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: 15-0059 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/24/2022 5: 25 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2022 5: 25 pm use only] Manually prepared cost report 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:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(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 RIVERVIEW HOSPITAL (15-0059) 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	Jay	na Friend	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	Jayna Friend			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	VVIIII			
		Title V					
	Cost Center Description		Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	544, 311	-133, 918	0	-16, 854	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	46, 772	-45		-54, 726	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	591, 083	-133, 963	0	-71, 580	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

	FAL AND HOSPITAL HEALTH CARE COMPLEY	RI VERVI EW		on CCN.	15 0050					2552-10
HUSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	er CCN:		Period: From 01/01/ To 12/31/	/2021 /2021	Workshe Part I Date/Ti 5/24/20	me Pre	pared:
	1.00	2. 00		3. 00			4. 00	0, 2 1, 20		o piii
1 00	Hospital and Hospital Health Care Co	omplex Address: PO Box:								1 00
1. 00 2. 00	Street: 395 WESTFIELD ROAD City: NOBLESVILLE	State: IN	Zip Code	e: 46060	- Count	y: HAMILTON				1. 00 2. 00
2.00	orty. Nobeloviele	Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P,	2.00
		·	Number	Number	Туре	Certified	T,	0, or	N)	
			0.00		1.00	5.00	V	XVIII	XIX	
	Hospital and Hospital-Based Componer	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	8.00	
3.00	Hospi tal	RI VERVI EW HOSPI TAL	150059	26900	1	07/07/1966	N	Р	0	3. 00
4. 00 5. 00	Subprovi der - IPF Subprovi der - IRF	RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994		Р	0	4. 00 5. 00
15. 00 16. 00 17. 00 18. 00	Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I	KEIAD								6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
19.00	Other					From:		То		19.00
						1. 00		2.0		
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	021	12/31/	′2021	20. 00
21. 00	Type of Control (see instructions)					9				21. 00
					1. 00	2. 00		3. 0	00	
	Inpatient PPS Information									
22. 00	Does this facility qualify and is it				Υ	N				22. 00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
22. 01	Did this hospital receive interim ur				Υ	Y				22. 01
	cost reporting period? Enter in coluthe portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft									
22. 02	Is this a newly merged hospital that				N	N				22. 02
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N			s)						
	cost reporting period prior to Octob	per 1. Enter in column 2	. "Y" for	ves						
	or "N" for no, for the portion of th									
	October 1.									
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar				N	N		N		22. 03
	adopted by CMS in FY2015? Enter in o									
	for the portion of the cost reportir			r						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			s						
	counted in accordance with 42 CFR 41		•							
00.04	yes or "N" for no.									00.04
22. 04	Did this hospital receive a geograph rural as a result of the revised OME				N	N		N		22. 04
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportir			r						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			s						
	counted in accordance with 42 CFR 41									
0.5	yes or "N" for no.									
23. 00	Which method is used to determine Me below? In column 1, enter 1 if date					3 N				23. 00
	if date of discharge. Is the method									
	reporting period different from the	method used in the prior	r cost							
	reporting period? In column 2, ente	er "Y" for yes or "N" fo	r no.							

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der C	CN: 15-0059	Peri od:	Worksheet S-2	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Prep 5/24/2022 5:29	
			NAHE 413.89 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2. 00	3.00	
Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent of """.	85? (se umn 1. CR) NAHE	ee If column 1	Y	Y		60. (
adjustement? Enter "Y" for yes or "N" for no in colu 0.01 If line 60 is yes, complete columns 2 and 3 for each instructions)		(see		23. 00	1	60.
,	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.
Old Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. (
.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. (
.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	Pro	gram Name	Program Cod	le Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4.00	
.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0. 00	0.00	61.
FTE unweighted count. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0. 00	0. 00	61.
the direct GME FTE unweighted count.					1.00	
ACA Provisions Affecting the Health Resources and Se				ariad for which		42
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct. O1 Enter the number of FTE residents that rotated from a	ctions)					62. 62.
during in this cost reporting period of HRSA THC pro				J		

Health Financial Systems	RI VI	ERVIEW HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CC		riod: com 01/01/2021 12/31/2021	Worksheet S-2 Part I Date/Time Prep 5/24/2022 5:2	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after J			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00		65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
	V 575 B 1 1 1 1		1.00	2. 00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	sEffective fo	r cost reporti	ng periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66. 00
Test dimit 1 di vi ded by (est dimit 1)	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67 00 Enter in column 1 the program	1. 00	2. 00	3. 00	4. 00	5. 00 0. 000000	67.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	J. 000000	67.00

		From 01/01 To 12/31	/2021	Part I Date/Ti 5/24/20		
			1. 00	2. 00	3.00	
Inpatient Psychiatric Facility PPS 0.00 Is this facility an Inpatient Psychiatr	ic Facility (IPF), or does it contain an IPF sul	oprovi der?	l N			70. (
Enter "Y" for yes or "N" for no.		•	''		_	
	cility have an approved GME teaching program in ovember 15, 2004? Enter "Y" for yes or "N" for				0	71.
42 CFR 412.424(d)(1)(iii)(c)) Column 2:	Did this facility train residents in a new team	chi ng				
	24 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for ich program year began during this cost reporti					
(see instructions)	ren program year began durrng this cost reporting	ig perrou.				
Inpatient Rehabilitation Facility PPS						
5.00 Is this facility an Inpatient Rehabilit subprovider? Enter "Y" for yes and "N"	ation Facility (IRF), or does it contain an IRF		Y			75.
	cility have an approved GME teaching program in	the most	N	N	0	76.
	or before November 15, 2004? Enter "Y" for yes					
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" f	esidents in a new teaching program in accordanc or yes or "N" for no. Column 3: If column 2 is '	ewith 42 Y.				
	g this cost reporting period. (see instructions		<u> </u>			
			-	1. 0	00	-
Long Term Care Hospital PPS						
0.00 Is this a long term care hospital (LTCH		, nor: ad2 F		N		80.
"Y" for yes and "N" for no.	r hospital for part or all of the cost reporting	g periou? E	inter	N		81.
TEFRA Providers						
	tion §413.40(f)(1)(i) TEFRA? Enter "Y" for yes subprovider (excluded unit) under 42 CFR Section		no.	N		85.
\$413. 40(f)(1)(ii)? Enter "Y" for yes a		ווע				00.
	disease care hospital classified under section			N		87.
1886(d)(1)(B)(vi)? Enter "Y" for yes or	N TOT NO.	V		XI	Χ	
		1. 00)	2. 0		
Title V and XIX Services D. 00 Does this facility have title V and/or	XIX inpatient hospital services? Enter "Y" for	N		Y		90.
yes or "N" for no in the applicable col		IN IN		1		70.
	and/or XIX through the cost report either in	N		Υ		91.
full or in part? Enter "Y" for yes or " 2.00 Are title XIX NF patients occupying tit	N" for no in the applicable column. Le XVIII SNF beds (dual certification)? (see			N		92.
instructions) Enter "Y" for yes or "N"	for no in the applicable column.					
3.00 Does this facility operate an ICF/IID f "Y" for yes or "N" for no in the applic	acility for purposes of title V and XIX? Enter	N		N		93.
	? Enter "Y" for yes, and "N" for no in the	N		N		94.
applicable column.						
5.00 If line 94 is "Y", enter the reduction 6.00 Does title V or XIX reduce operating co	st? Enter "Y" for yes or "N" for no in the	0. 00 N	,	O. C N		95.
applicable column.	st: Effet 1 Toll yes of W Toll Ho Till the					/0.
7.00 If line 96 is "Y", enter the reduction		0.00)	0.0		97.
	tle XVIII) for the interns and residents post col. 25? Enter "Y" for yes or "N" for no in	Y		Y		98.
column 1 for title V, and in column 2 f	or title XIX.					
	tle XVIII) for the reporting of charges on Wkst	Y		Y		98
title XIX.	no in column 1 for title V, and in column 2 for					
· ·	tle XVIII) for the calculation of observation	Y		Υ		98
bed costs on Wkst. D-1, Pt. IV, line 89 for title V, and in column 2 for title	? Enter "Y" for yes or "N" for no in column 1					
· ·	tle XVIII) for a critical access hospital (CAH)	N		N		98
	ost? Enter "Y" for yes or "N" for no in column	1				
for title V, and in column 2 for title 8.04 Does title V or XIX follow Medicare (ti		N		N		98.
outpatient services cost? Enter "Y" for	yes or "N" for no in column 1 for title V, and					/ 0
in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (ti	tle XVIII) and add back the RCE disallowance on	Y		Υ		98.
	es or "N" for no in column 1 for title V, and in			'		70.
column 2 for title XIX.						
	tle XVIII) when cost reimbursed for Wkst. D, "N" for no in column 1 for title V, and in	Y		Y		98.
column 2 for title XIX.						
Rural Providers		I A				105
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, ha	s it elected the all-inclusive method of paymen	t N				105
for outpatient services? (see instructi	ons)					
	ility eligible for cost reimbursement for I&R "N" for no in column 1. (see instructions)	N				107.
	or line 75 is Y, do you train I&Rs in an					
approved medical education program in t Enter "Y" for yes or "N" for no in colu						

RIVERVIEW HOS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15 0050 D	In Lie	u of Form CMS Worksheet S-	
NOSPITAL AND NOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		rom 01/01/2021	Part I Date/Time Pr	epared:
			V	5/24/2022 5: XI X	25 pm
			1. 00	2.00	
108.00 Is this a rural hospital qualifying for an exception to the CF CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	NA fee sche	dul e? See 42	N		108. 0
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2. 00 N	3. 00 N	4.00 N	109. 0
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Works applicable.	for yes or	"N" for no. If	yes,	N	110. 0
			1 00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in the			1. 00 N	2.00	111. 0
Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is partiferer all that apply: "A" for Ambulance services; "B" for addifor tele-health services.	mn 1 is Y, cipating in	enter the column 2.			
		1. 00	2. 00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting pe Enter "Y" for yes or "N" for no in column 1. If column 1 is " in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	ri od? Y", enter	N			112. 0
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "	N" for no	N			 0115. 0
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (ir psychiatric, rehabilitation and long term hospitals providers)	or E only) percent cludes				
the definition in CMS Pub.15-1, chapter 22, §2208.1. 	r yes or	N			116. 0
117.00 s this facility legally-required to carry malpractice insurar "Y" for yes or "N" for no.	ce? Enter	Y			117. C
118.00 s the malpractice insurance a claims-made or occurrence police if the policy is claim-made. Enter 2 if the policy is occurrence.	,	2			118. 0
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00	2.00	3.00	0 118. 0
10. Of Erst amounts of marpraetree premiums and para rosses.		030,003			0 110. 0
10.00 Are malarestics are missed and acid leaves reported in a cost of	nton other	+ban +ba	1. 00 N	2. 00	110 (
18.02 Are malpractice premiums and paid losses reported in a cost contain is strative and General? If yes, submit supporting schedul and amounts contained therein.			IN IN		118. 0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold F §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments	olumn 1, "Y ifies for t	" for yes or he Outpatient	N	N	119. (120. (
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implant	able device	s charged to	Υ		121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defir Act? Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.			N		122. (
Transplant Center Information	V00 UN''	for re- 10			105
25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter			N		125. (
in column 1 and termination date, if applicable, in column 2. 27.00 f this is a Medicare certified heart transplant center, enter					127. (
in column 1 and termination date, if applicable, in column 2.					
28.00 f this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.					128. (
129.00 If this is a Medicare certified lung transplant center, enter	τne certifi	cation date in			129. (
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, er					130. 0

Health Financial Systems		EW HOSPITAL				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	N: 15-0059		: 1/01/2021 2/31/2021	Worksheet S- Part I Date/Time Pr 5/24/2022 5:	epared:
					1. 00	2.00	
131.00 If this is a Medicare certified in	ntestinal transplant ce	nter, enter the ce	rti fi cati o		1.00	2.00	131. 00
date in column 1 and termination of 132.00 If this is a Medicare certified is	slet transplant center,	enter the certifi	cation date	Э			132. 00
in column 1 and termination date, 133.00 Removed and reserved	ir applicable, in colu	mn 2.					133. 00
134.00 If this is an organ procurement or and termination date, if applicable		r the OPO number i	n column 1				134. 00
All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or '					Υ		140. 00
are claimed, enter in column 2 the				ıs	3. 00		
If this facility is part of a chain home office and enter the home of		on lines 141 throu		name and		of the	
141. 00 Name:	Contractor's Name			ctor's Nu	mber:		141. 00
142.00 Street:	PO Box:		7. 0				142.00
143. 00 Ci ty:	State:		Zip Cod	ae:			143. 00
						1. 00	
144.00 Are provider based physicians' cos	sts included in Workshe	et A?				Υ	144. 00
					1. 00	2.00	
145.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility incomperiod? Enter "Y" for yes or "N"	' for yes or "N" for no clude Medicare utilizat	in column 1. If c	olumn 1 is		Y		145. 00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/g	gy changed from the pre n column 1. (See CMS Pu			lf	N		146.00
						1. 00	
147.00 Was there a change in the statisti 148.00 Was there a change in the order of						N N	147. 00 148. 00
149.00 Was there a change to the simplifi				or no.		N N	149.00
-	-	Part A	Part B	Т	itle V	Title XIX	
Does this facility contain a prov							
or charges? Enter "Y" for yes or '	'N" for no for each com	ponent for Part A N	and Part B	. (See 42	2 CFR §413 N	3. 13) N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157. 00 Subprovi der - I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	N		N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161. 00 CMHC			N		N	N	161. 00
Multicampus						1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more campu	ses in dif	ferent CE	3SAs?	N	165. 00
	Name O	County 1.00	State 2	Zip Code 3.00	CBSA 4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	-	55					00 166. 00
						1.00	
Health Information Technology (HI	•			ent Act			4,7,5
167.00 s this provider a meaningful usen 168.00 f this provider is a CAH (line 10				'), enter	the	Y	167. 00 168. 00
reasonable cost incurred for the H	HT assets (see instruc	tions)					
168.01 f this provider is a CAH and is r exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or	"N" for no. (see i	nstructions	s)	•		168. 01
169.00 f this provider is a meaningful u transition factor. (see instruction		and is not a CAH (line 105 is	s "N"), e	enter the	9. 9	99169. 00

Health Financial Systems	RI VERVI EW HOSPI TAL			In Lieu of Form CMS-2552-1			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-0059	Peri od:	Worksheet S-2)		
			From 01/01/2021 To 12/31/2021		narod:		
			10 12/31/2021	Date/Time Prepared: 5/24/2022 5:25 pm			
			Begi nni ng	Endi ng			
			1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)			170. 00				
			1. 00	2.00			
171.00 If line 167 is "Y", does this provide	er have any days for indiv	/iduals enrolled in	N	C	171. 00		
section 1876 Medicare cost plans repo							
"Y" for yes and "N" for no in column	1. If column 1 is yes, er	nter the number of sectio	n				
1876 Medicare days in column 2. (see	instructions)						

	Financial Systems RIVERVIEW AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021		2 epared:
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provided Company Institution and Company in the Company institution and Company in the Compan	l for all NO re	esponses. Ente	r all dates in t	the	
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	heginning of	the cost	N		1.0
00	reporting period? If yes, enter the date of the change in a	rolumn 2 (see	instructions)			1.0
	proporting portion. It yes, enter the date of the change the	301 GIIII 2. (300	Y/N	Date	V/I	
			1.00	2.00	3. 00	
00	Has the provider terminated participation in the Medicare F	Program? If	N			2.0
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including	ng management	N			3.0
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	der or its of the board				
	Trend tronsings: (See Tristi de trons)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
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,	Y	A	07/30/2020	4. C
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.				
	Approved Educational Activities			Y/N 1. 00	Legal Oper. 2.00	
00	Column 1: Are costs claimed for a nursing program? Column	2. If ves is	the provider	· N		6.0
00	is the legal operator of the program?	2 joo,	tilo providor			0.0
00 00	Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the N					7. 0 8. 0
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. (
0. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11. (
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Υ	12. (
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N	13. (
1. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	tructi ons.	N	14. (
	Bed Complement					
5. 00	Did total beds available change from the prior cost reporti	, , ,	-		N .+ D	15.0
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3.00	4. 00	
	PS&R Data	1.00	2.00	3. 00	4.00	
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16.0
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/15/2022	Y	03/15/2022	17. (
3. 00	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. (
9. 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. (

Heal th	Financial Systems RIVERVIEW	HOSPI TAL		In Lie	eu of Form CM	IS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time F 5/24/2022 5	Prepared:
		Descr	iption	Y/N	Y/N	
	1011 11 12 13 13 13 13 13 13 13 13 13 13 13 13 13		0	1. 00	3. 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
	report data for other: beserve the other day astments.	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 (EXC	EPT CHILDRENS H	HOSPI TALS)		1.00	
	Capital Related Cost		•			
22. 00	Have assets been relifed for Medicare purposes? If yes, se					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made du	ing the cost		23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into durina	this cost re	enorting period?		24. 00
27.00	If yes, see instructions	ca filto dui filg	ans cost It	sporting periou!		24.00
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period	? If yes, see		25. 00
0/ 05	instructions.			6		0
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	ne cost reporti	ng period? I	т yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during th	ne cost reportir	na period? It	ves. submit		27. 00
	copy.		.9	<i>J</i> = 0,		
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost	t reporting		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	hond funds (De	ht Service (Reserve Fund)		29. 00
27.00	treated as a funded depreciation account? If yes, see inst	•	DEL DEL VI CC I	(eserve runa)		27.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes	s, see		30. 00
	instructions.					
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes	s, see		31. 00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	ervices furnishe	ed through co	ontractual		32. 00
	arrangements with suppliers of services? If yes, see instr	uctions.				
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	pplied pertainin	ng to competi	tive bidding? If		33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Are services furnished at the provider facility under an a	rrangement with	n provi der-ba	ased physicians?		34.00
	If yes, see instructions.	9	•	. ,		
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	·		35. 00
				Y/N	Date	
	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 If yes, see instructions.	prepared by the	home office	?		37. 00
38. 00	If line 36 is yes , was the fiscal year end of the home of			-		38. 00
39. 00				5,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
	Thisti de trons.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information	L				
41. 00	Enter the first name, last name and the title/position	TINA		SEVERS		41. 00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
42. 00	Enter the employer/company name of the cost report	BLUE & CO., LL	_C			42. 00
	preparer.					
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEAN	DCO. COM	43. 00

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2					2552-10		
H0SPI 1	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/24/2022 5:2	pared:
				3. 00			
	Cost Report Preparer Contact Information						
41.00			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, respective	vel y.					

