0	1, 237, 882	0	4.00
5.00	Fi xed Equipment	6, 612	0		0	0	0	5.00
6.00	Movable Equipment	906, 237	84, 026		0	84, 026	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8. 00	Subtotal (sum of lines 1-7)	18, 984, 039	1, 323, 658		0	1, 323, 658	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	18, 984, 039	1, 323, 658		0	1, 323, 658	0	10.00
		Endi ng Bal ance	Ful I y					
			Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	4, 760, 955	0					1. 00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	1, 750	0					3.00
4.00	Building Improvements	14, 548, 117	0					4.00
5.00	Fi xed Equipment	6, 612	0					5.00
6.00	Movable Equipment	990, 263	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	20, 307, 697	0					8.00
9.00	Reconciling Items	0	0					9.00
10. 00	Total (line 8 minus line 9)	20, 307, 697	0					10.00

Heal th	Financial Systems	RIVER BEND	HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021		pared:	
			SL	JMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	800, 312	0		0 0	0	1. 00	
3.00	Total (sum of lines 1-2)	800, 312	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM						
1. 00	NEW CAP REL COSTS-BLDG & FIXT	0	800, 312				1. 00	
3. 00	Total (sum of lines 1-2)	0	800, 312				3. 00	

Health Financial Systems	RIVER BEND	HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				From 01/01/2021 To 12/31/2021	Part III   Date/Time Prep	pared:
					5/9/2022 2: 21	
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi talized	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col.			
			2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FLXT	20, 306, 390	l e	20, 306, 390			1. 00
3.00 Total (sum of lines 1-2)	20, 306, 390		20, 306, 390			3. 00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	/ 00	d Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	ENTERS			800, 312	0	1. 00
3.00 Total (sum of lines 1-2)	0	0		800, 312		3. 00
3.00   Total (Suill Of Titles 1-2)	0	<u> </u>	I JMMARY OF CAPI		U	3.00
		30	JIVIIVIART OF CAFT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	`	-	800, 312	1. 00
3.00  Total (sum of lines 1-2)	0	0	(	0	800, 312	3. 00

Health Financial Systems RIVER BEND HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-4005 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/9/2022 2: 21 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 REL COSTS-BLDG & FLXT (chapter IFI XT 2.00 Investment income - CAP REL 0 \*\*\* Cost Center Deleted \*\*\* 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 (chapter 2) Trade, quantity, and time 4.00 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of -4, 927 ADMINISTRATIVE & GENERAL 5.00 В expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 0.00 7 00 Tel ephone servi ces (pay 0.00 stations excluded) (chapter 8.00 Television and radio service 0.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 -619, 807 10.00 Provi der-based physician A-8-2

Health Financial Systems		RIVER BEND	HOSPI TAL	In Li€	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-4005	Peri od:	Worksheet A-8		
				From 01/01/2021 To 12/31/2021			
			Expense Classification o				
			To/From Which the Amount is	s to be Adjusted			
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
· ·	1.00	2.00	3. 00	4. 00	5. 00		
33. 00 HAF OFFSET	А	-106, 389	ADMINISTRATIVE & GENERAL	5.00	0	33. 00	
33. 01 PUBLIC RELATIONS	A	-62, 203	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01	
33. 02 DEPOSIT PAYBACK	A	-18, 049	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02	
50.00 TOTAL (sum of lines 1 thru 49)		-816, 995				50.00	
(Transfer to Worksheet A,							
column 6, line 200.)							
(1) Description - all chapter referen		lumn pertain to	CMS Pub. 15-1.				
(2) Basis for adjustment (see instruc							
A. Costs - if cost, including appli			ni ned.				
B. Amount Received - if cost cannot							
(3) Additional adjustments may be mad							
Note: See instructions for column 5	referencing to	worksneet A-7.					

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-4005

					-	Го 12/31/2021	Date/Time Pre 5/9/2022 2: 21	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	619, 807	619, 807				1. 00
2.00	0. 00		0	0	-			2. 00
3.00	0. 00		0	0	_	_		3. 00
4.00	0. 00		0	0	C	١	0	4. 00
5.00	0. 00		0	0	C	0	0	5. 00
6.00	0. 00		0	0	C	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8.00	0.00		0	0		0	0	8. 00
9.00	0.00		0	0		0	0	9. 00
10.00	0. 00		(40.007	(40.007		0	0	10.00
200.00	WI+ A I : "	C+ C+ (Db	619, 807				0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of	Cost of Memberships &	Provider Component	Physician Cost of Malpractice	
		rdentifier	LIIIII	Limit	Continuing	Share of col.	Insurance	
				LIIIII	Education	12	Trisui ance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	0.00	7.00				1. 00
2. 00	0.00		0	0	-			2. 00
3.00	0.00			Ö	-			3. 00
4. 00	0.00		0	0	_	0	o o	4. 00
5. 00	0.00		0	Ö	O.	l o	0	5. 00
6.00	0.00		0	0	C	0	0	6. 00
7. 00	0.00		0	0	C	0	0	7. 00
8.00	0.00		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 #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0		_			1. 00
2.00	0.00		0	0	-	1		2. 00
3.00	0. 00		0	0	_	1		3. 00
4.00	0.00		0	0	-	0		4. 00
5.00	0.00		0	0	_	0		5. 00
6.00	0.00		0	0	-	0		6. 00
7.00	0.00		0	0	_	0		7. 00
8.00	0.00			0		0		8. 00
9.00	0.00			0	_	0		9. 00
10.00	0. 00			0				10.00
200.00	l l		0	0	C	619, 807		200. 00

Health Financial Systems	RIVER BEND H	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/9/2022 2:21	pared:
Cost Center Description	Net Expenses for Cost	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	ADMI NI STRATI VE & GENERAL	Subtotal	

				''	0 12/31/2021	5/9/2022 2: 21	
	·		CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	Subtotal	ADMI NI STRATI VE	Subtotal	
		for Cost	FLXT		& GENERAL		
		Allocation					
		(from Wkst A					
		col. 7)					
		0	1. 00	1A	5. 00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	800, 312	800, 312				1. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 399, 321	60, 569	1, 459, 890	1, 459, 890		5. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	4, 899, 283	459, 593	5, 358, 876	677, 834	6, 036, 710	30. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	l ol	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	o	0	42.00
	ANCILLARY SERVICE COST CENTERS		-		-1		1
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	أم	0	59. 00
60.00	06000 LABORATORY	0	17	17	2	19	
60. 01	06001 BLOOD LABORATORY	0	17			19	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	17			19	
70.00	OUTPATIENT SERVICE COST CENTERS		17			17	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89. 00
90.00	09000 CLI NI C	0	0	0		0	90.00
90. 01	09001 DAY TREATMENT	0	0	0	0	0	90. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		J	0	Ĭ	O	92.00
72.00	OTHER REIMBURSABLE COST CENTERS			0			72.00
99 10	09910 CORF	0	0	0	ol	0	99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	0	<u> </u>	0	<u> </u>		77.10
109 00	10900 PANCREAS ACQUISITION	0	0	0	ام	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100 I SLET ACQUI SI TI ON	0	0	0			111.00
	11300   NTEREST EXPENSE		U	0	٥	U	113.00
118.00		7 000 01/	520, 213	6, 818, 817	477 040	4 024 747	
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	7, 098, 916	520, 213	0, 818, 817	677, 840	6, 036, 767	1118.00
104 00	NONREI MBURSABLE COST CENTERS 07950 OP AND RC	F 000 700	200,000	/ 102 000	702.050	/ O/ 4 OF O	104 00
		5, 902, 709	280, 099	6, 182, 808	782, 050		200. 00
200.00				0			
201.00	1 3	12 001 (25	000 212	12 001 /25	1 450 000		201. 00
202.00	TOTAL (sum lines 118 through 201)	13, 001, 625	800, 312	13, 001, 625	1, 459, 890	13, 001, 625	J2U2. UU

Health Financial Systems	HOSPI TAL		In Lie	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-4005		Worksheet B Part I Date/Time Pre 5/9/2022 2:21	pared:
Cost Center Description	Intern & Resi dents Cost & Post Stepdown Adjustments	Total				
CENEDAL SERVICE COST CENTERS	25. 00	26. 00				
GENERAL SERVICE COST CENTERS  1 00 00100 NEW CAP REL COSTS-BLDG & FLXT			I			1 00

	Cost Center Description	Intern &	Total	
		Residents Cost		
		& Post		
		Stepdown		
		Adjustments		
		25. 00	26. 00	
	GENERAL SERVICE COST CENTERS	,		4
1.				1. 00
5.				5. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			4
	.00 03000 ADULTS & PEDIATRICS	0	6, 036, 710	30. 00
	. 00   04100   SUBPROVI DER - I RF	0	0	41. 00
42	. 00 04200 SUBPROVI DER	0	0	42. 00
	ANCILLARY SERVICE COST CENTERS			4
	.00 05700 CT SCAN	0	0	57. 00
	.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58. 00
	. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	59. 00
	. 00   06000   LABORATORY	0	19	60. 00
	.01 06001 BLOOD LABORATORY	0	19	60. 01
	.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72. 00
73	.00 07300 DRUGS CHARGED TO PATIENTS	0	19	73. 00
	OUTPATIENT SERVICE COST CENTERS			4
	.00 08800 RURAL HEALTH CLINIC	0	0	88. 00
	.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89. 00
	. 00   09000   CLI NI C	0	0	90. 00
	.01 09001 DAY TREATMENT	0	0	90. 01
92	.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		92. 00
	OTHER REIMBURSABLE COST CENTERS	,		4
99	. 10 09910 CORF	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS			4
	9.00 10900 PANCREAS ACQUISITION	0	0	109. 00
	0.00 11000 INTESTINAL ACQUISITION	0	0	110. 00
	1.00 11100 I SLET ACQUI SI TI ON	0	0	111. 00
	3.00 11300 INTEREST EXPENSE			113. 00
11	8.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 036, 767	118. 00
	NONREI MBURSABLE COST CENTERS			4
	4.00 07950 OP AND RC	0	6, 964, 858	194. 00
	0.00 Cross Foot Adjustments	0	0	200. 00
	1.00 Negative Cost Centers	0	0	201. 00
20	2.00 TOTAL (sum lines 118 through 201)	0	13, 001, 625	202. 00

ALLUCA	TITON OF CAPITAL RELATED COSTS		Provider Co	F	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/9/2022 2:21	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	ADMINISTRATIVE & GENERAL	Subtotal	
		0	1.00	2A	5. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	60, 569	60, 569	60, 569		5. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1	450 500	150 500			
30.00	03000 ADULTS & PEDI ATRI CS	0	459, 593	l		487, 716	1
41. 00	04100 SUBPROVI DER - I RF	0	0	1	-1	0	
42. 00	04200 SUBPROVI DER	0	0		) 0	0	42. 00
F7 00	ANCILLARY SERVICE COST CENTERS  05700 CT SCAN					0	F7 00
57. 00 58. 00	05700  CT SCAN   05800  MAGNETIC RESONANCE IMAGING (MRI)	0	0	· ·		0	
59.00	05900 CARDI AC CATHETERI ZATI ON		0			0	
60.00	06000 LABORATORY		17	17	,	17	
60. 01	06001 BLOOD LABORATORY		17			17	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	l	1	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		17		1	17	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			٩	1,	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	o	0	89. 00
90.00	09000 CLI NI C	0	0	C	o	0	90.00
90. 01	09001 DAY TREATMENT	o	0	C	o	0	90. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			C			92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	C	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	C	0		109. 00
	11000   NTESTINAL ACQUISITION	0	0	0	0		110.00
	11100   SLET ACQUI SI TI ON	O	0			0	111.00
	11300 INTEREST EXPENSE		F20 212	F20 212	20 122	407 7/7	113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	l O	520, 213	520, 213	28, 123	487, 767	1118.00
104 00	07950 OP AND RC		280, 099	280, 099	32, 446	312, 545	104 00
200.00	1 1	١	200, 077	200, 099	32, 440		200. 00
200.00	1 1		0				201. 00
202.00		0	800, 312	800, 312	60, 569	800, 312	
202.00	1.0 (Sum 111105 110 tim Sugit 201)	١	000, 012	1 000, 012	., 55, 567	000, 012	1-32. 00

Heal th	Financial Systems	RI VER BEND	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	CCN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/9/2022 2:21	pared: _pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	OFNEDAL CEDIU OF COCT OFNEDO	25. 00	26. 00				
1.00	GENERAL SERVICE COST CENTERS  00100 NEW CAP REL COSTS-BLDG & FIXT  00500 ADMINISTRATIVE & GENERAL						1. 00 5. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
	03000 ADULTS & PEDI ATRI CS	0	487, 7	•			30.00
	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0		0			41. 00 42. 00
	ANCILLARY SERVICE COST CENTERS						
	05700 CT SCAN	0		0			57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0			58. 00
	05900 CARDI AC CATHETERI ZATI ON	0		0			59. 00
	06000 LABORATORY	0		17			60.00
	06001 BLOOD LABORATORY	0		17			60. 01
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0		17			73. 00
	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC						88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0			89.00
	09000 CLINIC						90.00
	09001 DAY TREATMENT						90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00

0

0

0 0 0

0

0

0

0

0

487, 767

312, 545

800, 312

99. 10

109. 00

110. 00

111. 00

113. 00

118. 00

194. 00

200. 00

201. 00

202. 00

200.00

201.00

202.00

99. 10 09910 CORF

SPECIAL PURPOSE COST CENTERS

109. 00 10900 PANCREAS ACQUISITION

110.00 11000 INTESTINAL ACQUISITION

111.00 11100 I SLET ACQUISITION

194.00 07950 OP AND RC

113.00 11300 INTEREST EXPENSE
118.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS

TOTAL (sum lines 118 through 201)

Cross Foot Adjustments

Negative Cost Centers

OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	RIVER BEND HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der C	F	Period: From 01/01/2021		
			Го 12/31/2021	Date/Time Pre 5/9/2022 2:21	
		CAPITAL RELATED COSTS			
Cost Center Description		NEW BLDG &	Reconciliation	ADMI NI STRATI VE	
		FLXT		& GENERAL	
		(SQUARE		(ACCUM.	
		FEET)		COST)	
		1.00	5A	5. 00	

			CAPI TAL		07 77 2022 2.21	<b>5</b>
	Cook Cooker Doorwinting		ELATED COSTS	D!!!-#!	ADMINI CTDATIVE	
	Cost Center Description		NEW BLDG & FLXT	Reconciliation	& GENERAL	
			(SQUARE		(ACCUM.	
			FEET)		COST)	
			1. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS	I	1.00	571	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		45, 916			1. 00
5.00	00500 ADMINISTRATIVE & GENERAL		3, 475	-1, 459, 890	11, 541, 735	5. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS		26, 368	0	5, 358, 876	30.00
41.00	04100 SUBPROVI DER - I RF		0	0	0	41.00
42.00	04200 SUBPROVI DER		0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS					
57.00	05700  CT   SCAN		0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0	0	58. 00
59. 00	05900  CARDI AC CATHETERI ZATI ON		0	0	0	59. 00
60.00	06000 LABORATORY		1	0	17	60.00
60. 01	06001 BLOOD LABORATORY		1	0	17	60. 01
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS		1	0	17	73.00
	OUTPAȚI ENT SERVI CE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89. 00
90.00	09000 CLI NI C		0	0	0	90.00
90. 01	09001 DAY TREATMENT		0	0	0	90. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	OTHER REIMBURSABLE COST CENTERS		_	_1		
99. 10	09910 CORF		0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS		_	_1	_	
	10900 PANCREAS ACQUISITION		0	0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON		0	0		110.00
	11100   SLET ACQUI SI TI ON		0	0	-	111. 00
	11300 I NTEREST EXPENSE		00.047	4 450 000		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS		29, 846	-1, 459, 890	5, 358, 927	118.00
194 00	07950 OP AND RC		16, 070	0	6, 182, 808	194 00
200.00			10, 070	J		200. 00
201.00						201. 00
202.00			800, 312		1, 459, 890	
203.00			17. 429915		0. 126488	
204.00			17. 72,713		60, 569	
205.00					0. 005248	
206. 00						206. 00
207. 00						200.00
207.00	man and cook man experien (moc. b, railto ill and iv)			'	· ·	

Health Financial Systems	RI VER BEND	HOSF	PI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		F	Provi der CC	CN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/9/2022 2:21	
			Title	XVIII	Hospi tal	PPS	
					Costs		
0 1 0 1 5 1 11	T	۱	[	T	505	T	

					10 12/31/2021	5/9/2022 2: 21	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	6, 036, 710		6, 036, 71	0	6, 036, 710	30. 00
		0			0	0	41.00
42.00	04200 SUBPROVI DER	0			0 0	0	42. 00
	ANCILLARY SERVICE COST CENTERS						
	05700 CT SCAN	0			0	0	07.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60.00	06000 LABORATORY	19		1	9 0	19	60.00
60. 01	06001 BLOOD LABORATORY	19		1	9 0	19	60. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	19		1	9 0	19	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00	09000 CLI NI C	0			0	0	90. 00
90. 01	09001 DAY TREATMENT	0			0	0	90. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 077		2, 07	7	2, 077	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0			0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0			0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0			0	0	110. 00
111.00	11100  SLET ACQUISITION	0			0	0	111. 00
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	6, 038, 844	0	6, 038, 84	4 0	6, 038, 844	200. 00
201.00	Less Observation Beds	2, 077		2, 07	7	2, 077	201. 00
202.00	Total (see instructions)	6, 036, 767	0	6, 036, 76	7 0	6, 036, 767	202. 00

Health Financial Systems	RIVER BEND	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-4005	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/9/2022 2:21	pared:
			: XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 889, 600		3, 889, 60	00		30. 00
41. 00   04100   SUBPROVI DER - I RF	0			0		41. 00
42. 00 04200 SUBPROVI DER	0			0		42. 00
ANCILLARY SERVICE COST CENTERS						
57. 00   05700 CT SCAN	0	0		0. 000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000		
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0. 000000		
60. 00  06000   LABORATORY	0	0	)	0. 000000		
60. 01  06001 BL00D LABORATORY	0	0	)	0. 000000		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0. 000000	l e	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	)	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	)	0		89. 00
90. 00  09000  CLI NI C	0	0	)	0. 000000		
90. 01  09001 DAY TREATMENT	0	0	)	0. 000000		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 340	1, 34	1. 550000	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS	,					
99. 10 09910 CORF	0	0		0		99. 10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	)	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	)	0		110. 00
111.00 11100 I SLET ACQUISITION	0	0	1	0		111. 00
113.00 11300 INTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	3, 889, 600	1, 340	3, 890, 94	10		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	3, 889, 600	1, 340	3, 890, 94	10		202. 00

Heal th Financial Systems RIVER BEND HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-4005 From 01/01/2021 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