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Health Financial Systems RIVE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0059

					Τ	o 12/31/2021	Date/Time Pre 5/24/2022 5: 2	
							I/P Days / 0/P	J 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		104	37, 960	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	
7.00	Total Adults and Peds. (exclude observation			104	37, 960	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		15	5, 475	0.00	0	
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			119	43, 435	0.00		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		24	8, 760		0	17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	C		0	
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			143				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	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	C)		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
00.66	outpatient days (see instructions)							00.00
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/24/2022 5:25 pm

						5/24/2022 5: 2	5 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 853	375	13, 024			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds)	2 005	2 224				2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	3, 905	3, 224				2. 00 3. 00
4. 00	HMO IRF Subprovider	888	362				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	000	0	()		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0				6. 00
7. 00	Total Adults and Peds. (exclude observation	3, 853	375	13, 024			7. 00
	beds) (see instructions)			·			
8.00	INTENSIVE CARE UNIT	961	0	4, 199	P		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)		0	1 512			12.00
13. 00 14. 00	NURSERY	4, 814	0 375	1, 512		000 24	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	4,814	3/5	18, 735 (988. 34	15. 00
16. 00	SUBPROVIDER - IPF	U	U		,		16. 00
17. 00	SUBPROVI DER - I RF	2, 277	13	4, 301	0.00	18. 79	
18. 00	SUBPROVI DER	2,2,,		., 55	0.00	10.77	18. 00
19.00	SKILLED NURSING FACILITY	o	0	C	0.00	0.00	
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)			167			24. 10
25. 00 26. 00	CMHC - CMHC						25. 00 26. 00
26. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	1
27. 00		J	O		0.00		1
28. 00	,		0	2, 697		1,007.10	28. 00
29. 00	Ambul ance Tri ps	o	_	_, -, -, -			29. 00
30.00)		30.00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	0	124	259			32.00
32. 01	Total ancillary labor & delivery room)		32. 01
	outpatient days (see instructions)						
33. 00	1	0					33.00
33.01	LTCH site neutral days and discharges	0		l	I	I	33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: |

					12/31/2021	5/24/2022 5: 2	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 014	64	4, 429	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)			705	638		2.00
3.00	HMO IPF Subprovider			703	030		3.00
4. 00	HMO IRF Subprovider				33		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				33		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	1, 014	64	4, 429	
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16. 00
17.00	SUBPROVIDER - IRF	0.00	0	198	2	372	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	0.00					19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						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)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days			0			33.00
33. UT	LTCH site neutral days and discharges			0			33. 01

Period: Worksheet S-3
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0059

3. 00 Non-physician anesthetist Part						1	rom 01/01/2021 o 12/31/2021		
Name Section						,		Average Hourly	5 pm
Manual M			Number	Reported				, ,	
Mart 1 - WacF DATA SALARIES					A-6)	3)	col. 4	ŕ	
MARIES 200 118 570 91 970 170 2,094,884 40 43,90 1.0		PART II - WAGE DATA	1. 00	2. 00	3.00	4.00	5. 00	6.00	
2		SALARI ES				1			
2.00 Ann. physic I an anestheritist Part 0 0 0 0.00	1.00		200. 00	91, 856, 500	113, 670	91, 970, 170	2, 094, 834. 45	43. 90	1.00
3.00 Son-physic Lan an estabethist Part 0 0 0 0 0.0	2.00			0	0	0	0.00	0. 00	2. 00
4. In Administrative	3.00			0	0	o	0.00	0. 00	3. 00
4. admin strative 4 - Teaching 7.00	4. 00	B Physician-Part A -		0	0	0	0.00	0. 00	4. 00
Physician=Part B for	4 01	Admi ni strati ve		0			0.00	0.00	1 01
Non-physician-Part B For Non-physician-Part		Physician and Non		0	0	0			
Nospi tal - based RRC and FORC SerVICOS	6. 00			0	0	0	0.00	0.00	6, 00
Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0		hospital-based RHC and FQHC				_		3.33	
Contract interins and residents (in an approved programs) 8.00 Home office and/or related of contract labor: Direct Patient (and approved programs) 10.00 Set Wilson (and approved programs) 10.00	7. 00	Interns & residents (in an	21. 00	0	0	o	0.00	0. 00	7. 00
Post office and proved programs 8.00 10me office and/or related 0 0 0 0 0 0 0 0 0	7 01			0	0	0	0.00	0.00	7 01
Nome office and/or related operations of the second of the second operation of the second operation of the second operation of the second operation operat	,,,,,	residents (in an approved		J			0.00	0.00	,,,,,,
SNE	8. 00			0	0	o	0.00	0. 00	8. 00
10.00 Excluded area salaries (see 12, 254, 850 411, 228 27, 666, 078 480, 067, 15 57, 63 10.00	9 00		44 00	0	0	0	0.00	0.00	9 00
OTHER WASES & RELATED COSTS 1.00 Contract labors: Direct Patient 1.866,311 0 1.866,311 24,835.00 75.15 1.00 Contract labor: Top level 0 0 0 0 0 0.00 0.00 12.00		Excluded area salaries (see	11.00	27, 254, 850	411, 228	27, 666, 078			
Care									
12.00 Contract abor: Top level management and other management and admini strative services	11. 00			1, 866, 311	0	1, 866, 311	24, 835. 00	75. 15	11. 00
management and admin is trative services	12. 00	Contract labor: Top level		0	0	0	0.00	0. 00	12. 00
Servi Ces									
A - Administrative	12 00	servi ces		404 212		404 212	2 002 00	150 02	12 00
organi zation salaries and wage-rel ated costs 14. 01 Home office salaries 0 0 0 0 0 0 0 0 0		A - Administrative		494, 312					
wage-related costs 0	14. 00			0	0	0	0.00	0.00	14. 00
14. 02 Related organization salaries 0 0 0 0 0 0 0 0 0	14 01	wage-related costs		0			0.00	0.00	14 01
- Administrativé Home office and Contract Physicians Part A - Teaching Home office Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching Wage-related costs (Core) (see instructions) Secondary Companies				0	0	0			
16.00 Home office and Contract 0 0 0 0 0.00 0.00 16.00 16.01 Home office Physicians Part A - Teaching 0 0 0 0 0.00 16.02 Home office contract 0 0 0 0 0.00 16.02 Home office contract 0 0 0 0 0.00 16.02 Home office contract 0 0 0 0 0.00 16.02 Home office contract 0 0 0 0 0.00 16.02 Home office contract 0 0 0 0 0.00 16.02 Home office contract 0 0 0 0 0.00 16.03 Home office contract 0 0 0 0 0 16.04 Home office contract 0 0 0 0 16.05 Home office contract 0 0 0 0 16.06 Home office contract 0 0 0 0 16.07 Home office contract 0 0 0 16.08 Home office contract 0 0 0 16.09 Home office contract 0 0 0 16.00 Home office wage-related (core) Home office contract 0 0 0 16.00 Home office contract 0 16.00 Home office contract 0 0 16.00 Home office contract 0 16.00 Home office contract 0 0 16.00 Home office contract 0	15. 00			0	0	0	0. 00	0. 00	15. 00
Home office Physicians Part A	16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
16.02 Home office contract 0 0 0 0 0.00 0.00 16.02	16. 01			0	0	o	0.00	0. 00	16. 01
Physicians Part A - Teaching	16 02	, i		0			0.00	0.00	16 02
17. 00 Wage-related costs (core) (see instructions) 18. 00 Wage-related costs (other) (see instructions) 18. 00 Wage-related costs (other) (see instructions) 19. 00 Excluded areas 20. 00 Non-physician anesthetist Part A Administrative 21. 00 Physician Part A - Administrative 22. 01 Physician Part A - Teaching 23. 00 Physician Part B 24. 00 Wage-related costs (RHC/FOHC) 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative -	10. 02	Physicians Part A - Teaching					0.00	0.00	10.02
18.00 Wage-rel ated costs (other) (see instructions) 18.00 18.00	17. 00			12, 797, 338	0	12, 797, 338			17. 00
19.00 Excluded areas 20.00 Non-physician anesthetist Part	18 00								18 00
20. 00 Non-physician anesthetist Part 0 0 0 0 21. 00 21. 00 Non-physician anesthetist Part 0 0 0 0 0 21. 00 22. 00 22. 00 Physician Part A - Administrative 0 0 0 0 0 0 22. 01 Physician Part A - Teaching 0 0 0 0 0 22. 01 23. 00 Physician Part B 0 0 0 0 23. 00 24. 00 Wage-related costs (RHC/FQHC) 0 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 25. 50 Home office wage-related (core) 25. 51 Related organization Wage-related (core) Home office: Physician Part A 0 0 0 0 25. 52 25. 52 Home office: Physician Part A 0 0 0 0 0 0 0 0 0		(see instructions)							
A Non-physician anesthetist Part D D D D D D D D D				4, 492, 333 0	0	4, 492, 333			
B		A		0					
Administrative 22.01 Physician Part A - Teaching		В		Ö					
22. 01 Physician Part A - Teaching 0 0 0 22. 01 23. 00 Physician Part B 0 0 0 0 23. 00 24. 00 Wage-related costs (RHC/FQHC) 0 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 25. 00 4 Home office wage-related (core) 0 0 0 0 0 25. 50 25. 51 Related organization wage-related (core) 0 0 0 0 25. 51 25. 52 Home office: Physician Part A - Administrative - 0 0 0 0 25. 52	22. 00	,		0	0	0			22. 00
24.00 Wage-related costs (RHC/FQHC) 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 25.00 25.50 Home office wage-related (core) 0 0 0 0 25.50 25.51 Related organization wage-related (core) 0 0 0 0 25.51 25.52 Home office: Physician Part A - Administrative - 0 0 0 0 25.52		Physician Part A - Teaching		0	0	0			22. 01
approved program 25.50 Home office wage-related (core) 0 0 0 25.50		, ,		0	0	0			
25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 45. 52 Home office: Physician Part A		Interns & residents (in an		0	0	0			25. 00
25. 51 Related organization 0 0 0 0 25. 51 wage-related (core) Home office: Physician Part A 0 0 0 0 25. 52 Administrative -	25. 50	Home office wage-related		0	0	0			25. 50
wage-related (core) 25.52 Home office: Physician Part A - Administrative -	25. 51			0	0	0			25. 51
- Administrative -		wage-related (core)		^					
wage-related (core)	∠3. 5∠	- Administrative -		U					∠5. 52
		wage-related (core)			I	I			

Provider CCN: 15-0059

Period: Worksheet S-3
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad:

					Т	o 12/31/2021	Date/Time Pre 5/24/2022 5: 2	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
27 00	OVERHEAD COSTS - DIRECT SALARIE		(40, 212		(42.212	17.0/1.05	25.77	27.00
26. 00	Employee Benefits Department	4. 00	642, 312		642, 312			26. 00
27. 00	Administrative & General	5. 00	9, 288, 756		9, 064, 525	·		
28. 00	Administrative & General under		240, 373	0	240, 373	570. 80	421. 12	28. 00
29. 00	contract (see inst.)	6. 00	0	_	_	0.00	0.00	29. 00
30.00	Maintenance & Repairs Operation of Plant	7.00	2 227 71/	0	2, 327, 716			
31.00	Laundry & Linen Service	7. 00 8. 00	2, 327, 716 74, 226		74, 226			
32.00	Housekeepi ng	9. 00	1, 071, 687	0	1, 071, 687	·		
32.00	, ,	9.00	1,0/1,00/	0	1,0/1,00/	49, 808. 73		
33.00	Housekeeping under contract (see instructions)		Ü	U		0.00	0.00	33.00
34.00	Di etary	10. 00	1, 298, 666	-940, 111	358, 555	16, 847. 42	21. 28	34.00
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	792, 376	792, 376	37, 231. 43	21. 28	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	703, 058	0	703, 058	16, 103. 25	43. 66	38. 00
39.00	Central Services and Supply	14. 00	715, 680	0	715, 680	26, 994. 50	26. 51	39. 00
40.00	Pharmacy	15. 00	2, 600, 303	-263, 493	2, 336, 810	59, 045. 00	39. 58	40. 00
41.00	Medical Records & Medical	16. 00	798, 359	0	798, 359	26, 611. 50	30.00	41.00
	Records Library							
42.00	Social Service	17. 00	697, 256	0	697, 256	·		42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION RI VERVI EW HOSPI TAL

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: | Part III | Par Provider CCN: 15-0059

					'	12/01/2021	5/24/2022 5: 25	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		92, 096, 873	113, 670	92, 210, 543	2, 095, 405. 25	44. 01	1.00
	instructions)							
2.00	Excluded area salaries (see		27, 254, 850	411, 228	27, 666, 078	480, 067. 15	57. 63	2.00
	instructions)							
3.00	Subtotal salaries (line 1		64, 842, 023	-297, 558	64, 544, 465	1, 615, 338. 10	39. 96	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2, 360, 623	0	2, 360, 623	27, 928. 00	84. 53	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		12, 797, 338	0	12, 797, 338	0. 00	19. 83	5. 00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		79, 999, 984	-297, 558	79, 702, 426	1, 643, 266. 10	48. 50	6. 00
7.00	Total overhead cost (see		20, 458, 392	-635, 459	19, 822, 933	610, 312. 65	32. 48	7. 00
	instructions)							

Health Financial Systems	RIVERVIEW HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL WAGE RELATED COSTS		Peri od: Worksheet S-3 From 01/01/2021 Part IV			

	To 12/31/2021	Date/Time Prep 5/24/2022 5: 2	
		Amount	<u>Б</u>
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 051, 457	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	9, 066, 844	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	220, 398	10. 00
11.00	Life Insurance (If employee is owner or beneficiary)	37, 369	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	261, 719	14. 00
15.00	'Workers' Compensation Insurance	240, 555	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	6, 309, 901	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	75, 288	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	26, 140	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	17, 289, 671	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Pre 5/24/2022 5:2	pared:
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identifi	cation:			
1.00	Total facility's contract labor and benefit co	ost	1, 866, 311	17, 289, 671	1.00
2.00	Hospi tal		1, 866, 311	17, 289, 671	2.00
3.00	Subprovi der - IPF				3. 00
4.00	Subprovi der - IRF		O	0	4. 00
5.00	Subprovi der - (Other)		o	0	5. 00
6.00	Swing Beds - SNF		o	0	6.00
7.00	Swing Beds - NF		o	0	7. 00
8.00	Hospi tal -Based SNF		o	0	8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11.00	Hospi tal -Based HHA				11. 00
10 00	C				1 40 00

12. 00 13. 00 14. 00 15. 00 16. 00 0 17. 00 0 18. 00

11.00 Hospital-Based HHA
12.00 Separately Certified ASC
13.00 Hospital-Based Hospice
14.00 Hospital-Based Health Clinic RHC
15.00 Hospital-Based Health Clinic FQHC
16.00 Hospital-Based-CMHC
17.00 Renal Dialysis
18.00 Other

Heal th	Financial Systems RIVERVIEW HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCI	N: 15-0059	Peri od:	Worksheet S-10			
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5: 2	pared: 5 pm		
					1. 00			
1 00	Uncompensated and indigent care cost computation		- 2021	- 0)	0 277120	1 00		
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by iin	e 202 corum	1 8)	0. 277128	1. 00		
2.00	Net revenue from Medicaid				3, 831, 105	2. 00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	ntal payments	from Medica	ai d?	Y	4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid			0	5. 00		
6.00	Medi cai d charges				56, 946, 568	6. 00		
7.00	Medicaid cost (line 1 times line 6)				15, 781, 488			
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minu	s sum of lir	nes 2 and 5; if	11, 950, 383	8. 00		
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions f</pre>	for each line	`					
9. 00	Net revenue from stand-alone CHIP	or each time)		0	9. 00		
10. 00	Stand-allone CHIP charges				0	10. 00		
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00		
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 min	us line 9; i	f < zero then	0			
	enter zero)							
	Other state or local government indigent care program (see ins							
13.00	Net revenue from state or local indigent care program (Not inc					13. 00 14. 00		
14. 00								
15. 00	10) State or local indigent care program cost (line 1 times line 1	(4)			0	15. 00		
16. 00	Difference between net revenue and costs for state or local in	,	program (lin	ne 15 minus line	Ö			
	13; if < zero then enter zero)	iai goire oar o	p. 09. a (· ·	10.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to f	unding chari	tv care		0	17. 00		
18.00	Government grants, appropriations or transfers for support of				0	18. 00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	al indigent c	are programs	s (sum of lines	11, 950, 383	19. 00		
	8, 12 and 16)							
			Uni nsured	Insured	Total (col. 1			
		-	patients 1.00	patients 2.00	+ col . 2) 3.00			
	Uncompensated Care (see instructions for each line)	I		2.00	0.00			
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	ncility	8, 906, 1	511, 410	9, 417, 550	20. 00		
21. 00	Cost of patients approved for charity care and uninsured disco	ounts (see	2, 468, 1	511, 410	2, 979, 551	21. 00		
21.00	instructions)	Junes (See	2, 100, 1	011, 110	2, 7, 7, 001	21.00		
22. 00	Payments received from patients for amounts previously writter	n off as		0 0	0	22. 00		
	charity care							
23. 00	Cost of charity care (line 21 minus line 22)		2, 468, 1	41 511, 410	2, 979, 551	23. 00		
					1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patie	ent days beyo	nd a Length	of stay limit	1. 00 N	24. 00		
21.00	imposed on patients covered by Medicaid or other indigent care		na a rengtir	or stay rrim t	.,,	21.00		
25. 00	If line 24 is yes, enter the charges for patient days beyond t stay limit		care progran	n's length of	0	25. 00		
26. 00	Total bad debt expense for the entire hospital complex (see in	nstructions)			13, 619, 952	26. 00		
27. 00	Medicare reimbursable bad debts for the entire hospital complete	,	uctions)		45, 321	27. 00		
27. 01	Medicare allowable bad debts for the entire hospital complex (•			69, 724			
28. 00	Non-Medicare bad debt expense (see instructions)	-	•		13, 550, 228			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see i	nstructions))	3, 779, 551	29. 00		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				6, 759, 102			
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			18, 709, 485	31.00		