			10 12/31/2021	5/9/2022 2:21 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
41. 00   04100   SUBPROVI DER -   RF				41. 00
42. 00   04200   SUBPROVI DER				42. 00
ANCILLARY SERVICE COST CENTERS				57.00
57. 00   05700   CT   SCAN	0. 000000			57. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0. 000000			73. 00
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00   09000   CLINIC	0. 000000			90.00
90. 01   09001 DAY TREATMENT	0. 000000			90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 550000			92.00
OTHER REIMBURSABLE COST CENTERS	1. 330000			72.00
99. 10 09910 CORF				99, 10
SPECIAL PURPOSE COST CENTERS				77.10
109. 00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110. 00
111.00 11100   SLET ACQUISITION				111.00
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	RIVER BEND I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/9/2022 2:21	
		Ti tl	e XIX	Hospi tal	Cost	
-				Cocts	·	

				-	To 12/31/2021	Date/Time Pre 5/9/2022 2:21	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26) 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	6, 036, 710		/ 02/ 71/		6, 036, 710	30.00
	04100 SUBPROVIDER - IRF	0, 030, 710		6, 036, 71	0	0, 036, 710	41.00
		U			0	_	
42.00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	l o			0 0	0	42. 00
57. 00	05700 CT SCAN			1	0 (	0	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58.00
	05900 CARDIAC CATHETERIZATION	0				0	59.00
	06000 LABORATORY	19		1		19	60.00
	06001 BLOOD LABORATORY	19		1		19	
	07200 I MPL. DEV. CHARGED TO PATIENTS	17		i	0 0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	19		1	-	_	
73.00	OUTPATIENT SERVICE COST CENTERS	17		1.	9  0	17	73.00
88 00	08800 RURAL HEALTH CLINIC	O		I	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER					o o	89. 00
	09000 CLINIC					,	90.00
	09001 DAY TREATMENT					o o	90. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 077		2, 07	7	2, 077	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	2,0,,		2,0.	•	2,0,,	72.00
99. 10	09910 CORF	0			O	0	99. 10
	SPECIAL PURPOSE COST CENTERS	'		•	•		
109.00	10900 PANCREAS ACQUISITION	0			o	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	o			0	0	110. 00
111.00	11100 ISLET ACQUISITION	o			0	0	111. 00
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		6, 038, 844	0	6, 038, 84	4 0	6, 038, 844	200.00
201.00	Less Observation Beds	2,077		2, 07	7	2, 077	201. 00
202.00	Total (see instructions)	6, 036, 767	0	6, 036, 76	7 0	6, 036, 767	202. 00
				•	•	•	•

Health Financial Systems	RIVER BEND	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/9/2022 2:21	
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	3, 889, 600		3, 889, 60	0		30.00
41. 00   04100   SUBPROVI DER - I RF	0			0		41. 00
42. 00 04200 SUBPROVI DER	0			0		42. 00
ANCILLARY SERVICE COST CENTERS						1
57. 00 05700 CT SCAN	0	0		0. 000000	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000	0. 000000	
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	
60. 00   06000   LABORATORY	0	0	)	0. 000000	0. 000000	
60. 01   06001   BL00D   LABORATORY	0	0	)	0. 000000	0. 000000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0. 000000	0. 000000	1
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	)	0. 000000	0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0. 000000	0. 000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	)	0. 000000	0. 000000	
90. 00   09000   CLI NI C	0	0	)	0. 000000	0. 000000	
90. 01   09001   DAY TREATMENT	0	0		0. 000000	0. 000000	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 340	1, 34	0 1. 550000	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS						1
99. 10 09910 CORF	0	0	)	0		99. 10
SPECIAL PURPOSE COST CENTERS						1
109.00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	)	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		0		111. 00
113.00 11300 INTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	3, 889, 600	1, 340	3, 890, 94	0		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	3, 889, 600	1, 340	3, 890, 94	0		202. 00

Health Financial Systems RIVER BEND HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-4005 | Period: From 01/01/2021 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

			To 12/31/2021	Date/Time Prepared: 5/9/2022 2:21 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
41. 00   04100   SUBPROVI DER - I RF				41.00
42. 00   04200   SUBPROVI DER				42.00
ANCILLARY SERVICE COST CENTERS				
57. 00   05700   CT   SCAN	0. 000000			57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 000000			60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000			60. 01
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			
88. 00   08800   RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00   09000   CLI NI C	0. 000000			90.00
90. 01   09001   DAY TREATMENT	0. 000000			90. 01
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
99. 10   09910   CORF				99. 10
SPECIAL PURPOSE COST CENTERS  109.00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON				110, 00
111.00 11100 ISLET ACQUISITION				111.00
113. 00 11300   NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201. 00 Less Observation Beds				201. 00
202.00 Total (see instructions)				201.00
202. 00   Total (See Histiactions)	1			1202.00

Heal th	Financial Systems	RI VER BEND	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2021	Worksheet D Part I	
					To 12/31/2021		pared:
						5/9/2022 2: 21	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col . 1 - col			
		26)	0.00	2)	4.00	F 00	
	LADATIENT DOUTLAG CEDVI OF COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	107.747		107.74		4/7.00	00.00
30.00	ADULTS & PEDI ATRI CS	487, 716	0	487, 71	6 2, 906	l .	•
41. 00	SUBPROVIDER - I RF	0	0		0	0.00	1
42.00	SUBPROVI DER	107.71	0	407.74	0	0.00	1
200.00	Total (lines 30 through 199)	487, 716		487, 71	6 2, 906		200. 00
	Cost Center Description	I npati ent	Inpatient				
		Program days	Program				
			Capital Cost (col. 5 x col.				
			6)				
		6. 00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00	ADULTS & PEDI ATRI CS	320	53, 706				30.00
41. 00	SUBPROVI DER - I RF	0	00,700				41. 00
42. 00	SUBPROVI DER		1				42. 00
	Total (lines 30 through 199)	320	53, 706				200. 00
200.00	1.2.2. (	1 020	1 55,700	1			

Heal th	Financial Systems	RI VER BEND	HOSE	I TAL		In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	F	Provider C	CN: 15-4005	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/9/2022 2:21	
					XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos	st Inpatient	Capital Costs	
		Related Cost					(column 3 x	
		(from Wkst. B,	Par	t I, col.	(col. 1 ÷ co	I. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1.00		2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
57.00	05700  CT SCAN	0		0	0.0000	00 0	0	57. 00
58.00	05800   MAGNETIC RESONANCE   MAGING (MRI)	0		0	0.0000	00 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		O	0.0000	00 0	0	59. 00
60.00	06000 LABORATORY	17		0	0.0000	00 0	0	60.00
60. 01	06001 BLOOD LABORATORY	17		0	0.0000	00 0	0	60. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0.0000	00 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	17		0	0.0000	00 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		О	0.0000	00 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.0000	00 0	0	89. 00
90.00	09000 CLI NI C	0		0	0.0000	00 0	0	90.00
90. 01	09001 DAY TREATMENT	0		0	0.0000	00 0	0	90. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	168		1, 340	0. 1253	73 0	0	92. 00
200.00	,	219		1, 340	1	0	0	200. 00

Health Financial Systems	RIVER BEND	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COST			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/9/2022 2:21	pared:
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
41. 00   04100   SUBPROVI DER -   RF	o	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	o	0		0	0	42.00
200.00 Total (lines 30 through 199)	o	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	*		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	2, 90	6 0.00	320	30.00
41. 00   04100   SUBPROVI DER -   RF	o	0		0.00	0	41.00
42. 00 04200 SUBPROVI DER	o	0		0.00	0	42.00
200.00 Total (lines 30 through 199)		0	2, 90	6	320	200.00
Cost Center Description	Inpatient			+		
·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
41. 00   04100   SUBPROVI DER -   RF	o					41.00
42. 00   04200   SUBPROVI DER	o					42. 00
200.00 Total (lines 30 through 199)	O					200.00
						•

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS  Provider CCN: 15-4005 From 01/01/2021 To 12/31/2021 For 01/01/2021 To 12/31/2021 From 01/01/2021 To 12/31/2021 From 01/01/2021 From 01/01/2021 To 12/31/2021 From 01/01/2021	
Title XVIII Hospital PPS	
Cost Center Description  Non Physician Nursing Program Post-Stepdown Adjustments  Non Physician Nursing Program Post-Stepdown Adjustments	
1.00 2A 2.00 3A 3.00	
ANCILLARY SERVICE COST CENTERS	
	57. 00
	8. 00
	9. 00
	60.00
	60. 01
	72. 00
	73. 00
OUTPATLENT SERVICE COST CENTERS	
	38. 00
	39. 00
	90.00
	90. 01
	92. 00 00. 00

Health Financial Systems	RIVER BEND	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021		nared·
				12/01/2021	5/9/2022 2: 21	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4. 00	5. 00	6.00		instructions)	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7. 00	8. 00	
57. 00 05700 CT SCAN			I		0. 000000	57. 00
58. 00   05700   CT   SCAN 58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0		0	0.00000	
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0		0	0.00000	
60. 00   06000   LABORATORY	0	0		0	0. 000000	
60. 01   06001 BLOOD LABORATORY	0	0		0	0. 000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0.000000	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	o o	0		0	0. 000000	
OUTPATIENT SERVICE COST CENTERS				<u> </u>	0.000000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0.000000	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0. 000000	
90. 00 09000 CLI NI C	0	0		0 0	0.000000	
90. 01 09001 DAY TREATMENT	0	0		0 0	0. 000000	90. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 340	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 1, 340		200. 00