Heal th	Financial Systems	RIVERVIEW H	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CC	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet A Date/Time Pre	pared:
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	5/24/2022 5: 2 Reclassified Trial Balance (col. 3 +-	5 pm
		1.00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		20, 307, 539	20, 307, 539	-381, 448	19, 926, 091	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	642, 312	7, 518, 044	8, 160, 356			
5.00	00500 ADMI NI STRATI VE & GENERAL	9, 288, 756	30, 701, 868	39, 990, 624			
7.00	00700 OPERATION OF PLANT	2, 327, 716	6, 499, 238	8, 826, 954		8, 826, 954	
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	74, 226 1, 071, 687	1, 703, 637 972, 062	1, 777, 863 2, 043, 749		1, 777, 863 2, 043, 749	
10.00	01000 DI ETARY	1, 298, 666	1, 919, 273	3, 217, 939			1
11. 00	01100 CAFETERI A	0	0	(1, 963, 413		1
13.00	01300 NURSING ADMINISTRATION	703, 058	98, 132	801, 190		801, 190	1
14.00	01400 CENTRAL SERVI CES & SUPPLY	715, 680	965, 670	1, 681, 350			
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 600, 303	18, 276, 230	20, 876, 533			1
17. 00	01700 SOCIAL SERVICE	798, 359 697, 256	546, 336 143, 404	1, 344, 695 840, 660		1, 344, 695 840, 660	1
23. 00	02300 PARAMED ED PRGM PHARMACY	077, 230	143, 404	040, 000			1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	10, 110, 616	1, 830, 658				
31.00	03100 NTENSI VE CARE UNIT	3, 536, 181	837, 374				
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 550, 026	1, 048, 790	2, 598, 816			
43.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	(0 0	0	
44.00	ANCI LLARY SERVICE COST CENTERS	9			<u> </u>		44.00
50.00	05000 OPERATI NG ROOM	4, 085, 657	8, 936, 467	13, 022, 124	-3, 776, 466	9, 245, 658	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 075, 588	704, 146	2, 779, 734			1
55. 00	05500 RADI OLOGY-THERAPEUTI C	506, 441	596, 386	1, 102, 827			1
57.00	05700 CT SCAN	362, 125	176, 806				1
57. 01 58. 00	03630 ULTRA SOUND	412, 391 317, 641	39, 776 91, 970				1
59. 00	05900 CARDI AC CATHETERI ZATI ON	873, 436	1, 810, 711	2, 684, 147			1
60.00	06000 LABORATORY	3, 271, 149	6, 258, 158	9, 529, 30			
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	639, 279	639, 279	9 0	639, 279	
64. 00	06400 NTRAVENOUS THERAPY	0	0	()	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 767, 743 5, 128, 917	522, 227 1, 575, 780	2, 289, 970 6, 704, 697		1	1
67. 00	06700 OCCUPATIONAL THERAPY	5, 120, 917	1, 373, 760	0, 704, 69	7 -7,230	0, 097, 401	1
68. 00	06800 SPEECH PATHOLOGY	o	Ö	,		ĺ	1
69. 00	06900 ELECTROCARDI OLOGY	592, 340	183, 915	776, 25	-70	776, 185	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	11, 292, 762	11, 292, 762	0	11, 292, 762	•
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	202 700	393, 780	0	0 391, 274	73.00
	03020 OTHER ANCI LLARY	0	393, 780 0	393, 700			76.00
76. 01	03140 CARDI AC REHAB	835, 217	593, 427	1, 428, 644	-	l	
76. 02	03070 WOMEN' S CENTER	453, 963	159, 856	613, 819			
76. 03	03330 ENDOSCOPY	0	0	(0	0	76. 03
00.00	OUTPATIENT SERVICE COST CENTERS	242 (74	477 (0)	F40 044	24 200	400.004	00.00
90. 00 90. 01	09000 CLI NI C 09001 OUTPATI ENT	342, 674 676, 899	176, 636 825, 684	519, 310 1, 502, 583			1
90. 01	09002 NEUROPSYCHOLOGY	311, 763	113, 843	425, 606		1	1
91. 00	09100 EMERGENCY	8, 722, 890	26, 140, 938	34, 863, 828			1
91. 01	09101 SHORT STAY	0	0	(l	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	50 557	07 704	00.044			
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	52, 557	37, 791	90, 348	3 0	90, 348	95. 00
118.00		66, 204, 233	154, 638, 593	220, 842, 826	297, 362	221, 140, 188	118 00
	NONREI MBURSABLE COST CENTERS	00/ 20 1/ 200	1017 0007 070	220/ 0 12/ 020	2777002	22171107100]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	83, 838	121, 896			205, 734	1
	19200 PHYSI CI ANS' PRI VATE OFFI CES	20, 358, 727	9, 590, 782	29, 949, 509		1	1
	19201	206, 030 966, 750	14, 617 207, 272	220, 647 1, 174, 022			1
	19206 HOME HEALTH PARTNERSHIP	900, 730	-224	1, 174, 022 -224		1	192. 02
	19207 WESTFI ELD SCHOOLS	1, 176, 014	160, 938	1, 336, 952			
	19203 PRACTICE MANAGEMENT	377, 399	546, 988	924, 387		l ''	1
	19204 MOB - NOBLESVILLE SQUARE	0	41, 601	41, 60			192. 06
	19208 PHYSI CLANS' PRI VATE OFFI CES	0	0	142.224	-	l	192. 07
	19205 RIVERVIEW MEDICAL ARTS 19209 BEHAVIOR CARE	400 144	143, 326	143, 326		143, 326 572, 483	
	19300 NONPALD WORKERS	408, 146	164, 338 0	572, 484 (192. 09
	19301 PHYSI CI AN SERVI CES-LYONS	139	253	392			193. 01
		· · · · · · · · · · · · · · · · · · ·	'		•	•	-

Health Financial Systems	RIVERVIEW H	IOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Period: From 01/01/2021	Worksheet A	
			l -	To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
193. 02 19302 UNI VERSITY HS ATHLETICS	60, 475	5, 377	65, 852	0	65, 852	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI	541, 135	90, 753	631, 888	0	631, 888	193. 03
193. 04 19304 OB/GYN SPEC GATHERS	132, 315	23, 333	155, 648	0	155, 648	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	565, 328	115, 586	680, 914	1 0	680, 914	193. 05
193. 06 19306 OUTPATIENT PHARMACY	534, 485	3, 682, 189	4, 216, 67	1 0	4, 216, 674	193. 06
194. 00 07950 WORKMED	241, 486	253, 262	494, 748	-3, 037	491, 711	194. 00
194.01 07951 MEALS ON WHEELS	O	0		366, 070	366, 070	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	91, 856, 500	169, 800, 880	261, 657, 380	0	261, 657, 380	200. 00

Health Fina	ncial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS	S-2552-10
RECLASSI FI C	ATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN	N: 15-0059	Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pi	repared:
	Coot Conton Decement on	Adiustments	Not Evnences		<u> </u>	5/24/2022 5:	: 25 pm
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7. 00				
	RAL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FLXT	-21, 162	19, 904, 929				1.00
1	DEMPLOYEE BENEFITS DEPARTMENT DAMINISTRATIVE & GENERAL	-52, 763 -15, 356, 550	8, 826, 533 25, 015, 522				4. 00 5. 00
	OPERATION OF PLANT	-8, 400	8, 818, 554				7. 00
	LAUNDRY & LINEN SERVICE	0,100	1, 777, 863				8. 00
	HOUSEKEEPI NG	0	2, 043, 749				9. 00
	D DI ETARY	0	882, 800				10. 00
	CAFETERI A	-725, 585	1, 237, 828				11. 00
	NURSING ADMINISTRATION	-5, 816	795, 374				13.00
	CENTRAL SERVICES & SUPPLY PHARMACY	0 -5, 449, 029	9, 149, 051 15, 150, 645				14. 00 15. 00
4	MEDICAL RECORDS & LIBRARY	-5, 449, 029	1, 342, 973				16.00
	SOCIAL SERVICE	0	840, 660				17. 00
	PARAMED ED PRGM PHARMACY	0	266, 402				23. 00
	TIENT ROUTINE SERVICE COST CENTERS						
4	ADULTS & PEDIATRICS	0	11, 452, 866				30.00
	DINTENSIVE CARE UNIT	-216	4, 028, 240				31.00
	SUBPROVIDER - IRF	0	2, 510, 028				41.00
	NURSERY SKILLED NURSING FACILITY	0	0				43. 00 44. 00
	LLARY SERVICE COST CENTERS	<u> </u>	0				44.00
	OPERATING ROOM	-2, 207, 534	7, 038, 124				50.00
	DELIVERY ROOM & LABOR ROOM	0	О				52. 00
	RADI OLOGY-DI AGNOSTI C	-3, 609	2, 771, 795				54.00
	RADI OLOGY-THERAPEUTI C	0	1, 100, 630				55. 00
	CT SCAN	-2, 891	440, 263				57. 00
57. 01 03630 58. 00 05800	ULTRA SOUND	-632 0	448, 268				57. 01 58. 00
	CARDI AC CATHETERI ZATI ON	-735, 000	403, 653 992, 448				59.00
	LABORATORY	-181, 393	9, 345, 328				60.00
	1 BLOOD LABORATORY	0	0				60. 01
	BLOOD STORING, PROCESSING & TRANS.	0	639, 279				63. 00
	INTRAVENOUS THERAPY	0	0				64. 00
	RESPI RATORY THERAPY	0	2, 168, 093				65. 00
4	PHYSI CAL THERAPY	-81, 894	6, 615, 567				66.00
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0				67. 00 68. 00
	ELECTROCARDI OLOGY	-95, 769	680, 416				69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	000, 410				71.00
4	IMPL. DEV. CHARGED TO PATIENTS	0	11, 292, 762				72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0	0				73. 00
	RENAL DIALYSIS	0	391, 274				74. 00
1	OTHER ANCILLARY	0	0				76. 00
	CARDI AC REHAB	-583	1, 305, 809				76. 01
76. 02 03070 76. 03 03330	WOMEN'S CENTER	-540 0	532, 596				76. 02 76. 03
	ATIENT SERVICE COST CENTERS	U	U				76.03
	CLINIC	0	488, 221				90.00
90. 01 0900°	1 OUTPATI ENT	-5, 450	1, 245, 618				90. 01
90. 02 09002	NEUROPSYCHOLOGY	0	425, 566				90. 02
-	DEMERGENCY	-13, 223, 408	20, 520, 167				91. 00
	SHORT STAY	0	0				91. 01
	O OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS						92. 00
	AMBULANCE SERVICES	-1, 750	88, 598				95. 00
	AL PURPOSE COST CENTERS	1,700	00, 070				70.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-38, 161, 696	182, 978, 492				118. 00
	EIMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	205, 734				190. 00
4	PHYSICIANS' PRIVATE OFFICES	0	29, 291, 030				192. 00
4	1 FOUNDATION	0	220, 647				192. 01
192. 02 1920	2 CLINICS 5 HOME HEALTH PARTNERSHIP	0	1, 172, 906 -224				192. 02 192. 03
	WESTFIELD SCHOOLS	0	1, 336, 153				192. 03
	B PRACTICE MANAGEMENT	n	924, 387				192. 05
	4 MOB - NOBLESVILLE SQUARE	Ö	41, 601				192. 06
	PHYSICIANS' PRIVATE OFFICES	0	0				192. 07
	RIVERVIEW MEDICAL ARTS	0	143, 326				192. 08
	BEHAVI OR CARE	0	572, 483				192. 09
	NONPALD WORKERS	1 0	O				193. 00
							100 01
	PHYSICIAN SERVICES-LYONS	0	392				193. 01
193. 02 19302		0 0	392 65, 852 631, 888				193. 01 193. 02 193. 03

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0059 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/24/2022 5: 25 pm

		372472022 3.23 pili
Adjustments	Net Expenses	
(See A-8)	For Allocation	
6. 00	7. 00	
0	155, 648	193. 04
0	680, 914	193. 05
0	4, 216, 674	193. 06
0	491, 711	194. 00
0	366, 070	194. 01
-38, 161, 696	223, 495, 684	200. 00
	(See A-8) 6.00 0 0 0	(See A-8) For Allocation 6.00 7.00 0 155, 648 0 680, 914 0 4, 216, 674 0 491, 711 0 366, 070

Peri od: Worksheet A-6
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/24/2022 5:25 pm

					10 12/01/2021	5/24/2022 5: 25 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	11. 00	792, 376	1, 171, 037		1.00
	TOTALS		792, 376	1, 171, 037		
	B - MEALS ON WHEELS RECLASS		,,	.,,		
1.00	MEALS ON WHEELS	194. 01	147, 735	218, 335		1. 00
1.00	TOTALS	— — 1711.01	147, 735	218, 335		1. 66
	C - INSURANCE RECLASS		147, 733	210, 333		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	381, 448		1.00
1.00	TOTALS			381, 448		1.00
			υĮ	301, 440		
1 00	D - MEDICAL SUPPLY RECLASS	14.00	ol	7 4/7 701		1 00
1.00	CENTRAL SERVICES & SUPPLY	14.00	-1	7, 467, 701		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0. 00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	О	0		14. 00
15.00		0.00	o	0		15. 00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17. 00
18.00		0.00	ol	0		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	Ö		20.00
21. 00		0.00	o	Ö		21. 00
22. 00		0.00	o	Ö		22. 00
23. 00		0.00	Ö	Ö		23. 00
24. 00		0.00	0	Ö		24.00
25. 00		0.00	Ö	Ö		25. 00
26. 00		0.00	0	Ö		26.00
27. 00		0.00	0	Ö		27. 00
28. 00		0.00	0	0		28. 00
26.00	TOTALS — — — —			7, 467, 701		28.00
	E - RSMA RECLASS		U	7,467,701		
1. 00	OPERATING ROOM	50.00	337, 901			1.00
			337, 901	/ 021		
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		<u>6, 921</u>		2. 00
	TOTALS		337, 901	6, 921	 	
4 00	F - PARAMED ED RECLASS	00.00	0/0 466	0.000		1.00
1. 00	PARAMED ED PRGM PHARMACY	2300	263, 493			1.00
	TOTALS		263, 493	2, 909		
	G - COMMUNITY RELATIONS RECLAS					
1.00	ADMI NI STRATI VE & GENERAL		0	22 <u>4, 2</u> 31		1.00
	TOTALS			224, 231	 	
	H - ALLOCATED BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	712, 019		1.00
	TOTALS	+		712, 019		
500.00	Grand Total: Increases		1, 541, 505	10, 184, 601		500.00
		ı		==:		1

| Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0059

					1	o 12/31/2021 Date/limeP 5/24/2022 5	
	-	Decreases				072172022 0	. 20 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
Α	- CAFETERIA RECLASS						
. 00 DI	I ETARY	<u>10.</u> 00	<u>792, 3</u> 76	<u>1, 171, 0</u> 37	0		1. (
TO	OTALS		792, 376	1, 171, 037			
В	- MEALS ON WHEELS RECLASS						
. 00 DI	I ETARY	10.00	147, 735	218, 335	0		1. (
TO	OTALS		147, 735	218, 335			
С	- INSURANCE RECLASS						
. 00 C/	AP REL COSTS-BLDG & FLXT	1.00	0	381, 448	12		1.
	OTALS			381, 448			
D	- MEDICAL SUPPLY RECLASS	•	•		<u> </u>		
. 00 DI	I ETARY	10.00		5, 656	0		1.
	HARMACY	15. 00		10, 457			2.
	DULTS & PEDIATRICS	30.00		488, 408			3. (
	NTENSIVE CARE UNIT	31.00		345, 099			4.
	UBPROVI DER – I RF	41.00		88, 788	1		5.
	PERATING ROOM	50.00	1	3, 769, 545	1		6.
	ADI OLOGY-DI AGNOSTI C	54.00		4, 330	1		7.
	ADI OLOGY-THERAPEUTI C	55. 00		2, 197	- 1		8.
	T SCAN	57. 00		95, 777	1		9.
	ILTRA SOUND	57. 00 57. 01		3, 267	1		10.
				· ·			
	IRI	58.00		5, 958			11.
	ARDI AC CATHETERI ZATI ON	59.00		956, 699	l l		12.
	ABORATORY	60.00		2, 586			13.
	ESPI RATORY THERAPY	65. 00		121, 877			14.
	HYSI CAL THERAPY	66.00		7, 236			15.
	LECTROCARDI OLOGY	69. 00		70			16.
	ENAL DIALYSIS	74.00		2, 506			17.
8. 00 C	ARDI AC REHAB	76. 01		122, 252			18.
9.00 W	OMEN'S CENTER	76. 02		80, 683	0		19.
D. 00 CI	LINIC	90.00		31, 089	0		20.
1.00 0	UTPATI ENT	90. 01		251, 515	0		21.
2. 00 NI	IEUROPSYCHOLOGY	90. 02		40	o		22.
3. 00 E	MERGENCY	91.00		408, 234	. 0		23.
4. 00 PI	'HYSICIANS' PRIVATE OFFICES	192.00		658, 479	0		24.
5. 00 CI	LINICS	192. 02		1, 116	i i		25.
	ESTFIELD SCHOOLS	192. 04		799			26.
	EHAVI OR CARE	192. 09		1	0		27.
	ORKMED	194.00		3, 037	1		28.
	OTALS	— — ·····+		7, 467, 701			
	- RSMA RECLASS		٥,	,, ,,,,,,,			
	PERATING ROOM	50.00	0	344, 822	. 0		1.
00	TENTINO ROOM	0.00	o	011,022	o o		2.
	OTALS	— — 		344, 822			
	- PARAMED ED RECLASS		<u> </u>	344, 022	1		
	HARMACY	15. 00	263, 493	2, 909	0		1.
_	OTALS			$\frac{2,909}{2,909}$			'-
	orals - COMMUNITY RELATIONS RECLA	cc	203, 493	2, 909	1		
_			224 224				_ ,
	DMI NI STRATI VE & GENERAL		224, 231	9	<u> </u>		1.
_	OTALS		224, 231		1		_
	I - ALLOCATED BENEFITS RECLAS		1		1		
_	MERGENCY	<u>91.</u> 00	•	71 <u>2, 0</u> 19			1.
-	OTALS		0	712, 019			
10 00 IC	rand Total: Decreases		1, 427, 835	10, 298, 271	1		500.