Heal th	Financial Systems	RIVER BEND	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der C	CN: 15-4005	Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/9/2022 2:21	
			Ti tl e	· XVIII	Hospi tal	PPS	рш
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	300 t 30.1101 20001 Pt 10.1	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	3	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	)	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	)	0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	0	)	0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	)	0 0	0	60. 01
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	)	0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	1	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	1	0	0	89. 00
90.00	09000  CLI NI C	0. 000000	0	1	0	0	90.00
90. 01	09001 DAY TREATMENT	0. 000000	0	1	0	0	90. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	1	0	0	92. 00
200.00	Total (lines 50 through 199)		O	l .	0 0	0	200. 00

Health Financial Systems	RIVER BEND HO	OSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OF	PERATING COST	Provi der CCN: 15-4005		Worksheet D-1 Date/Time Prepared: 5/9/2022 2: 21 pm
•		Title XVIII	Hosni tal	PPS

District All Products Code National Section (1992) and the state of th			Title XVIII	Hospi tal	5/9/2022 2: 21 PPS	pm
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description		,	'	
Inpattient days (Including private room days and sening-bed days, excluding newborn)   2,006   1.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding swing-bed and newborn days)   17 you have only private room days (occluding swing-bed and observation bed days)   17 you have only private room days (or only private room days)   3.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do complete this line.  Semi-private room days (excluding swing-bed and observation bed days). Provide room days of the cost complete this line.  Semi-private room days (excluding swing-bed and observation bed days). Through December 31 of the cost cost cost cost cost cost cost cost			,		· ·	
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22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  37.00 Private room cost differential adjustment (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21. 00	' " "	5)		6, 036, 710	21. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room Charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room cost differential (line 32 minus line 23)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 35 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 38 x line 31)  30.00 Average per diem private room cost differential (line 38 x line 31)  30.00 Average per diem private room cost differential (line 40 x line 38)  30.00 Average per diem private room cost differential (line 38 x line 35)  30.00 Average per diem charge (line 29 x line 38)  30.00 Average per die	22. 00		er 31 of the cost reporti	ng period (line		
x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  PRIVATE room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Average private room per diem charge (line 27 + line 28)  Average per diem private room per diem charge (line 30 + line 4)  Average semi-private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 3 x line 31)  Private room cost differential adjustment (line 3 x line 31)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 036, 710)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjus	22 00	· · · · · · · · · · · · · · · · · · ·	21 of the cost reporting	noried (line 6	0	22 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6,036,710 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 Average private room per diem charge (line 29 + line 3) 0.00 32.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 7) 0.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 7) 0.00 37.00 General inpatient routine service cost per diem (see instructions) 2,077.33 38.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,077.33 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	23.00		31 of the cost reporting	g perrou (Trile 6	U	23.00
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 32 minus line 31)  30. 00 Average per diem private room cost differential (line 32 minus line 31)  30. 00 Average per diem private room cost differential (line 32 minus line 31)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 01 Average per diem private room cost differential (line 32 minus line 33)  30. 01 Average per diem private room cost differential (line 32 minus line 33)  30. 01 Average per diem private room cost differential (line 32 minus line 33)  30. 01 Average per diem private room cost differential (line 32 minus line 33)  30. 01 Average per diem private room cost differential (line 32 minus line 33)  30. 01 Average per diem private r	24. 00	] 3 11 31	31 of the cost reporti	ng period (line	0	24. 00
x line 20)  26. 00  27. 00  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  O Average inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 036, 071)  Average line 10 patient routine service cost net of swing-bed cost and private room cost differential (line 6, 036, 710)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differen	25. 00	,	31 of the cost reporting	period (line 8	0	25. 00
27. 00    Conceral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   6,036,710     PRIVATE ROOM DIFFERENTIAL ADJUSTMENT     Conceral inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00     Private room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-private room charges (excluding swing-bed charges)   0   30. 00     General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0.000000     31. 00   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0.000000     33. 00   Average private room per diem charge (line 30 ÷ line 4)   0.00   32. 00     34. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0.00   34. 00     35. 00   Average per diem private room cost differential (line 34 x line 31)   0.00   35. 00     36. 00   Private room cost differential adjustment (line 3 x line 35)   0   36. 00     37. 00   Conceral inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)   0.00     PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   0.00   0.00   0.00   0.00     38. 00   Adjusted general inpatient routine service cost per diem (see instructions)   0.00		x line 20)		(		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 6, 036, 710)  31.00 Average per diem private room cost differential (line 6, 036, 710)  32.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 036, 710)  32.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 036, 710)  33.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 036, 710)  34.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 036, 710)  35.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 036, 710)  35.00 Average per diem private room cost net of swing-bed cost and privat		, ,	(1: 04 : 1: 04)			
28. 00 29. 00 29. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 30	27.00		(Tine 21 minus Tine 26)		6, 036, 710	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 and 1)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 29.00 30.00 0.00 30.00 0.00 31.00 0.00 32.00 0.00 0	28. 00		and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 000 000 000 000 000 000 000 000 0	29. 00					29. 00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36.00 0						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 and 0)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  37.00 36.00  9.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			: line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  0.00 35.00  0.00 35.00  0.00 36.00  37.00  2.077.33 38.00  0.00 36.						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 35.00  0.00 36.00  37.00 27 minus line 36)  0.00 40.00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 036, 710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 6, 036, 710 37.00 37				tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,036,710 2,7 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  6,036,710 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,710 37.00 6,036,71		, , , , , , , , , , , , , , , , , , , ,	ie 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 077. 33 38.00 Program general inpatient routine service cost (line 9 x line 38) 664, 746 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and anivota reem east 10	Fforontial (1:		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,077.33 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00		and private room cost di	rrerentiai (iine	6, 036, 710	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  2,077.33 38.00  39.00 40.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 664,746 39.00 40.00			JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38.00	Adjusted general inpatient routine service cost per diem (see	instructions)		2, 077. 33	38. 00
	39. 00	9 9	•			
41.00   Iotal Program general inpatient routine service cost (line 39 + line 40)   664,746   41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41. 00	lotal Program general inpatient routine service cost (line 39	+ IIne 40)		664, 746	41.00

	Financial Systems	RIVER BEND I				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	pared:
			Title	e XVIII	Hospi tal	5/9/2022 2: 21 PPS	pm
	Cost Center Description	Total Inpatient Costl	Total	Average Pei	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 0
46. 00	SURGICAL INTENSIVE CARE UNIT						46.0
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 0
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			`			48. 0
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	see instructio	ons)		664, 746	49.0
50. 00	Pass through costs applicable to Program inc	patient routine s	services (from	n Wkst. D, su	m of Parts I and	53, 706	50.0
					6.5		
51. 00	Pass through costs applicable to Program inpland IV)	oatient ancillary	/ services (fr	om Wkst. D,	sum of Parts II	0	51.0
52. 00	Total Program excludable cost (sum of lines	50 and 51)				53, 706	52. 0
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	611, 040	53. 0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54. 00	Program di scharges					0	
55.00	Target amount per discharge						55.0
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	rget amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	and tar	got amount (.		55)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	endi ng 1996, ເ	updated and c	ompounded by the	0. 00	59. 0
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	dated by the m	narket hasket		0.00	60.0
61. 00						0.00	1
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% o	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				n	62. 0
63. 00		nent (see instruc	ctions)			-	63. 0
, ,	PROGRAM I NPATIENT ROUTI NE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decem	nber 31 of the	e cost report	ing period (See	0	64. 0
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the d	ost reportin	g period (See	0	65. 0
44 00	instructions) (title XVIII only)	no costo (lino 4	4 plus lips 4	E) (+; +  o V//	II only) For	0	66.0
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	THE COSTS (TITLE O	94 prus rine (	os)(title xvi	ii diliy). Foi	0	00.0
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 d	of the cost r	eporting period	0	67. 0
68. 00	(line 12 x line 19)	no costs after Do	ocombor 21 of	the cost ron	orting poriod	0	68. 0
00.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ie costs arter be	ecember 31 01	the cost rep	of tring period		00.0
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)		70. 0
71. 00	Adjusted general inpatient routine service of				,		71. 0
72. 00	Program routine service cost (line 9 x line	•	<i>(</i> 1)	05)			72. 0
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.0
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 0
	26, line 45)		`				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 0 77. 0
78. 00	Inpatient routine service cost (line 74 minu						78. 0
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pr		*.			79. 0
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	n (line 78 mi	nus line 79)		80.0
82.00	Inpatient routine service cost per drem from		)				82. 0
83. 00	Reasonable inpatient routine service costs (	see instructions					83. 0
84.00	Program inpatient ancillary services (see in		ne)				84.0
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
	Total observation bed days (see instructions	5)				1	87.0
87. 00 88. 00	,	diam (11: 27	1:00 2)			2, 077. 33	00 0

Health Financial Systems	RI VER BEND	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/9/2022 2:21	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	487, 716	6, 036, 710	0. 08079	2, 077	168	90.00
91.00 Nursing Program cost	0	6, 036, 710	0.00000	0 2, 077	0	91.00
92.00 Allied health cost	0	6, 036, 710	0.00000	0 2, 077	0	92.00
93.00 All other Medical Education	0	6, 036, 710	0.00000	0 2,077	0	93.00

Health Financial Systems	RIVER BEND HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-4005	From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/9/2022 2: 21 pm
	Title XIX	Hospi tal	Cost