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RI VERVI EW HOSPI TAL

Provider CCN: 15-0059

						Date/Time Prep 5/24/2022 5: 2		
				Acqui si ti ons	5			
		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	Γ BALANCES						
1.00	Land	15, 961, 384	89, 030		0	89, 030	0	1.00
2.00	Land Improvements	3, 160, 234	70, 856		0	70, 856	0	2.00
3.00	Buildings and Fixtures	165, 529, 203	644, 100		0	644, 100	0	3. 00
4.00	Building Improvements	1, 399, 855	0		0	0	0	4. 00
5.00	Fixed Equipment	51, 814, 379	0		0	0	1, 513, 898	5. 00
6.00	Movable Equipment	117, 243, 801	4, 811, 441		0	4, 811, 441	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	355, 108, 856	5, 615, 427		0	5, 615, 427	1, 513, 898	8. 00
9.00	Reconciling Items	0	0		0	0	0	9. 00
10.00	Total (line 8 minus line 9)	355, 108, 856	5, 615, 427		0	5, 615, 427	1, 513, 898	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	16, 050, 414	0					1. 00
2.00	Land Improvements	3, 231, 090	0					2. 00
3.00	Buildings and Fixtures	166, 173, 303	0					3. 00
4.00	Building Improvements	1, 399, 855	0					4. 00
5.00	Fixed Equipment	50, 300, 481	0					5. 00
6.00	Movable Equipment	122, 055, 242	0					6. 00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	359, 210, 385	0					8. 00
9.00	Reconciling Items	0	0					9. 00
10. 00	Total (line 8 minus line 9)	359, 210, 385	0					10. 00

Heal th	Financial Systems	RIVERVIEW HOSPITAL			In Lieu of Form CMS-2552-10		
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der (CCN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	· · · · · · · · · · · · · · · · · · ·	•	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	20, 307, 539		0	0	0	1.00
3.00	Total (sum of lines 1-2)	20, 307, 539)	0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (su	n			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	20, 307, 53	9			1. 00
3.00	Total (sum of lines 1-2)	0	20, 307, 53	9			3. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2021 Fo 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/24/2022 5:25	
	COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	у ріп
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	359, 210, 385	0	359, 210, 38	1. 000000	0	1.00
3.00 Total (sum of lines 1-2)	359, 210, 385		359, 210, 38			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other Capi tal -Relate	Total (sum of cols. 5	Depreciation	Lease	
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0		20, 307, 539	0	1.00
3.00 Total (sum of lines 1-2)	0	0	(20, 307, 539	0	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see instructions)	through 14)	
	11. 00	12.00	13.00	14.00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	-21, 162	-381, 448	(0	19, 904, 929	1.00
3.00 Total (sum of lines 1-2)	-21, 162	-381, 448		o o	19, 904, 929	3. 00

Provider CCN: 15-0059

				T	o 12/31/2021			
				Expense Classification on		5/24/2022 5. 25	3 PIII	
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00		
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	0	1. 00	
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00	
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00	
	(chapter 2)		O					
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00	
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00	
6.00	Rental of provider space by		0		0.00	0	6. 00	
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00	
	stations excluded) (chapter 21)							
8.00	Television and radio service		0		0. 00	0	8. 00	
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00	
10. 00	Provider-based physician adjustment	A-8-2	-20, 031, 154			0	10. 00	
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00	
12. 00	(chapter 23) Related organization	A-8-1	281, 651			0	12. 00	
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-424, 000 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00	
	and others		0					
16. 00	Sale of medical and surgical supplies to other than		U		0.00	0	16. 00	
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00	
18. 00	patients Sale of medical records and		0		0.00	0	18. 00	
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00	
. ,	education (tuition, fees, books, etc.)		· ·		0.00		17.00	
20. 00	Vending machines		0		0.00	0		
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00	
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00	
22.00	overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00	
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00	
04.00	limitation (chapter 14)			DUVOLOAL TUEDADV			04.00	
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00	
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00	
2.00	physicians' compensation							
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00	
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27. 00	
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00	
29. 00	Physicians' assistant		0		0.00	0	29. 00	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30. 00	
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99	
	instructions)	A-8-3					31. 00	
31. 00	Adjustment for speech pathology costs in excess of	H-0-3	0	SPEECH PATHOLOGY	68. 00		31.00	
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00	
33. 00	Depreciation and Interest HAF EXPENSE	A	-9 077 065	ADMINISTRATIVE & GENERAL	5. 00	<u> </u>	33. 00	
	1	1 "	,, 5, 7, 003	r Grantive a Sevenine	3.00	·		

From 01/01/2021 | WUI NOTICE LA-0
From 12/31/2021 | Date/Time Prepared:

				T	12/31/2021	Date/Time Pre 5/24/2022 5: 2	
				Expense Classification on	Workshoot A	3/24/2022 3.2	o piii
				To/From Which the Amount is			
				TOTTION WITCH THE AMOUNT IS	to be Aujusteu		
	Cost Contor Doscription	Pacis/Codo (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	Cost Center Description	Basi s/Code (2)	2. 00	3.00	4. 00	5. 00	
33. 01	ADMI NI STRATI ON	1. 00 A		ADMI NI STRATI VE & GENERAL	5.00	5.00	33. 01
33.01	RECRUITMENT/SPECIAL E	A	-11, 470	ADMINISTRATIVE & GENERAL	5.00	U	33.01
33. 02	OTHER REV MEDICAL REPORT	В	1 700	MEDICAL RECORDS & LIBRARY	1/ 00	0	33. 02
	4	B B			16. 00	ı	
33. 03	OTHER REVENUES ->PURCHASE DI SCOUNTS	В	-42, 080	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	RADI OLOGY - OTHER REVENUE-CDS	В	2 057	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 04
33. 04	FOR LEG	D	-2, 937	RADI OLOGI - DI AGNOSTI C	34.00	U	33.04
33. 05	AMBULANCE OTHER REVENUE	В	1 750	AMBULANCE SERVICES	95. 00	0	33. 05
33. 06	LABORATORY -> OTHER REVENUE	В		LABORATORY	60.00	0	33. 06
33. 07	MATERNITY CENER OTHER REVNEU	В	· ·	OPERATION OF PLANT	7. 00	0	33. 00
33. 07	INFORMATION SYSTEMS OTHER REV	В	· ·	WOMEN'S CENTER	7. 00 76. 02	0	33. 07
33. 09	ADMINISTRATION LEAN TEAM	В		EMERGENCY	76. 02 91. 00	0	33. 09
		В				· -	
33. 10	EDUCATION -> OTHER REVENUE	1		ADMINISTRATIVE & GENERAL	5.00	0	33. 10
33. 11	OP PHARMACY REVENUE	A	-5, 449, 029	i e	15.00	0	33. 11
33. 12	DI ETARY SALES PR DEDUCT	В	· ·	CAFETERI A	11. 00	0	
33. 13	WELLNESS SERVICES - EXTERNAL->-OTHER	В	-14, 909	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 13
33. 14	OTHER REV PREMIER PROGRAM	В	0	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 14
33. 15	WESTFIELD BISTRO-OTHER REVENUE	1		CAFETERI A	11. 00	0	33. 15
33. 16	NON-OP REV -> MI SCELLANEOUS	B		CAP REL COSTS-BLDG & FIXT	1. 00	11	
	INTEREST						
33. 17	COMMUNITY RELATIONS	A	-2, 114, 993	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	COMMUNITY RELATIONS BENEFITS	A	-26, 396	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 18
33. 19	CRNA	A	-725, 250	OPERATING ROOM	50.00	0	33. 19
33. 20	IHA LOBBYING EXPENSE	A	-5, 836	ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	CV SERVICES-OTHER REVENUE	В	-120	ELECTROCARDI OLOGY	69. 00	0	33. 21
33. 22	CT SCAN-OTHER REVENUE	В	-2, 891	CT SCAN	57. 00	0	33. 22
33. 23	FISCAL SERVICES COMMERCE BANK	В	-91, 897	ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24	REBATE ULTRASOUND - OTHER REVENUE	В	422	ULTRA SOUND	57. 01	0	33. 24
33. 25	WOUND CARE-OTHER REVENUE	В		OUTPATI ENT	90. 01	0	33. 25
33. 26	NON-OP EXPENSE INVESTMENT FEES		· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 26	OTHER MISC REVENUE	B B	· ·	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 26
33. 27	l .	В	· ·	LABORATORY		0	
	RVH MEDICATION MGMT CLINIC	B B		•	60.00	ı	33. 28
33. 29	OTHER REV RADIOLOGY FILM	B B		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 29
33. 30	ADMIN DONATIONS	_		ADMINISTRATIVE & GENERAL	5. 00	0	33. 30
50.00	TOTAL (sum of lines 1 thru 49)		-38, 161, 696				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

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

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

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

 The been posted to worksheet N, cordinas i did of 2, the disease arrowable should be that dated in cordinar i or this part.									
			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:							

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

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

6.00	В	RSMA	100.00	0.00	6. 00
7.00			0.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Worksheet A-8, column 2,

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Financial Syste			RIVERVIEW HO	SPI TAL		In Lie	u of Form CMS-	
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED ORGANIZ	ATIONS AND HOME	Provider CCN	: 15-0059	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2021		
							To 12/31/2021		
								5/24/2022 5: 2	25 pm
		Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6, 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTA	MENTS REQUIRED A	AS A RESULT OF TR	ANSACTIONS WITI	H RELATED C	RGANIZATIONS OR (CLAIMED	
	HOME OFFICE CO								
1.00	281, 651								1.00
2.00	0	0							2. 00
3.00	0	,							3. 00
4. 00	٥	٥							4. 00
	201 / 51	0							
5.00	281, 651								5. 00
							ksheet A, column		
appropr	i ate. Posi ti ve	amounts increas	se cost and nega	itive amounts deci	rease cost. For	related or	ganization or hom	ne office cost	whi ch
has not	been posted to	o Worksheet A,	columns 1 and/o	or 2, the amount a	allowable shoul	d be indic	ated in column 4	of this part.	
	Related Orga	ani zati on(s)							
		me Office							

Related Organization(s)
and/or Home Office

Type of Business
6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	6.00
7. 00	7.00
8. 00	8.00
9. 00	8. 00 9. 00
10. 00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	10. 00 100. 00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0059

Wisst: A Line # Cost Center/Physician Identification Identificatio						1	Го 12/31/2021	Date/Time Pre 5/24/2022 5: 2	epared: 25 pm
1.00		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		•
1.00				Remuneration	Component	Component		ider Component	
1.00					·	·		Hours	
2.00		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
3.00	1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	11, 458	11, 458			0	1. 00
3.1.00 MTENSIVE CARE UNIT 216	2.00	5. 00	ADMINISTRATIVE & GENERAL	4, 113, 624	4, 113, 624			0	2.00
S. OO S. OO OPERATING ROOM 1,763,935 1,763,935 0 0 0 0 5.00	3.00	13. 00	NURSING ADMINISTRATION	5, 816	5, 816	_	_	0	3.00
0.00 5.9. OD_CARDIAC_CATHETERIZATION 7.35, DOD 0 0 0 0 0 0 0 0 0	4.00	31.00	INTENSIVE CARE UNIT	216	216	0	0	0	4.00
1.00	5.00					0	0	0	5.00
8. 00	6.00			735, 000		0	0	0	6. 00
9.00 76. 01 CARDIAC REHAB 583 583 0 253, 361 211, 500 2, 518 10.00 11.00 91.00 EMERGENCY 225, 361 13, 222, 979 13, 222, 979 20, 201, 154 235, 361 211, 500 2, 518 200.00 11.00 200.00	7.00			81, 894	81, 894	0	0	0	7. 00
10.00 90. 02 NEUROPSYCHOLOGY 13.222.979 20. 031, 154 235, 361 211, 500 2, 518 10. 00 20. 00	8.00			95, 649	95, 649	0	0	0	8. 00
11.00 91.00 EMERGENCY 13, 222, 979 13, 222, 979 20, 203, 154 235, 361 235, 361 225, 518 200. 003 1.00 2.00 1.00 2.00 1.00 2.00 1.	9.00			583	583		0	0	9. 00
Nest: A Line # Cost Center/Physician Limit Limit	10.00					235, 361	211, 500	2, 518	10.00
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Unadjusted RCE Limit Cost of Identifier Unadjusted RCE Limit Cost of Identifier Unadjusted RCE Limit Cost of Identifier Unadjusted RCE Unadjusted RCE Unadjusted RCE Sercent of Unadjusted RCE Sercent of Unadjusted RCE Cost of Unadjusted RCE Sercent of Unadjusted RCE Unadjusted RCE Education Share of col. Insurance Education Share of col. Insurance Component Share of col. Col.	11. 00	91.00	EMERGENCY	13, 222, 979	13, 222, 979	0	0	0	11. 00
Identifier	200.00			20, 266, 515		235, 361			200.00
1.00		Wkst. A Line #							
1.00			I denti fi er	Limit					
1.00					Limit			Insurance	
1.00									
2. 00 3. 00 13. 00 NURSI NG ADMIN ISTRATI VE & GENERAL 3. 00 3. 00 13. 00 NURSI NG ADMIN ISTRATION 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	4.00								1 00
3.00		•	1	0	_				
4.00				0	_	_			
5. 00 50. 00 OPERATI NG ROOM 0 0 0 0 0 0 0 0 0				0					
6. 00				0		_	1		
7. 00				0	0		0	· · · · · · · · · · · · · · · · · · ·	
8. 00 69. 00 ELECTROCARDI OLOGY 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0	0	-	
9. 00 76. 01 CARDI AC REHAB 0 0 0 0 0 0 0 0 0 0 0 0 10. 00 10. 00 10. 00 90. 02 NEUROPSYCHOLOGY 256, 037 12, 802 0 0 0 0 10. 00 10. 00 11. 00 200. 00 91. 00 EMERGENCY 0 0 0 0 0 0 0 11. 00 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0	0	-	
10.00				0	0	0	0		
11.00				25/ 027	12 002	0	0	ı -	
200.00 256,037 12,802 0 0 0 200.00				250, 037	12, 802	0	0	-	
Wkst. A Line # Cost Center/Physician Identifier Component Share of col. Limit Disallowance Disallowance Disallowance Adjustment Disallowance Disall		91.00	EMERGENCY	254 027	12 002	0	0		
Identifier Component Share of col. Limit Disallowance	200.00	Wkst Alino#	Cost Contor/Physician					U	200.00
Share of col 14		WKSt. A LITTE #			, ,		Aujustillerit		
14			ruentiffei		Limit	Di Sai i Owance			
1.00									
1. 00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 0 0 0 11, 458 1. 00 2. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 0 4, 113, 624 2. 00 3. 00 13. 00 NURSI NG ADMI NI STRATI ON 0 0 0 5, 816 3. 00 4. 00 31. 00 I NTENSI VE CARE UNI T 0 0 0 216 4. 00 5. 00 50. 00 OPERATI NG ROOM 0 0 0 1, 763, 935 5. 00 6. 00 59. 00 CARDI AC CATHETERI ZATI ON 0 0 0 735, 000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 0 0 81, 894 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 95, 649 8. 00 9. 00 76. 01 CARDI AC REHAB 0 0 0 583 9. 00 10. 00 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 <t< td=""><td></td><td>1, 00</td><td>2.00</td><td></td><td>16, 00</td><td>17. 00</td><td>18. 00</td><td></td><td></td></t<>		1, 00	2.00		16, 00	17. 00	18. 00		
2. 00 5. 00 ADMI NI STRATI VE & GENERAL 0 0 4, 113, 624 2. 00 3. 00 13. 00 NURSI NG ADMI NI STRATI ON 0 0 0 5, 816 3. 00 4. 00 31. 00 I NTENSI VE CARE UNI T 0 0 0 216 4. 00 5. 00 50. 00 OPERATI NG ROOM 0 0 0 1, 763, 935 5. 00 6. 00 59. 00 CARDI AC CATHETERI ZATI ON 0 0 0 735, 000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 0 0 81, 894 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 95, 649 8. 00 9. 00 76. 01 CARDI AC REHAB 0 0 0 583 9. 00 10. 00 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 13, 222, 979 11. 00	1. 00			0					1. 00
3. 00	2.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0			2. 00
5. 00 50. 00 OPERATI NG ROOM 0 0 0 1,763,935 5. 00 6. 00 59. 00 CARDI AC CATHETERI ZATI ON 0 0 0 7.35,000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 0 0 81,894 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 95,649 8. 00 9. 00 76. 01 CARDI AC REHAB 0 0 0 583 9. 00 10. 00 90. 02 NEUROPSYCHOLOGY 0 256,037 0 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 13, 222, 979 11. 00	3.00	13. 00	NURSING ADMINISTRATION	0	0	0			3.00
6. 00 59. 00 CARDI AC CATHETERI ZATI ON 0 0 0 735, 000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 0 0 0 81, 894 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 95, 649 8. 00 9. 00 76. 01 CARDI AC REHAB 0 0 0 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 13, 222, 979 11. 00	4.00	31.00	INTENSIVE CARE UNIT	0	0	0			4. 00
6. 00 59. 00 CARDI AC CATHETERI ZATI ON 0 0 0 735, 000 6. 00 7. 00 66. 00 PHYSI CAL THERAPY 0 0 0 0 81, 894 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 95, 649 8. 00 9. 00 76. 01 CARDI AC REHAB 0 0 0 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 13, 222, 979 11. 00	5.00			0	0	0			5. 00
7. 00 66. 00 PHYSI CAL THERAPY 0 0 81,894 7. 00 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 95,649 8. 00 9. 00 76. 01 CARDI AC REHAB 0 0 0 583 9. 00 10. 00 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 13, 222, 979 11. 00				ĺ	Ō	0			
8. 00 69. 00 ELECTROCARDI OLOGY 0 0 95, 649 8. 00 9. 00 76. 01 CARDI AC REHAB 0 0 0 583 9. 00 10. 00 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 13, 222, 979 11. 00	7. 00	•	1	0	0	0	· ·		7. 00
9. 00 76. 01 CARDI AC REHAB 0 0 0 583 9. 00 10. 00 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 13, 222, 979 11. 00		•	1	ĺ	l o	0	l '		
10. 00 90. 02 NEUROPSYCHOLOGY 0 256, 037 0 0 10. 00 11. 00 91. 00 EMERGENCY 0 0 0 13, 222, 979 11. 00		•	1	ĺ	Ō	0	l '		
11. 00 91. 00 EMERGENCY 0 0 13, 222, 979 11. 00		•	1	ĺ	256, 037	0	l e		
		•	1	l o	0		13, 222, 979		
				0	256, 037	0			