No.   Part					5/9/2022 2: 21	pm
DART I - ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	Cost	
PART 1 - ALL PROVIDER COMPONENTS   NAMELINE IMPS   PART 1 - ALL PROVIDER COMPONENTS   NAMELINE IMPS   PART 1 - ALL PROVIDER COMPONENTS   2.006   1.00		Cost Center Description				
IMPARTER BAYS		DART I ALL PROMINED COMPONENTS			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
Impatient days (including private room days, excluding safing-bed and nesborn days)   2,906   2,00	1 00		e eveluding newborn)		2 006	1 00
Defivate room days (excluding swing-bed and observation bed days). If you have only private room days, do 0 a.00 do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledary year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledary year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledary year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in patient days) (including private room days) after December 31 of the cost of the cost reporting period (in the world of the private room days) after December 31 of the cost reporting period (in the WIII only (Including private room days) after December 31 of the cost reporting period (in the WIII only (Including private room days) after December 31 of the cost reporting period (in tall will be will b						
do not complete this line.  4. 00 Semi-private room days (excluding swing-bed and observation bed days)  5. 01 Total swing-bed SW type Inpatient days (including private room days) after December 31 of the cost period the private property of the swing-bed SW type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SW type Inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SW type inpatient days (including private room days) by through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SW type inpatient days applicable to this line)  10. 00 Swing-bed SW type inpatient days applicable to the Program (excluding private room days)  10. 00 Swing-bed SW type inpatient days applicable to the SW type inpatient days applicable to swing-bed SW type inpatient			<i>y</i> ,	ivate room days	l	
Semi-private room days (excluding swing-bed and observation bed days)   2,905   4.00	3.00		73). IT you have only pr	vate room days,	l	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost opening period (if cell endar year, enter 0 on this line)	4.00	· ·	ed days)		2. 905	4.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total sing-bed SNF type Inpatient days (including private room days) after December 31 of the cost 1 on the cost 1 on this line) 8.00 Total sing-bed NF type Inpatient days (including private room days) after December 31 of the cost 1 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 177 p.00 newborn days) (see Instructions) 10.00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed and 177 p.00 newborn days) (see Instructions) 11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed NF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed NF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed NF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed NF type Inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed NF type Inpatient days applicable to services through December 31 of the cost 10.00 Swing-bed Sw				r 31 of the cost	l	
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reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to itiles XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to tiltles XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to tiltles XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  13. 00 Swing-bed SNF type inpatient days applicable to tiltles V or XIX only (including private room days) after through December 31 of the cost reporting period (see instructions)  13. 00 Swing-bed NF type inpatient days applicable to tiltles V or XIX only (including private room days) after of through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15. 00 10 10 10 10 10 10 10 10 10 10 10 10		reporting period (if calendar year, enter 0 on this line)				
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reporting period (if calendar year, enter 0 on this line)  10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (cluding private room days) after through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (cluding private room days) after through December 31 of the cost reporting period (see instructions)  13.00 Swing-bed NF type inpatient days applicable to title XVIII only (cluding private room days) through December 31 of the cost reporting period (see instructions)  13.00 Swing-bed NF type inpatient days applicable to titles X or XIX only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Indical nursery days (title Y or XIX only)  17.00 Nursery days (title Y or XIX only)  18.00					_	
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newborn days) (see Instructions)  10.00 Simple-bed SNE type inpatient days applicable to title XVIII only (including private room days)  10.00 Simple-bed SNE type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  12.00 Simple-bed SNE type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (ir calendar year, enter 0 on this line)  13.00 Simple-bed NE type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Simple-bed NE type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost of reporting period of the SNE type services applicable to services after December 31 of the cost of reporting period of reporting period of the symbol services applicable to services after December 31 of the cost of reporting period of reporting period of the symbol services applicable to services after December 31 of the cost of reporting period of reporting period of the symbol services applicable to services after December 31 of the cost of reporting period of reporting period of services applicable to services after December 31 of the cost of reporting period of reporting period of services applicable to services after December 31 of the cost of reporting period (line 6 of reporting period of services applicable to services after December 31 of the cost reporting period (line 6 of reporting period (line 6 of reporting period (line 6 of reporting period (line 8 of reporting p	0.00		the Dreamen (evaluding	owing had and	177	0.00
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31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential dijustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 000 32.00  0.00 32.00  0.00 33.00  0.00 35.00  0.00 35.00  35.00  36.00  37.00 27 minus line 36)  2.077.33 38.00  367,687 39.00					l e	1
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 32.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 36.00			line 28)		<b>l</b>	1
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710 and 0)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  36.00  37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  367,687 39.00		,	F 11116 20)		l e	1
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,036,710)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  0.00 34.00  0.00 35.00  0.00 36.00  37.00  2.077.33  38.00  367,687  39.00					l e	
35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 036, 710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 077. 33 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 367, 687 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00			nus line 33)(see instruc	tions)	l e	
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 036, 710 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 6, 036, 710 37.00 37					l	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 367, 687 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Adjusted general inpatient routine service cost (line 9 x line 38)		,	,		l	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 077. 33 38.00 Program general inpatient routine service cost (line 9 x line 38) 367, 687 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost di	fferential (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,077.33 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)2,077.3338.0039.00Program general inpatient routine service cost (line 9 x line 38)367,68739.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 367, 687 39.00 40.00						
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			*		i .	1
		, , ,	•		l	1
41.00   lotal Program general inpatient routine service cost (line 39 + line 40)   367,687   41.00					l e	1
	41.00	liotal Program general inpatient routine service cost (line 39	+ IINE 4U)		367, 687	41.00

	Financial Systems	RIVER BEND				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-4005	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	pared:
			Ti +I	e XIX	Hospi tal	5/9/2022 2: 21 Cost	pm
	Cost Center Description	Total Inpatient Costl	Total	Average Pei	Program Days	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
.2. 00	Intensive Care Type Inpatient Hospital Units						12.0
43. 00	INTENSIVE CARE UNIT						43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 0
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	, line 200)				48. 0
49. 00	Total Program inpatient costs (sum of lines			ons)		367, 687	49. 0
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	atient routine :	services (from	n Wkst. D. su	m of Parts I and	0	50. 0
			•				
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.0
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52. 0
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anest	hetist, and	0	53. 0
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 0 55. 0
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, i	updated and c	ompounded by the	0.00	59. 0
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the r	narket basket		0.00	60.0
61. 00						0	61. 0
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	rnstructrons)				0	62. 0
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 0
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost report	ing period (See	0	64. 0
0 11 00	instructions)(title XVIII only)	to the ought book		, 0001 . opo. t	9 po ou (000		" "
65. 00	,	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 0
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66.0
	CAH (see instructions)		•				
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost r	eporting period	0	67. 0
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after Do	ecember 31 of	the cost rep	orting period	0	68. 0
	(line 13 x line 20)						
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 0
70. 00	Skilled nursing facility/other nursing facil				)		70.0
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71. 0
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 0 73. 0
74. 00	Total Program general inpatient routine serv						74. 0
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from V	Vorksheet B,	Part II, column		75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 0
77. 00	Program capital-related costs (line 9 x line						77. 0
78. 00 79. 00	Inpatient routine service cost (line 74 minu		rovi don rocces	1e)			78. 0 79. 0
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	nus line 79)		80.0
31. 00	Inpatient routine service cost per diem limi			, , , , - , , , ,	,		81.0
32.00	Inpatient routine service cost limitation (I						82. 0
33. 00 34. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		5)				83. 0 84. 0
85. 00	Utilization review - physician compensation		ns)				85. 0
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 0
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions					1	87. 0
07.00	Adjusted general inpatient routine cost per	•	line 2)			2, 077. 33	
88. 00	That asted general impatrent routine cost per						

Health Financial Systems	RI VER BEND	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/9/2022 2:21	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C	COST					
90.00 Capital -related cost	487, 716	6, 036, 710	0. 08079	2, 077	168	90.00
91.00 Nursing Program cost	0	6, 036, 710	0.00000	0 2, 077	0	91.00
92.00 Allied health cost	0	6, 036, 710	0.00000	0 2, 077	0	92.00
93.00 All other Medical Education	0	6, 036, 710	0. 00000	0 2, 077	0	93. 00

Heal th	Financial Systems	RIVER BEND HOSPITAL		In Lie	eu of Form CMS-	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Pre 5/9/2022 2:21	pared:
		Titl∈	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				1	
	03000 ADULTS & PEDI ATRI CS			416, 000		30.00
	04100 SUBPROVI DER - I RF			0		41.00
42. 00	04200 SUBPROVI DER			0		42. 00
F7 00	ANCI LLARY SERVI CE COST CENTERS		0.00000		1 0	F7 00
	1		0.000000		1	
	05800  MAGNETIC RESONANCE I MAGING (MRI)   05900  CARDIAC CATHETERIZATION		0.000000		0	
60.00	06000 LABORATORY		0.000000		0	60.00
	06001 BLOOD LABORATORY				l ~	
	07200   MPL. DEV. CHARGED TO PATIENTS		0.000000		0	
	07300 DRUGS CHARGED TO PATIENTS		0.000000		0	1
73.00	OUTPATIENT SERVICE COST CENTERS		0.00000	J <sub> </sub> 0	0	/3.00
88. 00	08800 RURAL HEALTH CLINIC		0.000000	1	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.000000		0	1
90.00	09000 CLINIC		0.000000		0	1
	09001 DAY TREATMENT		0.000000		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 550000		0	
200.00	, ,	rough 98)	1. 330000	0	1	200.00
201.00	1 1 .					201.00
202.00		only onarges (Trie or)		0		202.00
	1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1	1	ı	1===.00

Heal th	Financial Systems	RIVER BEND HOSPITAL		In lie	eu of Form CMS-:	2552_10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Pre	pared:
		T. 11	VIV		5/9/2022 2: 21	pm
	0 1 0 1 0 1 1		e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cost		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1. 00	2. 00	3, 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			230, 100		30.00
	04100 SUBPROVI DER - I RF			250, 100		41.00
	04200 SUBPROVI DER			0		42.00
42.00	ANCI LLARY SERVI CE COST CENTERS		l			1 42.00
57. 00	05700 CT SCAN		0,00000	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.000000		0	
	05900 CARDI AC CATHETERI ZATI ON		0.000000		0	
60.00	06000 LABORATORY		0. 000000		l o	
60. 01	06001 BLOOD LABORATORY		0. 000000		0	60. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 000000	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.000000	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	89. 00
90.00	09000 CLI NI C		0. 000000	0	0	90.00
90. 01	09001 DAY TREATMENT		0. 000000	0	0	90. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 550000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96	through 98)		0	0	200. 00
201.00	Less PBP Clinic Laboratory Services-Progr	ram only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			0		202. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-4005

				10 12/31/2021	5/9/2022 2: 21	
		Title XVIII		Hospi tal F		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		207, 87		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	U	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3. 04 3. 05				0	0	3. 04 3. 05
3.05	Provider to Program			U	U	3.03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ABSOSTMENTS TO TROOK III			o	o o	3. 51
3. 52				o	o	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		207, 87	70	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provi der to Program		T			
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51 5. 52				0	0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
5. 77	5. 50-5. 98)			٩		3. //
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 87	0	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		209, 74		0	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		)	1. 00	2. 00	8. 00
0.00	Traine of contractor			1	1	0.00

Health Financial Systems	RIVER BEND HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4005		Worksheet E-3 Part II Date/Time Prepared: 5/9/2022 2:21 pm