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0059

					T	0 12/31/2021	Date/Time Prep 5/24/2022 5: 2	
				CAPI TAL			372472022 3.2	5 piii
Cost Center Description			Net Expenses	RELATED COSTS BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		·	for Cost		BENEFITS		& GENERAL	
			Allocation (from Wkst A		DEPARTMENT			
			col. 7)					
	CENED	AL CEDVICE COCT CENTEDS	0	1. 00	4. 00	4A	5. 00	
1.00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	19, 904, 929	19, 904, 929				1. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8, 826, 533	83, 737	8, 910, 270			4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	25, 015, 522 8, 818, 554	1, 531, 217 6, 782, 925		27, 431, 110 15, 828, 580	27, 431, 110 2, 214, 545	5. 00 7. 00
8.00	1	LAUNDRY & LINEN SERVICE	1, 777, 863					
9.00		HOUSEKEEPI NG	2, 043, 749					9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	882, 800 1, 237, 828		1	1, 321, 425 1, 315, 135		
13. 00		NURSI NG ADMI NI STRATI ON	795, 374	0		863, 967	120, 876	•
14.00		CENTRAL SERVICES & SUPPLY PHARMACY	9, 149, 051	221, 003		9, 439, 879		
15. 00 16. 00	1	MEDICAL RECORDS & LIBRARY	15, 150, 645 1, 342, 973	275, 611 73, 329	227, 989 77, 891	15, 654, 245 1, 494, 193	2, 190, 154 209, 050	15. 00 16. 00
17. 00	01700	SOCIAL SERVICE	840, 660	52, 133	68, 027	960, 820	134, 426	17. 00
23. 00		PARAMED ED PRGM PHARMACY LENT ROUTINE SERVICE COST CENTERS	266, 402	4, 918	25, 707	297, 027	41, 556	23. 00
30. 00		ADULTS & PEDIATRICS	11, 452, 866	2, 973, 842	986, 432	15, 413, 140	2, 156, 422	30. 00
31.00		INTENSIVE CARE UNIT	4, 028, 240			4, 816, 677	673, 892	31.00
41. 00 43. 00		SUBPROVI DER - I RF NURSERY	2, 510, 028 0	474, 085 0		3, 135, 340 0	438, 659 0	41. 00 43. 00
44. 00		SKILLED NURSING FACILITY	0	0		0	Ö	44. 00
FO 00	ANCI L	LARY SERVICE COST CENTERS OPERATING ROOM	7 020 124	1 (0/ 401	431, 580	0.07/ 105	1 2/0 021	FO 00
50. 00 52. 00		DELIVERY ROOM & LABOR ROOM	7, 038, 124 0	1, 606, 481 0		9, 076, 185 0	1, 269, 831 0	50. 00 52. 00
54.00		RADI OLOGY-DI AGNOSTI C	2, 771, 795					
55. 00 57. 00		RADI OLOGY-THERAPEUTI C CT SCAN	1, 100, 630 440, 263	227, 698 0		1, 377, 738 475, 593		55. 00 57. 00
57. 00		ULTRA SOUND	448, 268	0		488, 503		
58. 00	05800	l e e e e e e e e e e e e e e e e e e e	403, 653		,	434, 643		•
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	992, 448 9, 345, 328			1, 152, 548 10, 126, 184		59. 00 60. 00
60. 01	1	BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	639, 279	78, 374 0	1	717, 653 0		63. 00 64. 00
65. 00	1	RESPIRATORY THERAPY	2, 168, 093	_		_		
66. 00		PHYSI CAL THERAPY	6, 615, 567	149, 070	500, 398	7, 265, 035		66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	680, 416	210, 563	57, 791	948, 770	132, 741	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0 11, 292, 762	0	0	0 11, 292, 762	0 1, 579, 948	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATTENTS	11, 292, 762	-		0	0	73. 00
		RENAL DIALYSIS	391, 274	29, 478	1	420, 752	58, 867	
76. 00 76. 01		OTHER ANCILLARY CARDI AC REHAB	1, 305, 809	0 349, 003		0 1, 736, 299		
76. 02	03070	WOMEN'S CENTER	532, 596			869, 346		76. 02
76. 03		ENDOSCOPY TLENT SERVICE COST CENTERS	0	0	0	0	0	76. 03
90. 00		CLINIC	488, 221	76, 502	33, 433	598, 156	83, 687	90. 00
90. 01		OUTPATI ENT	1, 245, 618			1, 423, 065		
90. 02 91. 00		NEUROPSYCHOLOGY EMERGENCY	425, 566 20, 520, 167	53, 878 672, 749		509, 861 22, 043, 956	71, 334 3, 084, 126	
91. 01	1	SHORT STAY	0	0,2,717	1	0	0,001,120	91. 01
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
95. 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	88, 598	8, 662	5, 128	102, 388	14, 325	95. 00
	SPECI.	AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	182, 978, 492	18, 274, 650	6, 393, 159	178, 831, 102	21, 182, 072	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	205, 734	191, 017	8, 180	404, 931	56, 653	190. 00
		PHYSICIANS' PRIVATE OFFICES	29, 291, 030	1, 439, 262				
		FOUNDATION CLINICS	220, 647 1, 172, 906	0	20, 101 94, 320	240, 748 1, 267, 226		
		HOME HEALTH PARTNERSHIP	-224	0	74, 320	-224	0	192. 03
		WESTFIELD SCHOOLS	1, 336, 153		114, 737	1, 450, 890		•
		PRACTICE MANAGEMENT MOB - NOBLESVILLE SQUARE	924, 387 41, 601	0 0		961, 208 41, 601		192. 05 192. 06
192. 07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	Ō	0	0	192. 07
192. 08	19205	RIVERVIEW MEDICAL ARTS	143, 326	0	0	143, 326	20, 052	192. 08

					5/24/2022 5: 2	
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	for Cost		BENEFITS		& GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1. 00	4. 00	4A	5. 00	
192. 09 19209 BEHAVI OR CARE	572, 483	0	39, 820	612, 303		
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	392	0	14	406	57	193. 01
193. 02 19302 UNI VERSITY HS ATHLETICS	65, 852	0	5, 900	71, 752	10, 039	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI	631, 888	0	52, 795	684, 683	95, 793	193. 03
193.04 19304 OB/GYN SPEC GATHERS	155, 648	0	12, 909	168, 557	23, 582	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	680, 914	0	55, 156	736, 070	102, 982	193. 05
193. 06 19306 OUTPATIENT PHARMACY	4, 216, 674	0	52, 146	4, 268, 820	597, 242	193. 06
194. 00 07950 WORKMED	491, 711	0	23, 560	515, 271	72, 091	194. 00
194.01 07951 MEALS ON WHEELS	366, 070	0	14, 414	380, 484	53, 233	194. 01
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	223, 495, 684	19, 904, 929	8, 910, 270	223, 495, 684	27, 431, 110	202. 00

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/24/2022 5:25 pm

				'') 12/31/2021	5/24/2022 5: 2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	•	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	18, 043, 125					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	72, 391	2, 159, 874	Į.			8. 00
9.00	00900 HOUSEKEEPI NG	58, 560	O	2, 550, 004			9. 00
10.00	01000 DI ETARY	632, 915	O	5,000	2, 144, 218		10.00
11. 00		ol	0	70,000	0	1, 569, 133	11.00
13. 00		ol	0	0	0	20, 448	13.00
14. 00		346, 533	17, 504	2, 500	0	34, 278	14. 00
15. 00		432, 159	.,, 55.	62, 500	0	72, 150	1
16. 00		114, 980	0	12, 500	0	36, 616	
17. 00	l i	81, 745	0	0	0	23, 463	
23. 00		7, 712	0		0	2, 825	23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7,712		,, ,	<u> </u>	2,023	23.00
30. 00		4, 663, 005	729, 940	857, 503	1, 453, 372	288, 209	30.00
			· ·			-	1
31.00		695, 306	170, 169	1	197, 427	68, 705	31.00
41. 00		743, 368	181, 944	1	493, 419	49, 633	•
43.00		0	U	0	0	0	43. 00
44. 00		0	U)	U	0	44. 00
EO 00	ANCILLARY SERVICE COST CENTERS	2 510 070	227 222	420.004		140.074	E0 00
50.00		2, 518, 972	226, 022		0	148, 876	50.00
52.00		0	0	0	0	70,001	52.00
54. 00		661, 125	136, 371	1	0	70, 901	54.00
55. 00	l i	357, 031	18, 840		0	11, 869	55. 00
57. 00		0	0	0	0	12, 075	1
57. 01	03630 ULTRA SOUND	0	0	0	0	10, 859	1
58. 00		0	0	2, 500	0	9, 418	
59. 00		117, 418	60, 086	1	0	21, 532	59. 00
60. 00		723, 964	0	157, 500	0	123, 741	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00		122, 891	0	0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	73, 237	0	7, 500	0	47, 078	65.00
66.00	06600 PHYSI CAL THERAPY	233, 742	19, 636	12, 500	0	179, 931	66.00
67.00	06700 OCCUPATI ONAL THERAPY	l ol	0	0	0	0	67.00
68. 00		ol	0		0	0	68. 00
69. 00	l i	330, 165	19, 986	100,000	0	19, 894	69.00
71. 00		0	. , , , , , ,	0	0	0	71.00
72. 00			Ô	ol o	0	0	72.00
73. 00	l i		Ô	ol o	0	0	73. 00
74. 00	1	46, 221	0		0	0	74.00
76. 00	1	70, 221	0		0	0	76.00
76. 00	03140 CARDI AC REHAB	547, 239	1, 719	67, 500	0	25, 206	76. 01
76. 01	l i	458, 578	11, 616		0	18, 787	76. 01
76. 02		436, 376	11,010	02, 300	0	16, 767	76. 02
70.03	OUTPATIENT SERVICE COST CENTERS	l ol	U)l O	U	U	70.03
00 00		110 OE4	2 151		٥	12 740	00 00
90.00		119, 956	3, 151		0	13, 749	
90. 01		174, 685	63, 268	17, 500	U	20, 312	90. 01
90. 02	l i	84, 482	044.007	010 500	0	6, 647	1
91.00		1, 054, 875	314, 337	212, 500	0	184, 180	
91. 01		0	O	ס ס	이	0	91. 01
92. 00	· ·						92. 00
	OTHER REIMBURSABLE COST CENTERS		_		_1		
95. 00		13, 583	0	0	0	2, 179	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 0	, ,	15, 486, 838	1, 974, 589	2, 415, 004	2, 144, 218	1, 523, 561	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	299, 516	0	2, 500	0		190. 00
192. 0	0 19200 PHYSICIANS' PRIVATE OFFICES	2, 256, 771	183, 694	0	0		192. 00
192.0	1 19201 FOUNDATI ON	O	0	0	0	6, 098	192. 01
192.0	2 19202 CLI NI CS	O	827	132, 500	O		192. 02
	3 19206 HOME HEALTH PARTNERSHIP	l ol	0	0	ol	0	192. 03
	4 19207 WESTFIELD SCHOOLS	o	O	0	o		192. 04
	5 19203 PRACTICE MANAGEMENT	o	764	. 0	ol		192. 05
	6 19204 MOB - NOBLESVILLE SQUARE	o o	O	0	o		192. 06
	7 19208 PHYSI CI ANS' PRI VATE OFFI CES	ا م	n	o	n		192. 07
	8 19205 RI VERVI EW MEDI CAL ARTS	ا	n	ol ő	n n		192. 08
	9 19209 BEHAVI OR CARE	ا	n	ol ŏ	n		192. 09
	0 19300 NONPALD WORKERS	ا م	n	م ا	n		193. 00
	1 19301 PHYSI CI AN SERVI CES-LYONS	o	0		ol O		193. 00
	2 19302 UNI VERSI TY HS ATHLETI CS	l ő	n		n		193. 02
	3 19303 OB/GYN SPEC NEMUNALTI		0		0		193. 02
. , 5. 0		<u>, </u>		., 0	<u> </u>	2,041	1.75.55

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0059 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

				0 12/01/2021	5/24/2022 5: 2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	•
	PLANT	LINEN SERVICE				
	7.00	8. 00	9. 00	10.00	11.00	
193. 04 19304 OB/GYN SPEC GATHERS	0	0	C	0	5, 214	193. 04
193.05 19305 OB SPECIALISTS DAVENPORT	0	0	C	0	0	193. 05
193. 06 19306 OUTPATIENT PHARMACY	0	0	C	0	18, 007	193. 06
194. 00 07950 WORKMED	0	0	C	0	0	194. 00
194.01 07951 MEALS ON WHEELS	0	0	C	0	8, 815	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum Lines 118 through 201)	18, 043, 125	2, 159, 874	2, 550, 004	2, 144, 218	1, 569, 133	202.00

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/24/2022 5:25 pm

				12/31/2021	5/24/2022 5: 2	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	12.00	SUPPLY	15.00	LI BRARY	17.00	
GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13.00 O1300 NURSING ADMINISTRATION	1, 005, 291					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	11, 161, 409				14. 00
15. 00 01500 PHARMACY	0	0	18, 411, 208			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	1, 867, 339		16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	1, 200, 454	17. 00
23. 00 02300 PARAMED ED PRGM PHARMACY	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	400,440	ما	0	F20, 000	1 024 176	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	490, 468 116, 922	0	0	528, 899		30. 00 31. 00
41. 00 04100 SUBPROVI DER - I RF	84, 465	0	0	264, 450	73, 262 93, 016	41.00
43. 00 04300 NURSERY	04, 405	0	0	0	93,016	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY		0	0	0	0	44.00
ANCI LLARY SERVICE COST CENTERS		<u> </u>	0			1 44.00
50. 00 05000 OPERATING ROOM	O	O	0	291, 434	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	ol	o	0	0	l o	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	o	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	0	0	21, 588	0	55. 00
57. 00 05700 CT SCAN	o	0	0	0	0	57. 00
57. 01 03630 ULTRA SOUND	o	o	0	0	0	57. 01
58. 00 05800 MRI	O	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	16, 191	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	340, 007	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	27 005	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	11 1/1 400	0	26, 985		69.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 161, 409	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS		0	18, 411, 208	0	0	73.00
74. 00 07400 RENAL DI ALYSI S		0	10, 411, 200	0	0	74.00
76. 00 03020 OTHER ANCI LLARY		0	0	0	0	76.00
76. 01 03140 CARDI AC REHAB		0	0	286, 037	0	76. 01
76. 02 03070 WOMEN' S CENTER		0	0	0	l o	76. 02
76. 03 03330 ENDOSCOPY	o	o	0	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS		'			•	İ
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 OUTPATI ENT	0	0	0	0	0	90. 01
90. 02 09002 NEUROPSYCHOLOGY	0	0	0	0	0	90. 02
91. 00 09100 EMERGENCY	313, 436	0	0	70, 160		91.00
91. 01 09101 SHORT STAY	0	0	0	0	0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						05.55
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS	1 005 004	44 4/4 400	10 111 000	4 045 754	1 000 454	440.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117	1, 005, 291	11, 161, 409	18, 411, 208	1, 845, 751	1, 200, 454]118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ما	0	^	_	190. 00
	0	0	-	0		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATI ON	0	o o	0	0		192. 00
192. 01 19201 FOUNDATION 192. 02 19202 CLINICS		0	0	21, 588	l .	192. 01
192. 03 19206 HOME HEALTH PARTNERSHIP		0	0	∠1,500 ∩		192. 02
192. 04 19207 WESTFIELD SCHOOLS		0	0	0	1	192. 03
192. 05 19203 PRACTICE MANAGEMENT		0	n	0		192. 05
192. 06 19204 MOB - NOBLESVILLE SQUARE	ا	o O	n	0		192.06
192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES	o	ol	o	0		192. 07
192. 08 19205 RI VERVI EW MEDI CAL ARTS	o	ō	0	0		192. 08
192. 09 19209 BEHAVI OR CARE	0	o	0	0		192. 09
193. 00 19300 NONPALD WORKERS	0	o	0	0	0	193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	o	o	0	0		193. 01
193. 02 19302 UNI VERSITY HS ATHLETICS	0		0	0	0	193. 02

Heal th Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0059 Period: Worksheet B

	Fre		Part I Date/Time Prepared:
	10	12/31/2021	5/24/2022 5: 25 pm
			3/24/2022 3.23 pill