Net IPF PPS GCT Payments					5/9/2022 2: 21	pm
PART I I - MEDICARE PART A SERVICES - IFF PPS			Title XVIII	Hospi tal	PPS	
PART I I - MEDICARE PART A SERVICES - IFF PPS						
Net Tederal IPF PPS Dayments (excluding outlier, ECT, and medical education payments) 279, 400 1.0 Net IPF PPS Outlier Payments 0.0 2.0 2.0 2.0 1.0 Net IPF PPS Outlier Payments 0.0 3.0 0.0 1.5 2.004. (see instructions) 0.0 4.0 1.5 2.004. (see instructions) 0.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0 1.0					1. 00	
0.00 Net IPF PPS CtTPayments						
0.00   Net IPF PPS ECT Payments   0.00   0.00   15. 2004. (see instructions)   0.00	1.00		cal education payments)			1. 00
Description	2.00					2. 00
1 5, 2004. (see instructions) 1 Cap Increases for the unwelghted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CRF \$412, 424(d)(1)(ii)(ii)(f)(f) or (2) (see instructions) 2 New Teaching program adjustment. (see instructions) 3 Ower Teaching program adjustment. (see instructions) 4 Ower Teaching program adjustment. (see instructions) 5 Ower Teaching program adjustment. (see instructions) 6 Ower Teaching program adjustment to fisk excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 6 Ower Teaching program adjustment (see instructions) 7 Ower Teaching program adjustment (see instructions) 7 Ower Teaching Program (see instructions) 8 Owerage Daily Gensus (see instructions) 9 Ower Teaching Adjustment Fish (see instructions) 9 Ower Teaching and All icel Heal and the Managed Care payment (see instructions) 9 Ower Teaching and All icel Heal and the Managed Care payment (see instructions) 9 Ower Teaching and All icel Heal the Managed Care payment (see instructions) 9 Ower Teaching and All icel Heal and the Managed Care payment (see instructions) 9 Ower Teaching and All icel Heal the Managed Care payment (see instructions) 9 Ower Teaching Adjustment Teaching Te	3.00					3. 00
1.01   Cap increases for the unwel ghted Intern and resident FTE count for residents that were displaced by program or hospital cilcosure, that would not be counted without a temporary cap adjustment under 42   CRF §412.424(d)(1)(1)(1)(F)(1) or (2) (see instructions)   0.00   0.0	4.00		ost report filed on or be	efore November	0.00	4. 00
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(d)(1)(ii)(F)(1) or (2) (see instructions)  ON New Teaching program adjustment. (see Instructions)  Outpring year's unweighted FTE count for IR sectuding FTEs in the new program growth period of a "new teaching program" (see Instructions)  Outpring year's unweighted IR FEE count for residents within the new program growth period of a "new teaching program" (see Instructions)  Outpring year's unweighted IR FEE count for residents within the new program growth period of a "new teaching program" (see Instructions)  Intern and resident count for IPF PS medical education adjustment (see instructions)  ON Teaching Program" (see Instructions)  ON Teaching Adjustment Eator (f(r of line 8/Iline 9)) raised to the power of .5150 -1).  ON OBJOINT (in International Part of International Part o						
OFF   S412 424(d) (1) (iii) (F) (1) or (2) (see instructions)	4. 01				0.00	4. 01
New Teaching program adjustment. (see instructions)			t a temporary cap adjustr	ment under 42		
Current year's unweighted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   0.00						
teaching program" (see instructions)  0 Current year's unweighted IAR FIE count for residents within the new program growth period of a "new teaching program" (see instructions)  1 Intern and resident count for IPF PPS medical education adjustment (see instructions)  1 Average Daily Census (see instructions)  1 Teaching Adjustment Factor ((rl. + (line 8/line 9)) raised to the power of .5150 -1).  2 O Teaching Adjustment Factor ((rl. + (line 8/line 9)) raised to the power of .5150 -1).  3 O Nursing Adjustment (line 1 multiplied by line 10).  3 ON Internal and Internal Resident (rl. + (line 8/line 9)) raised to the power of .5150 -1).  4 O O Adjustment (line 1 multiplied by line 10).  5 ON O Eaching Adjustment (line 1 multiplied by line 10).  5 ON O O Subtration and Ilied Heal th Managed Care payment (see instruction)  6 ON O Subtration (line 1 line 1 multiplied by line 10).  7 ON OP Internal and Ilied Heal th Managed Care payment (see instructions)  8 ON OUT ON	5.00					5. 00
Current Year's unwelighted IRR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   7.0	6.00		the new program growth pe	eriod of a "new	0.00	6. 00
teaching program" (see instructions)		,				
Intern and resident count for IPF PPS medical education adjustment (see instructions)   0.00   8.0	7.00		the new program growth pe	eriod of a "new	0.00	7. 00
Average Daily Census (see instructions)   7. 958904   9. 0						
Decorating Adjustment Factor (((1 + (line 8/line 9)) raised to the power of .5150 -1).   0.000000   10.0   11.0   10.0   Teaching Adjustment (line 1 multiplied by line 10).   0.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.0000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.000000   10.0   0.0000000   10.0   0.0000000   10.0   0.0000000   10.0   0.00000000   10.0   0.0000000000	8. 00	,	tment (see instructions)			
1.00   Teaching Adjustment (line 1 multiplied by line 10).   279,400   12.0   279,400   1	9. 00					
Adjusted Net IPF PPS Payments (sim of Lines 1, 2, 3 and 11)   279, 400   12.0   3.0   13.0			the power of .5150 -1}.			
3.00   Nursing and Allied Health Managed Care payment (see instruction)   13.0   14.0   00   07gan acquisition (D0 NOT USE THIS LINE)   14.0   15.0		, , , , , , , , , , , , , , , , , , , ,				
14. 00   Organ acquisition (D0 NOT USE THIS LINE)   14. 00   0   0   0   0   0   0   0   0   0	12. 00					
Cost of physicians' services in a teaching hospital (see instructions)   15.00   15.	13. 00		on)		0	13. 00
Subtotal (see instructions)   279, 400   16, 00   17, 0	14.00	, ,				14.00
Primary payer payments   0   17.00	15. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)			
8.00   Subtotal (ine 16 less line 17).   279, 400   41, 108   19, 00   00   00   00   00   00   00   00	16.00	Subtotal (see instructions)			279, 400	16. 00
9.00   Deductibles	17.00	Primary payer payments				17. 00
0.00   Subtotal (line 18 minus line 19)   238, 292   20.0   30, 422   21.0   20.0	18.00	Subtotal (line 16 less line 17).			279, 400	18. 00
1.00	19.00	Deducti bl es			41, 108	19. 00
2.00   Subtotal (line 20 minus line 21)   207,870   22.0	20.00	Subtotal (line 18 minus line 19)			238, 292	20. 00
Allowable bad debts (exclude bad debts for professional services) (see instructions)   2,877   23.0	21.00	Coi nsurance			30, 422	21. 00
Adjusted reimbursable bad debts (see instructions)   1,870   24.0	22. 00	Subtotal (line 20 minus line 21)			207, 870	22. 00
Allowable bad debts for dual eligible beneficiaries (see instructions)	23.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		2, 877	23. 00
Subtotal (sum of lines 22 and 24)   209, 740   26. 0	24.00	Adjusted reimbursable bad debts (see instructions)			1, 870	24.00
7. 00 Direct graduate medical education payments (see instructions) 8. 00 Other pass through costs (see instructions) 9. 00 Outlier payments reconciliation 9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9. 05 O Pi oneer ACO demonstration payment adjustment (see instructions) 9. 09 Demonstration payment adjustment amount before sequestration 9. 09 Demonstration payment adjustment amount before sequestration 9. 1. 00 Total amount payable to the provider (see instructions) 9. 1. 01 Sequestration adjustment (see instructions) 9. 1. 02 Demonstration payment adjustment amount after sequestration 9. 1. 01 Sequestration adjustment (see instructions) 9. 1. 02 Demonstration payment adjustment amount after sequestration 9. 1. 02 Demonstration payments 9. 00 Demonstration payment adjustment amount after sequestration 9. 1. 01 Sequestration adjustment (for contractor use only) 9. 1. 01 Demonstration payments 9. 00 Demonstration payments 9. 00 Total amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	25.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		2, 877	25. 00
8.00 Other pass through costs (see instructions) 0 Utilier payments reconciliation 0 0 29.00 Outlier payments reconciliation 0 0 29.00 Outlier payments reconciliation 0 0 29.00 O.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.9 Outlier payment adjustment amount before sequestration 0 30.9 Demonstration payment adjustment amount before sequestration 0 30.9 Demonstration payment adjustment amount before sequestration 0 30.9 Outlier payment adjustment (see instructions) 0 31.0 Outlier payment adjustment (see instructions) 0 31.0 Outlier payment adjustment (see instructions) 0 31.0 Outlier payments 0 209,740 31.0 Outlier payments 0 209,740 31.0 Outlier payments 0 209,740 31.0 Outlier payments 0 30.0 Outlier payments 0 30.0 Outlier payments 0 30.0 Outlier payment adjustment amount after sequestration 0 31.0 Outlier payments 0 30.0 Outlier payment adjustment amount in payment amou	26.00	Subtotal (sum of lines 22 and 24)			209, 740	26. 00
9.00 Outlier payments reconciliation 0 29.0 0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.0 0.50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 30.5 0.98 Recovery of accelerated depreciation. 0 30.9 0.99 Demonstration payment adjustment amount before sequestration 0 30.9 1.00 Total amount payable to the provider (see instructions) 209,740 31.0 1.01 Sequestration adjustment (see instructions) 209,740 31.0 1.02 Demonstration payment adjustment amount after sequestration 0 31.0 1.02 Demonstration payment adjustment amount after sequestration 0 31.0 1.01 Interim payments 207,870 32.0 1.02 Demonstration payment adjustment amount after sequestration 0 31.0 1.02 Demonstration payment adjustment amount after sequestration 0 31.0 1.02 Demonstration payment adjustment amount after sequestration 0 31.0 1.01 Interim payments 207,870 32.0 1.02 Demonstration payment adjustment amount after sequestration 0 31.0 1.02 Demonstration payment adjustment amount after sequestration 0 31.0 1.03 Demonstration payment adjustment amount after sequestration 0 31.0 1.04 Demonstration payment adjustment amount after sequestration 0 31.0 1.05 Demonstration payment adjustment amount after sequestration 0 31.0 1.06 Demonstration payment adjustment amount after sequestration 0 31.0 1.07 Demonstration payment adjustment amount after sequestration 0 31.0 1.08 Demonstration payment adjustment amount after sequestration 0 31.0 1.09 Demonstration payment adjustment amount after sequestration 0 31.0 1.00 Outlier reconciliation adjustment amount (see instructions) 0 51.0 1.00 Outlier reconciliation adjustment amount (see instructions) 0 55.0 1.00 Outlier reconciliation adjustment amount (see instructions) 0 55.0 1.00 Outlier reconciliation adjustment amount (see instructions) 0 55.0 1.00 Outlier reconciliation adjustment amount (see instructions) 0 55.0 1.00 Outlier reconciliation adjustment amount after sequestration 0 50.0 1.00 Outlier reconciliation adjustment amount after sequestration 0 50.0 1.00 Outlier reconcilia	27.00	Direct graduate medical education payments (see instructions)			0	27. 00
O. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pi oneer ACO demonstration payment adjustment (see instructions) Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration O. 30. 9 1. 00 1. 01 1. 01 1. 02 1. 02 1. 03 1. 03 1. 03 1. 04 1. 00 1. 02 1. 04 1. 05 1. 05 1. 06 1. 07 1. 07 1. 08 1. 0	28. 00	Other pass through costs (see instructions)			0	28. 00
Pioneer ACO demonstration payment adjustment (see instructions)  Recovery of accelerated depreciation.  Demonstration payment adjustment amount before sequestration  Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  O 31.00  Interim payments  Tentative settlement (for contractor use only)  Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  Since Completed By Contractor  Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  O.0000000000000000000000000000000	29.00	Outlier payments reconciliation			ol	29. 00
Recovery of accelerated depreciation.  0.99 Demonstration payment adjustment amount before sequestration  1.00 Total amount payable to the provider (see instructions)  1.01 Demonstration adjustment (see instructions)  1.02 Demonstration payment adjustment amount after sequestration  1.03 Demonstration payment adjustment amount after sequestration  1.02 Demonstration payment adjustment amount after sequestration  1.01 Demonstration payment adjustment amount after sequestration  1.02 Demonstration payment adjustment amount after sequestration  1.03 Demonstration payment adjustment amount after sequestration  1.00 Demonstration payment adjustment amount after sequestration  1.01 Demonstration payment adjustment amount after sequestration  1.02 Demonstration payment adjustment amount after sequestration  1.03 Demonstration adjustment amount after sequestration  1.04 Demonstration adjustment amount after sequestration  1.05 Demonstration adjustment amount after sequestration  1.06 Demonstration adjustment amount after sequestration  1.07 Demonstration adjustment amount after sequestration  1.08 Demonstration adjustment amount after sequestration  1.09 Demonstration adjustment amount after sequestration  1.00 Demonstration adjustment insurations  1.00 Demonstration adjustment amount after sequestration  1.01 Demonstration adjustment insurations  1.02 Demonstration adjustment amount after sequestration  1.00 Demonstration adjustment insurations  1.00 Demonstration adjustment amount after sequestration  1.00 Demonstration adjustment amount after sequestration  1.01 Demonstration adjustment amount after sequestration  1.02 Demonstration adjustment amount after sequestration  1.00 Demonstration adjustment amount after sequestration  1.01 Demonstration adjustment amount after sequestration  1.01 Demonstration adjustment amount after sequestration  1.02 Demonstration adjustment amount after sequestration  1.02 Demonstration adjustment amount after sequestration  1.00 Demonstration adjustment amount after sequestration  1.0	30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.00
Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Sequestration Interim payments Sequestration Interim payments Sequestration Sequestratio	30. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		l ol	30. 50
Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  1.02  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment amount after sequestration  Total amount payable to the provider (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration  Demon	30. 98	Recovery of accelerated depreciation.			j ol	30. 98
1.01 Sequestration adjustment (see instructions)  1.02 Demonstration payment adjustment amount after sequestration  1.03 Demonstration payment adjustment amount after sequestration  1.04 Demonstration payments  207,870  32.0  33.00 Tentative settlement (for contractor use only)  4.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  0.00 Original outlier amount from Worksheet E-3, Part II, line 2  0.00 Outlier reconciliation adjustment amount (see instructions)  1.00 Outlier reconciliation adjustment amount (see instructions)  1.00 Outlier reconciliation adjustment amount (see instructions)  2.00 Time Value of Money (see instructions)  3.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  7.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  3.10 Octoor 31.00 Octoor 32.00 Octoor 33.00	30. 99	Demonstration payment adjustment amount before sequestration			j ol	30. 99
1.02 Demonstration payment adjustment amount after sequestration 2.00 Interim payments 3.00 Tentative settlement (for contractor use only) 4.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5.15.2 70 BE COMPLETED BY CONTRACTOR  0.00 Original outlier amount from Worksheet E-3, Part II, line 2 0.100 Outlier reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the Time Value of Money 1.00 Time Value of Money (see instructions) 1.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  7.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 3.10 October 1.00 October 1.00 October 2.00 October 3.00 O	31.00	Total amount payable to the provider (see instructions)			209, 740	31.00
2.00 Interim payments  3.00 Tentative settlement (for contractor use only)  4.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  §115.2  TO BE COMPLETED BY CONTRACTOR  0.00 Original outlier amount from Worksheet E-3, Part II, line 2  0.00 Outlier reconciliation adjustment amount (see instructions)  2.00 The rate used to calculate the Time Value of Money  3.00 Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.0000000 99.0	31. 01	Sequestration adjustment (see instructions)			ol	31. 01
Tentative settlement (for contractor use only)  4.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 35.0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 02	Demonstration payment adjustment amount after sequestration			0	31. 02
33.00 Tentative settlement (for contractor use only) 4.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 51.15.2 TO BE COMPLETED BY CONTRACTOR  0.00 Original outlier amount from Worksheet E-3, Part II, line 2 0.00 Outlier reconciliation adjustment amount (see instructions) 0.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0.00 Time Value of Money (see instructions) 0.00 To COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.0000000 99.0	32.00	Interim payments			207, 870	32. 00
4.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.0 S115.2 TO BE COMPLETED BY CONTRACTOR  0.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.0 Outlier reconciliation adjustment amount (see instructions) 0 51.0 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 53.0 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.0	33.00					33. 00
5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\text{S115.2}}{\text{T0 BE COMPLETED BY CONTRACTOR}}\$  0.00 Original outlier amount from Worksheet E-3, Part II, line 2  0.01 Outlier reconciliation adjustment amount (see instructions)  1.00 The rate used to calculate the Time Value of Money  3.00 Time Value of Money (see instructions)  1.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  3.5.0 Spinsor 1, contact the second se	34.00	,	2. 32 and 33)		1.870	
\$115.2 TO BE COMPLETED BY CONTRACTOR  0.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 to Utlier reconciliation adjustment amount (see instructions) 0 the rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 to 52.0 Time Value of Money (see instructions) 0 to 53.0 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.0	35. 00	1 9 0		chapter 1		35. 00
0.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 0.00 0.00 0.00 0.00 0.00 0.00						
0.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 0.00 0.00 0.00 0.00 0.00 0.00						
1.00 Outlier reconciliation adjustment amount (see instructions)  2.00 The rate used to calculate the Time Value of Money  3.00 Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.0	50.00				0	50.00
2.00 The rate used to calculate the Time Value of Money 0.00 52.0 3.00 Time Value of Money (see instructions) 0 53.0 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.0	51.00					
3.00 Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.0	52. 00	,				
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.0	53.00					
9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.0			BEGINNING BEFORE THE FNO	OF THE COVID-19		
	99. 00					99. 00
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		, , , , , , , , , , , , , , , , , , , ,	,			