						5/24/2022 5: 2	5 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13.00	14.00	15. 00	16. 00	17. 00	
193. 03 19303	OB/GYN SPEC NEMUNALTI	0	0	0	0	0	193. 03
193. 04 19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193. 04
193. 05 19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193. 05
193. 06 19306	OUTPATIENT PHARMACY	0	0	0	0	0	193. 06
194.00 07950	WORKMED	0	0	0	0	0	194. 00
194. 01 07951	MEALS ON WHEELS	0	0	0	0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 005, 291	11, 161, 409	18, 411, 208	1, 867, 339	1, 200, 454	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems RIVERVIEW HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0059 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/24/2022 5: 25 pm Cost Center Description PARAMED ED Total Subtotal Intern & PRGM PHARMACY Residents Cost & Post Stepdown Adjustments 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 02300 PARAMED ED PRGM PHARMACY 23.00 349, 120 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 27, 615, 134 30.00 03000 ADULTS & PEDIATRICS 30.00 0 27, 615, 134 0 0 7, 199, 310 31.00 03100 INTENSIVE CARE UNIT 0 7, 199, 310 31.00 41.00 04100 SUBPROVIDER - IRF 0 5, 377, 344 0 5, 377, 344 41.00 0 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 44 00 C ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 13, 951, 321 13, 951, 321 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 4, 779, 447 54 00 4, 779, 447 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 2,004,823 2, 004, 823 55.00 05700 CT SCAN 554, 207 0 57.00 554, 207 57.00 03630 ULTRA SOUND 567, 707 567, 707 57.01 57.01 507, 371 0 05800 MRI 507.371 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 1, 512, 835 1, 512, 835 59.00 06000 LABORATORY 60 00 12, 564, 314 12, 564, 314 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 940, 949 940, 949 63 00 06400 I NTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 2, 849, 081 2, 849, 081 65.00 06600 PHYSI CAL THERAPY 66.00 9,067,288 9, 067, 288 66,00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 1, 578, 541 1, 578, 541 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11, 161, 409 0 11, 161, 409 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 12, 872, 710 12, 872, 710 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 349, 120 18, 760, 328 18, 760, 328 73.00 07400 RENAL DIALYSIS 74.00 0 525, 840 0 525, 840 74.00 03020 OTHER ANCILLARY 76.00 0 76.00 76.01 03140 CARDI AC REHAB 2, 906, 922 2, 906, 922 76.01 0 0 03070 WOMEN'S CENTER 1, 542, 455 1, 542, 455 76.02 76.02 03330 ENDOSCOPY 0 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 818, 699 818, 699 90.00 09001 OUTPATIENT 0 1, 897, 928 1, 897, 928 90. 01 0 90.01 0 09002 NEUROPSYCHOLOGY 0 90.02 672, 324 672, 324 90.02 91.00 09100 EMERGENCY 0 27, 277, 570 0 27, 277, 570 91.00 91.01 09101 SHORT STAY 0 91.01 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92 00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 132, 475 0 132, 475 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 349, 120 118.00 169, 638, 332 0 169, 638, 332 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 768, 194 0 768, 194 39, 734, 373 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 39, 734, 373 0 192.00 192. 01 19201 FOUNDATION 280, 529 0 280, 529 192. 01 0 192. 02 19202 CLI NI CS 1, 599, 436 0 1, 599, 436 192.02 192. 03 19206 HOME HEALTH PARTNERSHIP 192. 03 -224 -224 192. 04 19207 WESTFI ELD SCHOOLS 0 0 1, 653, 881 0 1, 653, 881 192. 04 192. 05 19203 PRACTICE MANAGEMENT 1, 096, 453 0 1,096,453 192. 05 192.06 19204 MOB - NOBLESVILLE SQUARE 192.06 47, 421 47, 421 192. 07 19208 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192. 07 0 192. 08 19205 RIVERVIEW MEDICAL ARTS 163, 378 163.378 192. 08

697, 969

697, 969

192. 09

193. 00

192. 09 19209 BEHAVI OR CARE

193.00 19300 NONPALD WORKERS

Health Financial Systems	RI VERVI EW I	In Lieu of Form CMS-2552-1				
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/24/2022 5:2	
Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cos & Post	Total		

					5/24/2022 5: 25 pm
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM PHARMACY		Residents Cost		
			& Post		
			Stepdown		
			Adjustments		
	23. 00	24.00	25. 00	26.00	
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	666	0	666	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	81, 791	0	81, 791	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI	0	783, 117	0	783, 117	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	197, 353	0	197, 353	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	839, 052	0	839, 052	193. 05
193.06 19306 OUTPATIENT PHARMACY	0	4, 884, 069	0	4, 884, 069	
194. 00 07950 WORKMED	0	587, 362	0	587, 362	194. 00
194.01 07951 MEALS ON WHEELS	0	442, 532	0	442, 532	194. 01
200.00 Cross Foot Adjustments	0	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	349, 120	223, 495, 684	0	223, 495, 684	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: 5/24/2022 5:25 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0059

				10) 12/31/2021	5/24/2022 5: 2	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT		02 727	00 707	00 707		1.00
4. 00 5. 00	OO400	0	83, 737 1, 531, 217		83, 737 8, 312		4. 00 5. 00
7. 00	00700 OPERATION OF PLANT		6, 782, 925		2, 135		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	46, 168		68		8. 00
9.00	00900 HOUSEKEEPI NG	0	37, 347	37, 347	983	17, 162	9. 00
10.00	01000 DI ETARY	0	403, 643	403, 643	329		10. 00
11.00	01100 CAFETERI A	0	0		727		11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	221, 003		645 656		13. 00 14. 00
15. 00	01500 PHARMACY		275, 611	1	2, 143		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	73, 329	1	732		16. 00
17. 00	01700 SOCIAL SERVICE	0	52, 133		639	7, 544	17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY	0	4, 918	4, 918	242	2, 332	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 072 042	2 072 042	9, 271	121, 024	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	2, 973, 842 443, 433		3, 243		30. 00 31. 00
41. 00	04100 SUBPROVI DER – I RF	0	474, 085	1	1, 421	24, 619	41. 00
43.00	04300 NURSERY	0	0		0		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1, 606, 481	1, 606, 481	4, 056	71, 266	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 000, 461	1, 000, 481	4, 030		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	421, 634		1, 903	-	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	227, 698	227, 698	464	10, 818	55. 00
57. 00	05700 CT SCAN	0	0		332		57. 00
57. 01 58. 00	03630 ULTRA SOUND	0	0	0	378 291	3, 836 3, 413	57. 01 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	74, 884	74, 884	801		
60. 00	06000 LABORATORY	0	461, 710		3, 000		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	78, 374	1	0	5, 635	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 46, 707	0 46, 707	0 1, 621	1	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	149, 070		4, 703		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	210, 563		543		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	88, 671 0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0	29, 478	29, 478	0	3, 304	74. 00
76. 00	03020 OTHER ANCI LLARY	0	0	0	0	0	76. 00
76. 01	03140 CARDI AC REHAB	0	,		766		
76. 02 76. 03	03070 WOMEN'S CENTER 03330 ENDOSCOPY	0		1	416 0		76. 02 76. 03
76.03	OUTPATIENT SERVICE COST CENTERS	0		ıj U	0	<u> </u>	70.03
90.00	09000 CLI NI C	0	76, 502	76, 502	314	4, 697	90. 00
90. 01	09001 OUTPATI ENT	0	111, 406		621		90. 01
90. 02	09002 NEUROPSYCHOLOGY	0	53, 878		286		90. 02
91. 00 91. 01	09100 EMERGENCY 09101 SHORT STAY	0	672, 749 0		7, 999 0		91. 00 91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		٥		0		92. 00
	OTHER REIMBURSABLE COST CENTERS			-			
95. 00	09500 AMBULANCE SERVICES	0	8, 662	8, 662	48	804	95. 00
110.00	SPECIAL PURPOSE COST CENTERS		10 074 /50	10 274 (50	/0.000	1 100 700	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	18, 274, 650	18, 274, 650	60, 088	1, 188, 793	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	191, 017	191, 017	77	3, 180	190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 439, 262		18, 662		1
	19201 FOUNDATION	0	0	0	189		192. 01
	19202 CLINICS	0	0	0	887 0		192. 02 192. 03
	19206 HOME HEALTH PARTNERSHIP 19207 WESTFIELD SCHOOLS	0	0	0	1, 078		
	19203 PRACTICE MANAGEMENT	0	0	Ö	346		192. 05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0	327	192. 06
	19208 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	•	192. 07
	19205 RIVERVIEW MEDICAL ARTS 19209 BEHAVIOR CARE	0	0		0 374		192. 08 192. 09
- 72.0	1.723 / SERWION OFFICE	1	1 0	i 9	374	1 7,000	1.72.07

| Peri od: | Worksheet B | From 01/01/2021 | Part II | Date/Time Prepared: | 5/24/2022 5:25 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RI VERVI EW HOSPI TAL Provider CCN: 15-0059

					5/24/2022 5: 2	5 pm
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Directly	BLDG & FIXT	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	Assigned New			BENEFI TS	& GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 00	
193. 00 19300 NONPALD WORKERS	0	0	C	0	0	193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	C	0	3	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	C	55	563	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI	0	0	C	496	5, 376	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	0	C	121	1, 324	193. 04
193.05 19305 OB SPECIALISTS DAVENPORT	0	0	C	518	5, 780	193. 05
193.06 19306 OUTPATIENT PHARMACY	0	0	C	490	33, 519	193. 06
194. 00 07950 WORKMED	0	0	C	221	4, 046	194. 00
194.01 07951 MEALS ON WHEELS	0	0	C	135	2, 988	194. 01
200.00 Cross Foot Adjustments			C			200. 00
201.00 Negative Cost Centers		0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	19, 904, 929	19, 904, 929	83, 737	1, 539, 529	202. 00

Provider CCN: 15-0059

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/24/2022 5:25 pm

				, 12,01,2021	5/24/2022 5: 2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	2.22	40.00		
CENEDAL CEDALCE COCT CENTEDO	7. 00	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 4.00 00400 EMPLOYEE BENEFLTS DEPARTMENT						1. 00 4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 OO700 OPERATION OF PLANT	4 000 244					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	6, 909, 346	88, 336				8.00
9. 00 00900 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	27, 721	00, 330				9.00
10. 00 01000 DI ETARY	22, 425	0	77, 917 153	656, 866		10.00
11. 00 01100 CAFETERI A	242, 365 0	0	2, 139	030, 000	13, 192	11.00
13. 00 01100 CAPETERTA 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	2, 139	0	13, 192	
14. 00 01400 CENTRAL SERVICES & SUPPLY	1	716	-	0	288	14. 00
	132, 700	/10		0		•
	165, 489	0	1, 910	0	607	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	44, 030	0	382 0	0	308 197	16.00
17.00 01700 SOCIAL SERVICE 23.00 02300 PARAMED ED PRGM PHARMACY	31, 303 2, 953	0	0	0		17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 903	U	<u> </u>	<u> </u>	24	23. 00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 785, 627	29, 854	26, 200	445, 230	2, 422	30.00
31. 00 03100 NTENSI VE CARE UNI T	266, 257	6, 960		60, 480	578	31.00
41. 00 04100 SUBPROVI DER - I RF	284, 662	7, 441	4, 813	151, 156	417	41.00
43. 00 04300 NURSERY	204, 002	7, 441	4, 813	131, 130	0	43.00
44. 00 04400 SKILLED NURSING FACILITY		0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS	ı y	U	0	<u> </u>	0	44.00
50. 00 05000 OPERATING ROOM	964, 603	9, 244	12, 833	ol	1, 252	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	704, 003	7, 244	12, 033	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	253, 168	5, 577		0	596	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	136, 720	771	764	0	100	55. 00
57. 00 05700 CT SCAN	100,720	,,,	0	0	102	57. 00
57. 01 03630 ULTRA SOUND	0	0	o o	0	91	57. 01
58. 00 05800 MRI	0	0	76	0	79	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	44, 964	2, 457		0	181	59. 00
60. 00 06000 LABORATORY	277, 231	2, 107		0	1, 040	60.00
60. 01 06001 BLOOD LABORATORY	277,231	0	0	0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	47, 059	0	0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	28, 045	0	229	0	396	65. 00
66. 00 06600 PHYSI CAL THERAPY	89, 508	803		0	1, 513	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	07,000	000	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	126, 432	817	-	0	167	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	120, 102	017	0,000	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0	o o	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	0	o o	0	0	73. 00
74. 00 07400 RENAL DIALYSIS	17, 700	0	o o	0	0	74. 00
76. 00 03020 OTHER ANCI LLARY	17,700	0	o o	0	0	76.00
76. 01 03140 CARDI AC REHAB	209, 557	70	2, 063	0	212	76. 01
76. 02 03070 WOMEN' S CENTER	175, 606	475		0	158	76. 02
76. 03 03330 ENDOSCOPY	0	0	· ·	0	0	76. 03
OUTPATIENT SERVICE COST CENTERS	<u> </u>		١	٥		70.00
90. 00 09000 CLINIC	45, 935	129	0	0	116	90. 00
90. 01 09001 0UTPATI ENT	66, 893	2, 588		0	171	90. 01
90. 02 09002 NEUROPSYCHOLOGY	32, 351	2,000	0	0	56	90. 02
91. 00 09100 EMERGENCY	403, 949	12, 856	6, 493	0	1, 548	1
91. 01 09101 SHORT STAY	0	.2,000	0, .,,	0	0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		, , , , , , , , , , , , , , , , , , ,	Ĭ	Ĭ	ŭ	92.00
OTHER REIMBURSABLE COST CENTERS						/2.00
95. 00 09500 AMBULANCE SERVI CES	5, 201	0	0	0	18	95. 00
SPECIAL PURPOSE COST CENTERS	0,20.		<u> </u>	<u> </u>		70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 930, 454	80, 758	73, 792	656, 866	12, 809	118. 00
NONREI MBURSABLE COST CENTERS	0,700,101	00,700	707772	000,000	12,007	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	114, 695	0	76	0	39	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	864, 197	7, 513		o		192. 00
192. 01 19201 FOUNDATION	0	0	0	0		192. 01
192. 02 19202 CLI NI CS	0	34	-	0		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	ا	0	, 047 n	0		192. 02
192. 04 19207 WESTFI ELD SCHOOLS	ا م	n	ا م	ol Ol		192. 04
192. 05 19203 PRACTICE MANAGEMENT		31	1	0		192. 05
192. 06 19204 MOB - NOBLESVILLE SQUARE		0	ا	ol Ol		192. 06
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES	ا م	n	ا م	ol Ol		192. 07
192. 08 19205 RI VERVI EW MEDI CAL ARTS	ا	0		ol O		192. 08
192. 09 19209 BEHAVI OR CARE	l o	0	١	ol O		192. 09
193. 00 19300 NONPALD WORKERS	l o	0	١	ol O		193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	l o	0	١	ol O		193. 01
193. 02 19302 UNI VERSITY HS ATHLETICS	O	n	Ö	ol O		193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	l ő	n	l ő	ol Ol		193. 03
	<u>ı </u>		<u> </u>	<u> </u>	22	1

Heal th Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0059
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

				' '		5/24/2022 5: 2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	·	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
193. 04	19304 OB/GYN SPEC GATHERS	0	0	0	0	44	193. 04
193. 05	19305 OB SPECIALISTS DAVENPORT	0	0	0	0	0	193. 05
193. 06	19306 OUTPATIENT PHARMACY	0	0	0	0	151	193. 06
194.00	07950 WORKMED	0	0	0	0	0	194. 00
194. 01	07951 MEALS ON WHEELS	0	0	0	0	74	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum Lines 118 through 201)	6, 909, 346	88, 336	77. 917	656, 866	13, 192	202.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0059

23. 00 02300 PARAMED ED PRGM PHARMACY 0 0 0 0 0 0 0 0 0	
SENERAL SERVICE COST CENTERS 13.00 14.00 15.00 16.00 17.00	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 23. 00
1.00	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 23. 00
17, 00 01700 SOCI AL SERVICE 0 0 0 0 0 0 0 0 0	316 17. 00 0 23. 00 099 30. 00
IMPATIENT ROUTINE SERVICE COST CENTERS 3,708	30.00
30. 00 03000 ADULTS & PEDIATRICS 3,708 0 0 36,965 79 31. 00 03100 INTENSIVE CARE UNIT 884 0 0 18,483 5 41. 00 04100 SUBPROVI DER - IRF 639 0 0 0 0 43. 00 04300 NURSERY 0 0 0 0 0 44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 40. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 40. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 40. 00 05000 DEPRATING ROOM 0 0 0 0 50. 00 05000 DEPRATING ROOM 0 0 0 0 51. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 53. 00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 54. 00 05400 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 55. 00 05700 CT SCAN 0 0 0 0 0 57. 01 03630 ULTRA SOUND 0 0 0 0 58. 00 05800 MRI 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 61. 00 06000 LABORATORY 0 0 0 0 62. 00 06000 LABORATORY 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 64. 00 06400 NTRAVENOUS THERAPY 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 CCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 07400 RENAL DI ALYSI S 0 0 0 0 60. 00 07400 RENAL DI ALYSI S 0 0 0 0 60. 00 07400 CUPATI OLA THERAPY 0 0 0 0 60. 00 07400 CUPATI OLA THERAPY 0 0 0 0 60. 00 07400 OKONO 0 0 60. 00 07400 OKONO 0 0 0 60. 00 07400 OKONO 0	•
50. 00 05000 0PERATI NG ROOM 0 0 0 0 0 0 0 0 0	114 41.00 0 43.00 0 44.00
S2.00 O5200 DELI VERY ROOM & LABOR ROOM O O O O O O O O O O O O O O O O O	0 50.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0	0 52.00 0 54.00 0 55.00 0 57.00 0 57.01 0 58.00 0 59.00 0 60.00 0 60.01 0 63.00 0 64.00
OUTPATIENT SERVICE COST CENTERS	0 65.00 0 66.00 0 67.00 0 68.00 0 69.00 0 71.00 0 72.00 0 73.00 0 74.00 0 76.00 0 76.01 0 76.02 0 76.03
90. 00 09000 CLINI C 0 0 0 0	
90. 01 09001 0UTPATI ENT 0 0 0 0 0 0 0 0 0	0 90.00 0 90.01 0 90.02 0 91.00 0 91.01 92.00
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS	0 95.00
	316 118. 00
190. 00 19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0 190. 00 0 192. 00 0 192. 01 0 192. 02 0 192. 03 0 192. 04 0 192. 05 0 192. 06 0 192. 07 0 192. 08 0 192. 09 0 193. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/24/2022 5:25 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RI VERVI EW HOSPI TAL Provider CCN: 15-0059