Health Financial Systems	RIVER BEND HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4005	Peri od: Worksheet E-3

From 01/01/2021 To 12/31/2021 Part VII
Date/Time Prepared: 5/9/2022 2: 21 pm Title XIX Hospi tal Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 367, 687 1.00 2.00 Medical and other services Ω 2.00 3.00 Organ acquisition (certified transplant centers only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 367, 687 4.00 Inpatient primary payer payments 5.00 5.00 Outpatient primary payer payments 6.00  $\cap$ 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 367, 687 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 230, 100 8.00 9.00 Ancillary service charges 0 9.00 10.00 Organ acquisition charges, net of revenue 0 10.00 Incentive from target amount computation 11 00 11 00 0 12.00 Total reasonable charges (sum of lines 8 through 11) 230, 100 0 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 230, 100 16.00 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 137, 587 0 18.00 (see instructions) 19.00 Interns and Residents (see instructions) 19.00 0 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 0 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 230, 100 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers

Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,

0

0 22.00

0 43.00

22.00

43.00

chapter 1, §115.2

Other than outlier payments

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

Provider CCN: 15-4005 Pe

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/9/2022 2:21 pm

OH y)					5/9/2022 2: 21	pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	504, 988, 708		_	_	
2.00	Temporary investments	0	0			2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	239, 926	0	0	0	3. 00 4. 00
5.00	Other receivable	239, 920		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7. 00	Inventory	149, 070	Ö	Ō	ō	
8.00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	1
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	505, 377, 704	. 0	0	0	11. 00
12. 00	FIXED ASSETS Land	4, 760, 955	0	0	0	12. 00
13. 00	Land improvements	4, 700, 755		_	_	13.00
14. 00	Accumulated depreciation		o o	_		14. 00
15. 00	Bui I di ngs	14, 548, 117	0	0	0	15. 00
16.00	Accumulated depreciation	-5, 009, 474	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumul ated depreciation	0	0	_	0	18. 00
19.00	Fixed equipment	8, 362	0	0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0		0	0	20.00
21.00	Accumulated depreciation			0	0	22.00
23. 00	Major movable equipment	1, 093, 192	1	0	Ö	23. 00
24. 00	Accumulated depreciation	-841, 777	1	o o	ő	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	_	0	28. 00
29. 00	Mi nor equipment-nondepreciable	14 550 275	0	_	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	14, 559, 375	0	0	0	30.00
31. 00	Investments	1 0	0	0	0	31.00
32. 00	Deposits on Leases	0	Ö	Ō		32. 00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	0	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	0	0	_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	519, 937, 079	9 0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	6, 188, 841	T 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	141, 062	1	0	_	38.00
39. 00	Payrol I taxes payable	141,002		0	Ö	
40. 00	Notes and Loans payable (short term)	0	Ö	Ō	ō	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0	)			42. 00
43. 00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	( 220 002	0	0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	6, 329, 903	0	0	0	45. 00
46. 00	Mortgage payable	1 0	0	0	0	46. 00
47. 00	Notes payable		o o	_	_	
48. 00	Unsecured Loans	0	0	0		
49.00	Other long term liabilities	1, 914, 819	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 914, 819			_	
51. 00	Total liabilities (sum of lines 45 and 50)	8, 244, 722	2 0	0	0	51.00
F2 00	CAPI TAL ACCOUNTS	F11 (02 2F7	,			F2 00
52. 00 53. 00	General fund balance Specific purpose fund	511, 692, 357	0		•	52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			Ö		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	F11 (00 055	,	_	_	F0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58)	511, 692, 357		0	0	
00.00	Total liabilities and fund balances (sum of lines 51 and 59)	519, 937, 079				00.00
	1/	1	1	I	1	1

RIVER BEND HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 01/01/2021 Provider CCN: 15-4005

					To 12/31/2021	Date/Time Prep 5/9/2022 2:21	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		473, 401, 822 38, 290, 535		0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		511, 692, 357		0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6. 00 7. 00		0			0	0	6. 00 7. 00
8. 00		0			0		8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		0		10. 00
11.00	Subtotal (line 3 plus line 10)		511, 692, 357		0		11. 00 12. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)				0	0	12. 00 13. 00
14. 00					o	Ö	14. 00
15.00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	O	0		0	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		511, 692, 357		0		19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	U	0		0		3. 00 4. 00
5. 00	(Specify)		Ö				5. 00
6.00			0				6. 00
7.00			0				7. 00
8. 00 9. 00			0				8. 00 9. 00
10. 00	Total additions (sum of line 4-9)	0	J		0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12. 00	Deductions (debit adjustments) (specify)		0				12. 00
13. 00 14. 00			0				13. 00 14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)						19. 00
			'	•	•		

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-4005

			To	12/31/2021	Date/Time Prep 5/9/2022 2:21	
	Cost Center Description	Int	pati ent	Outpati ent	Total	p
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		3, 889, 600		3, 889, 600	1. 00
2.00	SUBPROVIDER - I PF		, , , , , , , , ,		2, 22., 222	2. 00
3.00	SUBPROVIDER - IRF		0		0	3. 00
4. 00	SUBPROVI DER		Ö		0	4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		J		ŭ.	7. 00
8. 00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		3, 889, 600		3, 889, 600	
	Intensive Care Type Inpatient Hospital Services		0,007,000		0,007,000	10.00
11. 00	INTENSIVE CARE UNIT					11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	ines	0		0	16. 00
	11-15)		J		ŭ.	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		3, 889, 600		3, 889, 600	17. 00
18. 00	Ancillary services		0	اه	0	18. 00
19. 00	Outpatient services		0	1, 340	1, 340	
20. 00	RURAL HEALTH CLINIC		0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	ol	0	21. 00
22. 00	HOME HEALTH AGENCY		J	Ĭ	ŭ.	22. 00
23. 00	AMBULANCE SERVI CES					23. 00
24. 00	CMHC					24. 00
24. 10	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		J	Ĭ	ŭ.	25. 00
26. 00	HOSPI CE					26. 00
27. 00	PROFESSI ONAL FEES		575, 843	٥	575, 843	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst	4, 465, 443	1, 340	4, 466, 783	28. 00
20.00	G-3, line 1)	io intot.	1, 100, 110	1, 010	1, 100, 100	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			13, 818, 620		29. 00
30. 00	ADD (SPECIFY)		0	, ,		30. 00
31. 00	(0. 2011.)		Ö			31. 00
32. 00			0			32. 00
33. 00			Ö			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		Ü	o		36. 00
37. 00	DEDUCT (SPECIFY)		0	Ĭ		37. 00
38. 00	DEBOOT (SEESTED)		Ö			38. 00
39. 00			0			39. 00
40. 00			Ö			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		٩	n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		13, 818, 620		43. 00
	to Wkst. G-3, line 4)	(3. 3		.5,5.5,626		.0.00
	1	ı	ļ	ı		

Heal th	Financial Systems RIVER BEND	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-4005	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/9/2022 2:21	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	•		4, 466, 783	
2.00	Less contractual allowances and discounts on patients' acco	ounts		1, 836, 177	
3.00	Net patient revenues (line 1 minus line 2)	40)		2, 630, 606	
4.00	Less total operating expenses (from Wkst. G-2, Part II, lin	ne 43)		13, 818, 620	
5. 00	Net income from service to patients (line 3 minus line 4)			-11, 188, 014	5. 00
	OTHER I NCOME			0	/ 00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			62, 746, 364	7. 00
8.00	Revenues from telephone and other miscellaneous communicati	on services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
13.00	Revenue from laundry and linen service Revenue from meals sold to employees and guests			- 1	14.00
14.00	, , , , ,			-	15. 00
15. 00	Revenue from rental of living quarters Revenue from sale of medical and surgical supplies to other	than nationta		-	16. 00
16.00	Revenue from sale of drugs to other than patients	than patrents		0	
17. 00 18. 00	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			- 1	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	
20. 00 21. 00	Rental of vending machines			-	20.00
21.00	Rental of hospital space			0	
	·			0	23. 00
23. 00	Governmental appropriations			-	
24. 00	OTHER I NOME			77, 762	
24. 01	UNREALIZED GAIN ON INVESTMENT			-13, 345, 577	
24. 50	COVI D-19 PHE Funding			0	
	Total other income (sum of lines 6-24)			49, 478, 549	
	Total (line 5 plus line 25)			38, 290, 535	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			20, 200, 525	
29. 00	Net income (or loss) for the period (line 26 minus line 28)			38, 290, 535	29.00