						5/24/2022 5:2	o piii
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13. 00	14.00	15. 00	16.00	17. 00	
193. 03 19303	OB/GYN SPEC NEMUNALTI	0	0	0	0	0	193. 03
193. 04 19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193. 04
193. 05 19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193. 05
193. 06 19306	OUTPATIENT PHARMACY	0	0	0	0	0	193. 06
194. 00 07950	WORKMED	o	0	0	0	0	194. 00
194. 01 07951	MEALS ON WHEELS	o	0	0	0	0	194. 01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	7, 601	429, 561	568, 677	130, 513	91, 816	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RI VERVI EW HOSPI TAL Provider CCN: 15-0059 Peri od: From 01/01/2021 To 12/31/2021 Cost Center Description PARAMED ED Intern & Total Subtotal

	cost center bescription	PRGM PHARMACY	Subtotal	Resi dents Cost & Post Stepdown	iotai	
		23.00	24. 00	Adjustments 25.00	26. 00	
	GENERAL SERVICE COST CENTERS	23.00	24.00	23.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE				+	7. 00 8. 00
9. 00	00900 HOUSEKEEPING			•		9.00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY			•		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY	10, 469				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS		5, 513, 242	1	5, 513, 242	30.00
31. 00 41. 00	03100 NTENSI VE CARE UNI T 04100 SUBPROVI DER - RF		847, 485 956, 367	1	847, 485 956, 367	31. 00 41. 00
43. 00	04300 NURSERY		730, 307	1	930, 307	43. 00
44. 00	04400 SKILLED NURSING FACILITY		0	1	Ö	44. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		2, 690, 104	1	2, 690, 104	50.00
52. 00 54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC		710, 765	1	0 710, 765	52. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		378, 844	1	378, 844	55. 00
57. 00	05700 CT SCAN		4, 168		4, 168	57. 00
57. 01	03630 ULTRA SOUND		4, 305	0	4, 305	57. 01
58. 00	05800 MRI		3, 859	1	3, 859	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		132, 337		132, 337	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY		828, 437	0	828, 437	60. 00 60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		131, 068		131, 068	63. 00
64.00	06400 I NTRAVENOUS THERAPY		0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY		95, 743	1	95, 743	65. 00
66.00	06600 PHYSI CAL THERAPY		326, 788	1	326, 788	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0	0	0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY		350, 914	_	350, 914	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		429, 561	1	429, 561	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		88, 671	1	88, 671	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		568, 677	1	568, 677	73. 00
74.00	07400 RENAL DIALYSIS		50, 482	1	50, 482	74.00
76. 00 76. 01	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB		595, 296	0	0 595, 296	76. 00 76. 01
	03070 WOMEN' S CENTER		477, 851	1	477, 851	76. 02
	03330 ENDOSCOPY		0	1	0	76. 03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		127, 693	1	127, 693	90.00
90. 01 90. 02	09001 OUTPATI ENT 09002 NEUROPSYCHOLOGY		193, 388 90, 574	1	193, 388 90, 574	90. 01 90. 02
91. 00	09100 EMERGENCY		1, 285, 957	1	1, 285, 957	91.00
91. 01	09101 SHORT STAY		0	1	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92. 00
05.00	OTHER REIMBURSABLE COST CENTERS		44.700		4.4.700	05.00
95. 00	09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS		14, 733	0	14, 733	95. 00
118. 00		0	16, 897, 309	0	16, 897, 309	118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		309, 084	1	309, 084	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FOUNDATI ON		2, 586, 552	1	2, 586, 552	192.00
	1920 FOUNDATTON 19202 CLI NI CS		2, 130 16, 429		2, 130 16, 429	192. 01 192. 02
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP		10, 429	0	10, 429	192. 02
	19207 WESTFIELD SCHOOLS		12, 470	_	12, 470	192. 04
	19203 PRACTICE MANAGEMENT		7, 924	1	7, 924	192. 05
	19204 MOB - NOBLESVILLE SQUARE		327	1	327	192. 06
	7 19208 PHYSICIANS' PRIVATE OFFICES		1 125	_	1 125	192. 07 192. 08
	3 19205 RIVERVIEW MEDICAL ARTS 19209 BEHAVIOR CARE		1, 125 5, 182	1	1, 125 5, 182	192. 08
	19300 NONPALD WORKERS		0, 102	1	0	193. 00
		·				·

Health Financial Systems	RIVERVIEW H	OSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B
				From 01/01/2021 To 12/31/2021	Part II Date/Time Prepared:
				10 12/31/2021	5/24/2022 5: 25 pm
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM PHARMACY		Residents Cos	t	
			& Post		
			Stepdown		
			Adjustments		
	23. 00	24. 00	25. 00	26.00	
193. 01 19301 PHYSI CI AN SERVI CES-LYONS		5		0 5	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS		618		0 618	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI		5, 894		0 5, 894	193. 03
193.04 19304 OB/GYN SPEC GATHERS		1, 489		0 1, 489	193. 04
193.05 19305 OB SPECIALISTS DAVENPORT		6, 298		0 6, 298	193. 05
193.06 19306 OUTPATIENT PHARMACY		34, 160		0 34, 160	193. 06
194. 00 07950 WORKMED		4, 267		0 4, 267	194. 00
194.01 07951 MEALS ON WHEELS		3, 197		0 3, 197	194. 01
200.00 Cross Foot Adjustments	10, 469	10, 469		0 10, 469	200. 00
201.00 Negative Cost Centers	0	0		0 0	201. 00
202.00 TOTAL (sum lines 118 through 201)	10, 469	19, 904, 929		0 19, 904, 929	202. 00

				DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
				SALARI ES)				
			1. 00	4. 00	5A	5. 00	7. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	627, 313		I			1. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT	2, 639	91, 327, 858				4. 00
5. 00		ADMINISTRATIVE & GENERAL	48, 257	9, 064, 525		196, 064, 798		5. 00
7.00	00700	OPERATION OF PLANT	213, 767	2, 327, 716	0	15, 828, 580	362, 650	7. 00
8.00		LAUNDRY & LINEN SERVICE	1, 455	74, 226		1, 831, 273		8. 00
9.00	1	HOUSEKEEPI NG	1, 177	1, 071, 687		2, 185, 654		9.00
10. 00 11. 00		DI ETARY CAFETERI A	12, 721 0	358, 555 792, 376		1, 321, 425 1, 315, 135		10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	0	792, 376 703, 058		863, 967	l .	13.00
14. 00		CENTRAL SERVICES & SUPPLY	6, 965	715, 680	•	9, 439, 879		
15. 00	01500	PHARMACY	8, 686	2, 336, 810		15, 654, 245		•
16. 00	1	MEDICAL RECORDS & LIBRARY	2, 311	798, 359		1, 494, 193	l	
17. 00		SOCIAL SERVICE	1, 643	697, 256		960, 820		•
23. 00		PARAMED ED PRGM PHARMACY LENT ROUTINE SERVICE COST CENTERS	155	263, 493	0	297, 027	155	23. 00
30. 00		ADULTS & PEDIATRICS	93, 722	10, 110, 616	0	15, 413, 140	93, 722	30.00
31. 00		INTENSIVE CARE UNIT	13, 975	3, 536, 181		4, 816, 677		
41. 00		SUBPROVI DER - I RF	14, 941	1, 550, 026	0	3, 135, 340	14, 941	41. 00
43. 00	1	NURSERY	0	0		0		
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	50, 629	4, 423, 558	l 0	9, 076, 185	50, 629	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	00,027	0 1, 120, 000		0	00,027	52. 00
54.00		RADI OLOGY-DI AGNOSTI C	13, 288	2, 075, 588	0	3, 395, 932	13, 288	54.00
55.00		RADI OLOGY-THERAPEUTI C	7, 176	506, 441	0	1, 377, 738		
57. 00	1	CT SCAN	0	362, 125		475, 593		
57. 01		ULTRA SOUND	0	412, 391		488, 503	l .	
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	2, 360	317, 641 873, 436		434, 643 1, 152, 548		58. 00 59. 00
60.00		LABORATORY	14, 551	3, 271, 149		10, 126, 184		60.00
60. 01	1	BLOOD LABORATORY	0	0	Ō	0	0	60. 01
63. 00	06300	BLOOD STORING, PROCESSING & TRANS.	2, 470	0	0	717, 653	2, 470	63. 00
64. 00		I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00		RESPI RATORY THERAPY	1, 472	1, 767, 743		2, 387, 268		•
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	4, 698	5, 128, 917 0	1	7, 265, 035 0		
68. 00		SPEECH PATHOLOGY	Ö	0	Ö	Ö	Ö	68. 00
69. 00		ELECTROCARDI OLOGY	6, 636	592, 340	0	948, 770	6, 636	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11, 292, 762	l	72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0 929	0	0	420, 752	0 929	73. 00 74. 00
76. 00		OTHER ANCILLARY	727	0		420, 732	727	
76. 01		CARDI AC REHAB	10, 999	835, 217	1	1, 736, 299	_	
76. 02	03070	WOMEN'S CENTER	9, 217	453, 963		869, 346		76. 02
76. 03		ENDOSCOPY	0	0	0	0	0	76. 03
00.00		TIENT SERVICE COST CENTERS	2 411	242 (74		598, 156	2, 411	00 00
90. 00 90. 01	1	OUTPATI ENT	2, 411 3, 511	342, 674 676, 899		1, 423, 065		
90. 02		NEUROPSYCHOLOGY	1, 698	311, 763		509, 861		
91.00	09100	EMERGENCY	21, 202	8, 722, 890	0	22, 043, 956	21, 202	91. 00
91. 01		SHORT STAY	0	0	0	0	0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	273	52, 557	0	102, 388	273	95. 00
73.00		AL PURPOSE COST CENTERS	273	32, 337		102, 300	273	75.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	575, 934	65, 527, 856	-27, 431, 110	151, 399, 992	311, 271	118. 00
		IMBURSABLE COST CENTERS			_		1	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 020	83, 838		l		190. 00
		PHYSICIANS' PRIVATE OFFICES FOUNDATION	45, 359	20, 358, 727 206, 030	•	32, 716, 530 240, 748		192. 00 192. 01
	1	CLINICS	Ö	966, 750		1, 267, 226		192. 02
		HOME HEALTH PARTNERSHIP	0	0	224	0		192. 03
192. 04	19207	WESTFIELD SCHOOLS	o	1, 176, 014	0	1, 450, 890	0	192. 04
	1	PRACTI CE MANAGEMENT	0	377, 399	1	961, 208		192. 05
	1	MOB - NOBLESVILLE SQUARE	0	0	•	41, 601		192. 06 192. 07
		PHYSICIANS' PRIVATE OFFICES RIVERVIEW MEDICAL ARTS	O N	0		0 143, 326	l .	192. 07 192. 08
1 /2. 00	117200	IN VERVIEW MEDITORE ARTS	0		1 0	143, 320	1 0	11 /2. 00

From 01/01/2021 12/31/2021 Date/Time Prepared: 5/24/2022 5: 25 pm CAPI TAL RELATED COSTS **EMPLOYEE** Reconciliation ADMINISTRATIVE OPERATION OF Cost Center Description BLDG & FIXT (SQUARE FEET) **BENEFITS** & GENERAL PLANT (ACCUM. COST) (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1.00 4.00 5A 5. 00 7. 00 192. 09 19209 BEHAVI OR CARE 0 408, 146 0 612, 303 0 192. 09 193. 00 19300 NONPALD WORKERS 0 0 193. 00 193. 01 19301 PHYSI CI AN SERVI CES-LYONS 139 0 406 0 193. 01 193. 02 19302 UNI VERSITY HS ATHLETICS 60, 475 71, 752 0 193. 02 193. 03 19303 OB/GYN SPEC NEMUNALTI 0 0 193. 03 541, 135 684, 683 193. 04 19304 OB/GYN SPEC GATHERS 0 0 193. 04 132, 315 168, 557 193.05 19305 OB SPECIALISTS DAVENPORT 565, 328 736, 070 0 193. 05 193. 06 19306 OUTPATIENT PHARMACY 0 0 193. 06 534, 485 4, 268, 820

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0059 Peri od:

COST ALLOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre	pared:
Cost Center Description	LAUNDRY & H LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	5/24/2022 5: 2 NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HR)	5 piii
	8. 00	9. 00	10.00	11. 00	13. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	67, 867					4. 00 5. 00 7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	0	1, 020	74 055			9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	2 28	71, 855	1, 235, 728		10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	o	0	0	16, 103		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	550	1	0	26, 995		14. 00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0	25	0	56, 820 28, 836		15. 00 16. 00
17. 00 01700 SOCIAL SERVICE		0	0	26, 636 18, 478		17. 00
23. 00 02300 PARAMED ED PRGM PHARMACY	Ö	0	0	2, 225	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	22, 936 5, 347	343 49	48, 704 6, 616	226, 970 54, 107		30. 00 31. 00
41. 00 04100 SUBPROVI DER - I RF	5, 347	63	16, 535	39, 087	39, 087	41. 00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	7, 102	168	0	117, 243	0	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	7, 102	0	0	117, 249		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 285	16	0	55, 836	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	592	10	0	9, 347	0	55. 00
57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND	0	0	0	9, 509 8, 552	0	57. 00 57. 01
58. 00 05800 MRI		1	0	7, 417		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 888	0	0	16, 957	0	59. 00
60. 00 06000 LABORATORY	0	63	0	97, 449		60.00
60. 01 06001 BLOOD LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	60. 01 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	o	Ö	0	0	Ö	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	3	0	37, 075		65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	617	5	0	141, 700	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		0	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	628	40	0	15, 667	0	69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S		0	0	0		74. 00
76.00 03020 OTHER ANCILLARY	О	0	0	0	0	76. 00
76. 01 03140 CARDI AC REHAB	54	27	0	19, 850		76. 01
76. 02 03070 WOMEN' S CENTER 76. 03 03330 ENDOSCOPY	365 0	25 0	0	14, 795 0		76. 02 76. 03
OUTPATIENT SERVICE COST CENTERS	<u> </u>	J.	9			70.00
90. 00 09000 CLI NI C	99	0	0	10, 828		90.00
90. 01 09001 0UTPATI ENT 90. 02 09002 NEUROPSYCHOLOGY	1, 988	7	0	15, 996 5, 235		90. 01 90. 02
91. 00 09100 EMERGENCY	9, 877	85	0	145, 046		91. 00
91. 01 09101 SHORT STAY	0	0	0	0	0	91. 01
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	O	0	0	1, 716	0	95. 00
SPECIAL PURPOSE COST CENTERS	J 31	٩	<u> </u>	.,,		70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	62, 045	966	71, 855	1, 199, 839	465, 210	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	1	0	3, 618	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	5, 772	0	0	3,018		190.00
192. 01 19201 FOUNDATI ON	0	0	0	4, 802		192. 01
192. 02 19202 CLINICS	26	53	0	0		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFIELD SCHOOLS		0	0	0		192. 03 192. 04
192. 05 19203 PRACTICE MANAGEMENT	24	o	0	0		192. 04
192.06 19204 MOB - NOBLESVILLE SQUARE	o	o	0	0	0	192. 06
192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 07
192. 08 19205 RI VERVI EW MEDI CAL ARTS 192. 09 19209 BEHAVI OR CARE		O O	0	0		192. 08 192. 09
193. 00 19300 NONPALD WORKERS		0	o	0		193. 00
	· · · · · · · · · · · · · · · · · · ·	<u> </u>			<u>'</u>	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS RIVERVIEW HOSPITAL Provider CCN: 15-0059

				To	12/31/2021	Date/Time Prep 5/24/2022 5: 2	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	э рііі
	,	LINEN SERVICE	(HOURS OF	(MEALS SERVED)		ADMI NI STRATI ON	
		(POUNDS OF	SERVIC)	,	·		
		LAUNDR)				(DIRECT NRSING	
						HR)	
		8. 00	9. 00	10.00	11.00	13. 00	
193. 01 19301	PHYSI CI AN SERVI CES-LYONS	0	0	0	160	0	193. 01
193. 02 19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193. 02
193. 03 19303	OB/GYN SPEC NEMUNALTI	0	0	0	2, 080	0	193. 03
	OB/GYN SPEC GATHERS	0	0	0	4, 106		193. 04
	OB SPECIALISTS DAVENPORT	0	0	0	0		193. 05
	OUTPATIENT PHARMACY	0	0	0	14, 181		193. 06
194. 00 07950		0	0	0	0		194. 00
	MEALS ON WHEELS	0	0	0	6, 942		194. 01
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	2, 159, 874	2, 550, 004	2, 144, 218	1, 569, 133	1, 005, 291	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	31. 825099	2, 500. 003922		1. 269805		
204. 00	Cost to be allocated (per Wkst. B,	88, 336	77, 917	656, 866	13, 192	7, 601	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	1. 301605	76. 389216	9. 141549	0. 010675	0. 016339	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLO							
	OCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/24/2022 5:2	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		y piii
la-		14. 00	15. 00	16. 00	17. 00	23. 00	
	NERAL SERVICE COST CENTERS 2100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00 5.00 00 7.00 00 8.00 00 9.00 01 11.00 01 13.00 01 14.00 01 15.00 01 16.00 01 17.00 01 23.00 02	10400 EMPLOYEE BENEFITS DEPARTMENT 10500 ADMINISTRATIVE & GENERAL 10700 OPERATION OF PLANT 10800 LAUNDRY & LINEN SERVICE 10900 HOUSEKEEPING 1000 OLETARY 1000 CAFETERIA 1000 CAFETERIA 1000 CAFETERIA 1000 CENTRAL SERVICES & SUPPLY 1000 PHARMACY 1000 MEDICAL RECORDS & LIBRARY 1000 PARAMED ED PRGM PHARMACY 1001 PARAMED ED PRGM PHARMACY	100 0 0 0	100 0 0 0	346 C C	4, 801	100	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 23. 00
	3000 ADULTS & PEDI ATRI CS	0	0	98		0	30. 00
4	3100 I NTENSI VE CARE UNI T	0	0	49		0	31.00
1	100 SUBPROVIDER - IRF 1300 NURSERY	0	0		1	0	41. 00 43. 00
1	400 SKILLED NURSING FACILITY	0	0			0	44. 00
	CILLARY SERVICE COST CENTERS	-,		_			
1	OOO OPERATING ROOM	0	0	54		0	50. 00
1	5200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
	5400 RADI OLOGY-DI AGNOSTI C 5500 RADI OLOGY-THERAPEUTI C	0	0		0	0	54. 00 55. 00
1	5700 CT SCAN	0	0	1 4	0	0	57.00
1	3630 ULTRA SOUND	0	0	Č	0	0	57. 01
1	800 MRI	0	0	C	0	0	58. 00
	900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
	0000 LABORATORY	0	0	3	0	0	60.00
1	0001 BLOOD LABORATORY 0300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	60. 01 63. 00
	400 INTRAVENOUS THERAPY	0	0		0	0	64. 00
	500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
1	600 PHYSI CAL THERAPY	0	0	63	0	0	66. 00
1	0700 OCCUPATIONAL THERAPY 0800 SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
	9900 ELECTROCARDI OLOGY	0	0	5	0	0	69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	100	Ō	Č	Ö	0	71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	c	0	0	72. 00
	300 DRUGS CHARGED TO PATIENTS	0	100	C	0	100	
	400 RENAL DIALYSIS 3020 OTHER ANCILLARY	0	0		0	0	74. 00 76. 00
1	8140 CARDI AC REHAB	o	0	53		Ö	76. 01
	3070 WOMEN'S CENTER	0	0	c	0	0	76. 02
	3330 ENDOSCOPY	0	0	C	0	0	76. 03
	ITPATIENT SERVICE COST CENTERS	O	0	C	0	0	90.00
	2001 OUTPATI ENT	o	0		0	Ö	90. 01
90. 02 09	0002 NEUROPSYCHOLOGY	0	0	C	0	0	90. 02
4	2100 EMERGENCY	0	0	13	0	0	91.00
	2101 SHORT STAY 2200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	0	0	91. 01 92. 00
	HER REIMBURSABLE COST CENTERS						92.00
	2500 AMBULANCE SERVICES	0	0	С	0	0	95. 00
	PECIAL PURPOSE COST CENTERS						
	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	100	100	342	4, 801		118. 00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	2200 PHYSICIANS' PRIVATE OFFICES 2201 FOUNDATION	0	0		0		192. 00 192. 01
	2202 CLINICS	0	0	4	0		192. 01
	206 HOME HEALTH PARTNERSHIP	o	0	ď	o o		192. 03
192. 04 19	2207 WESTFIELD SCHOOLS	O	0	C	0	0	192. 04
	2203 PRACTICE MANAGEMENT	0	0	C	0		192. 05
	204 MOB - NOBLESVILLE SQUARE	0	0	C			192.06
	2208 PHYSICIANS' PRIVATE OFFICES 2205 RIVERVIEW MEDICAL ARTS	0	0		0		192. 07 192. 08
4	2209 BEHAVI OR CARE	0	0				192. 09
	NONPALD WORKERS	o	O		o o		193. 00
		·					

Health Financial Systems	RI VERVI EW HOSPI TAL	RI VERVI EW HOSPI TAL		
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0059	Peri od:	Worksheet B-1	

COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(COSTED	RECORDS &		PRGM PHARMACY	
		SUPPLY	REQUI S.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
		(COSTED		(TIME SPENT)		TIME)	
		REQUIS.)					
		14. 00	15. 00	16. 00	17. 00	23. 00	
4	PHYSI CI AN SERVI CES-LYONS	0	0	'	0		193. 01
	UNI VERSITY HS ATHLETICS	0	0	,	0		193. 02
	OB/GYN SPEC NEMUNALTI	0	0	,	0		193. 03
	OB/GYN SPEC GATHERS	0	0	,	0		193. 04
	OB SPECIALISTS DAVENPORT	0	0	1	0		193. 05
	OUTPATI ENT PHARMACY	0	0	1	0		193. 06
194. 00 07950		0	0		0		194. 00
	MEALS ON WHEELS	0	0		0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	11, 161, 409	18, 411, 208	1, 867, 33	9 1, 200, 454	349, 120	202. 00
	Part I)						
203. 00	, , , , , , , , , , , , , , , , , , , ,	111, 614. 090000	184, 112. 080000	5, 396. 93352			1
204.00	Cost to be allocated (per Wkst. B,	429, 561	568, 677	130, 51	91, 816	10, 469	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	4, 295. 610000	5, 686. 770000	377. 20520.	2 19. 124349	104. 690000	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated					0	206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					0. 000000	207. 00
	Parts III and IV)						

Provider CCN: 15-0059 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/24/2022 5:25 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 27, 615, 134 27, 615, 134 27, 615, 134 03100 INTENSIVE CARE UNIT 7, 199, 310 7, 199, 310 0 7, 199, 310 31.00 31.00 04100 SUBPROVIDER - IRF 5, 377, 344 o 41.00 5, 377, 344 5, 377, 344 41.00 04300 NURSERY 43.00 0 43.00 C 0 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 13, 951, 321 13, 951, 321 13, 951, 321 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 Λ 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 779, 447 4, 779, 447 4, 779, 447 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2,004,823 2, 004, 823 0 0 0 2, 004, 823 55.00 57.00 05700 CT SCAN 554, 207 554, 207 554, 207 57.00 03630 ULTRA SOUND 567, 707 567, 707 567, 707 57.01 57.01 58.00 05800 MRI 507, 371 507, 371 507, 371 58.00 05900 CARDIAC CATHETERIZATION 59.00 1, 512, 835 1, 512, 835 0 1, 512, 835 59.00 06000 LABORATORY 60 00 12, 564, 314 12, 564, 314 12, 564, 314 60 00 60.01 06001 BLOOD LABORATORY Ω Λ 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 940, 949 940, 949 0 940, 949 63.00 63.00 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 0 2, 849, 081 06500 RESPIRATORY THERAPY 2 849 081 2, 849, 081 65 00 65 00 66.00 0 06600 PHYSI CAL THERAPY 9,067,288 9,067,288 9,067,288 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 0 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 68 00 0 0 0 69.00 06900 ELECTROCARDI OLOGY 1, 578, 541 1, 578, 541 1, 578, 541 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11, 161, 409 11, 161, 409 11, 161, 409 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 12, 872, 710 12, 872, 710 12, 872, 710 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 18, 760, 328 18, 760, 328 18, 760, 328 73 00 07400 RENAL DIALYSIS 74.00 525, 840 525, 840 525, 840 74.00 03020 OTHER ANCILLARY 0 76.00 76.00 0 0 76.01 03140 CARDI AC REHAB 2, 906, 922 2, 906, 922 2, 906, 922 76.01 76.02 03070 WOMEN'S CENTER 1, 542, 455 1, 542, 455 76.02 1, 542, 455 76.03 03330 ENDOSCOPY 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 818, 699 818, 699 0 818, 699 90.00 90.01 09001 OUTPATI ENT 1, 897, 928 0 1, 897, 928 1, 897, 928 90.01 90.02 09002 NEUROPSYCHOLOGY 672, 324 672, 324 0 672, 324 90.02 91.00 09100 EMERGENCY 27, 277, 570 27, 277, 570 0 27, 277, 570 91.00 09101 SHORT STAY 0 91.01 91.01 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 4, 737, 496 4, 737, 496 4, 737, 496 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 132, 475 132, 475 132, 475 95.00 Subtotal (see instructions) 174, 375, 828 200. 00 200.00 174, 375, 828 0 174, 375, 828 0

4, 737, 496

169, 638, 332

4, 737, 496

169, 638, 332

4, 737, 496 201. 00

169, 638, 332 202. 00

201.00

202.00

Less Observation Beds

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Peri od: Worksheet C From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/24/2022 5:25 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 40, 685, 928 40, 685, 928 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 14, 315, 544 14, 315, 544 31.00 04100 SUBPROVI DER - I RF 6, 620, 772 6, 620, 772 41.00 41.00 43.00 04300 NURSERY C 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 16, 788, 344 82, 568, 404 99, 356, 748 0 140416 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 057, 180 54.00 12, 362, 919 14, 420, 099 0.331443 0.000000 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 123, 459 9, 797, 425 9, 920, 884 0.202081 0.000000 55.00 57.00 05700 CT SCAN 4, 552, 542 18, 736, 469 23, 289, 011 0.023797 0.000000 57.00 1, 229, 163 9, 376, 152 03630 ULTRA SOUND 8, 146, 989 0.000000 57.01 0.060548 57.01 58.00 05800 MRI 695, 065 6, 447, 646 7, 142, 711 0.071033 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 10, 198, 976 17, 015, 118 27, 214, 094 0.055590 0.000000 59.00 60.00 06000 LABORATORY 18, 594, 663 50, 503, 702 69, 098, 365 0.181832 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0.000000 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 242, 612 546, 277 1, 788, 889 0.525996 0.000000 63.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 7, 704, 992 2, 148, 118 9, 853, 110 0. 289156 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 7, 833, 651 23, 450, 272 31, 283, 923 0.289839 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 8, 593, 775 69 00 06900 ELECTROCARDI OLOGY 2, 559, 343 11, 153, 118 0 141534 0 000000 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 18, 134, 512 28, 749, 474 46, 883, 986 0.238064 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 919, 176 16, 438, 780 22, 357, 956 0.575755 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 024, 653 45, 377, 274 63, 401, 927 0.295895 0.000000 73.00 07400 RENAL DIALYSIS 0.744120 74.00 696, 544 10, 116 706, 660 0.000000 74.00 76.00 03020 OTHER ANCILLARY 0.000000 0.000000 76.00 03140 CARDIAC REHAB 76. 01 747, 576 15, 495, 537 16, 243, 113 0.178963 0.000000 76.01 76 02 03070 WOMEN'S CENTER 13.836 7, 757, 630 7, 771, 466 0 198477 0.000000 76 02 03330 ENDOSCOPY 76.03 0.000000 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 48, 945 5, 397, 966 5, 446, 911 0. 150305 0.000000 90.00 90 01 09001 OUTPATI ENT 8, 243, 915 0.000000 90 01 225, 347 8,018,568 0 230222 90.02 09002 NEUROPSYCHOLOGY 1,812,692 1, 812, 692 0.370898 0.000000 90.02 09100 EMERGENCY 4, 853, 922 52, 000, 991 0.479775 0.000000 91.00 56, 854, 913 91.00 91.01 09101 SHORT STAY 0.000000 0.000000 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 5, 580, 084 0.000000 92.00 1, 306, 231 6, 886, 315 0.687958 92.00

185, 172, 976

185, 172, 976

426, 956, 226

426, 956, 226

612, 129, 202

612, 129, 202

0.000000

0.000000

95.00

200. 00

201. 00

202.00

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

09500 AMBULANCE SERVICES

95.00

200.00

201.00

202.00

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Period: Worksheet C
From 01/01/2021 Part I

From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/24/2022 5: 25 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 43.00 04300 NURSERY 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 0. 140416 05000 OPERATING ROOM 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 331443 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 202081 55.00 57. 00 | 05700 CT SCAN 0.023797 57.00 57. 01 03630 ULTRA SOUND 0.060548 57.01 05800 MRI 0.071033 58.00 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.055590 59.00 60.00 06000 LABORATORY 0. 181832 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 0. 525996 63.00 63.00 0.000000 64.00 64 00 65.00 06500 RESPIRATORY THERAPY 0. 289156 65.00 06600 PHYSI CAL THERAPY 0. 289839 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.141534 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 238064 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.575755 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 295895 73.00 74.00 07400 RENAL DIALYSIS 0. 744120 74.00 76.00 03020 OTHER ANCILLARY 0.000000 76.00 03140 CARDI AC REHAB 76.01 0.178963 76.01 76. 02 | 03070 | WOMEN' S CENTER 0. 198477 76.02 03330 ENDOSCOPY 76.03 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.150305 90.01 09001 OUTPATI ENT 0. 230222 90.01 09002 NEUROPSYCHOLOGY 90.02 0.370898 90.02 09100 EMERGENCY 91.00 0.479775 91.00 09101 SHORT STAY 91.01 0.000000 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.687958 92.00 OTHER REIMBURSABLE COST CENTERS

0.000000

95.00

200. 00

201.00

202.00

95.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Subtotal (see instructions)

Less Observation Beds

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Peri od: Worksheet C From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/24/2022 5:25 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 27, 615, 134 27, 615, 134 27, 615, 134 03100 INTENSIVE CARE UNIT 7, 199, 310 7, 199, 310 0 7, 199, 310 31.00 31.00 04100 SUBPROVI DER - I RF 5, 377, 344 o 41.00 5, 377, 344 5, 377, 344 41.00 04300 NURSERY 43.00 0 43.00 C 0 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 13, 951, 321 13, 951, 321 13, 951, 321 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 Λ 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 779, 447 4, 779, 447 4, 779, 447 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2,004,823 2, 004, 823 0 0 0 2, 004, 823 55.00 57.00 05700 CT SCAN 554, 207 554, 207 554, 207 57.00 03630 ULTRA SOUND 567, 707 567, 707 567, 707 57.01 57.01 58.00 05800 MRI 507, 371 507, 371 507, 371 58.00 05900 CARDIAC CATHETERIZATION 59.00 1, 512, 835 1, 512, 835 0 1, 512, 835 59.00 06000 LABORATORY 60 00 12, 564, 314 12, 564, 314 12, 564, 314 60 00 60.01 06001 BLOOD LABORATORY Ω Λ 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 940, 949 940, 949 0 940, 949 63.00 63.00 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 0 2, 849, 081 06500 RESPIRATORY THERAPY 2 849 081 2, 849, 081 65 00 65 00 66.00 0 06600 PHYSI CAL THERAPY 9,067,288 9,067,288 9,067,288 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 0 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 68 00 0 0 0 69.00 06900 ELECTROCARDI OLOGY 1, 578, 541 1, 578, 541 1, 578, 541 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11, 161, 409 11, 161, 409 11, 161, 409 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 12, 872, 710 12, 872, 710 12, 872, 710 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 18, 760, 328 18, 760, 328 18, 760, 328 73 00 07400 RENAL DIALYSIS 74.00 525, 840 525, 840 525, 840 74.00 03020 OTHER ANCILLARY 0 76.00 76.00 0 0 76.01 03140 CARDI AC REHAB 2, 906, 922 2, 906, 922 2, 906, 922 76.01 76.02 03070 WOMEN'S CENTER 1, 542, 455 1, 542, 455 76 02 1, 542, 455 76.03 03330 ENDOSCOPY 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 818, 699 818, 699 0 818, 699 90.00 90.01 09001 OUTPATI ENT 1, 897, 928 0 1, 897, 928 1, 897, 928 90.01 90.02 09002 NEUROPSYCHOLOGY 672, 324 672, 324 0 672, 324 90.02 91.00 09100 EMERGENCY 27, 277, 570 27, 277, 570 0 27, 277, 570 91.00 09101 SHORT STAY 0 91.01 91.01 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 4, 737, 496 4, 737, 496 4, 737, 496 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 132, 475 132, 475 132, 475 95.00 Subtotal (see instructions) 174, 375, 828 200. 00 200.00 174, 375, 828 0 174, 375, 828 0

4, 737, 496

169, 638, 332

4, 737, 496

169, 638, 332

4, 737, 496 201. 00

169, 638, 332 202. 00

201.00

202.00

Less Observation Beds

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Peri od: Worksheet C From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/24/2022 5:25 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 40, 685, 928 40, 685, 928 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 14, 315, 544 14, 315, 544 31.00 04100 SUBPROVI DER - I RF 6, 620, 772 6, 620, 772 41.00 41.00 43.00 04300 NURSERY C 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 16, 788, 344 82, 568, 404 99, 356, 748 0 140416 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 057, 180 54.00 12, 362, 919 14, 420, 099 0.331443 0.000000 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 123, 459 9, 797, 425 9, 920, 884 0.202081 0.000000 55.00 57.00 05700 CT SCAN 4, 552, 542 18, 736, 469 23, 289, 011 0.023797 0.000000 57.00 1, 229, 163 9, 376, 152 03630 ULTRA SOUND 8, 146, 989 0.000000 57.01 0.060548 57.01 58.00 05800 MRI 695, 065 6, 447, 646 7, 142, 711 0.071033 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 10, 198, 976 17, 015, 118 27, 214, 094 0.055590 0.000000 59.00 60.00 06000 LABORATORY 18, 594, 663 50, 503, 702 69, 098, 365 0.181832 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0.000000 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 242, 612 546, 277 1, 788, 889 0.525996 0.000000 63.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 7, 704, 992 2, 148, 118 9, 853, 110 0. 289156 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 7, 833, 651 23, 450, 272 31, 283, 923 0.289839 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 8, 593, 775 69 00 06900 ELECTROCARDI OLOGY 2, 559, 343 11, 153, 118 0 141534 0 000000 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 18, 134, 512 28, 749, 474 46, 883, 986 0.238064 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 919, 176 16, 438, 780 22, 357, 956 0.575755 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 024, 653 45, 377, 274 63, 401, 927 0.295895 0.000000 73.00 07400 RENAL DIALYSIS 0.744120 74.00 696, 544 10, 116 706, 660 0.000000 74.00 76.00 03020 OTHER ANCILLARY 0.000000 0.000000 76.00 03140 CARDIAC REHAB 76. 01 747, 576 15, 495, 537 16, 243, 113 0.178963 0.000000 76.01 76 02 03070 WOMEN'S CENTER 13.836 7, 757, 630 7, 771, 466 0 198477 0.000000 76 02 03330 ENDOSCOPY 76.03 0.000000 0.000000 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 48, 945 5, 397, 966 5, 446, 911 0. 150305 0.000000 90.00 90 01 09001 OUTPATI ENT 8, 243, 915 0 000000 90 01 225, 347 8,018,568 0 230222 90.02 09002 NEUROPSYCHOLOGY 1,812,692 1, 812, 692 0.370898 0.000000 90.02 09100 EMERGENCY 4, 853, 922 52, 000, 991 0.479775 0.000000 91.00 56, 854, 913 91.00 91.01 09101 SHORT STAY 0.000000 0.000000 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 5, 580, 084 0.000000 92.00 1, 306, 231 6, 886, 315 0.687958 92.00 OTHER REIMBURSABLE COST CENTERS

185, 172, 976

185, 172, 976

426, 956, 226

426, 956, 226

612, 129, 202

612, 129, 202

0.000000

0.000000

95.00

200. 00

201. 00

202.00

95.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Subtotal (see instructions)

Less Observation Beds

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES RI VERVI EW HOSPI TAL Provider CCN: 15-0059

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/24/2022 5:25 pm

			T' II VIV		5/24/2022 5: 25 piii
	Cook Cooker December 1	DDC 1 11	Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
- I	WEATHERT BOUTLINE OFFICE OF CONT. OFFITEDO	11. 00			
	NPATIENT ROUTINE SERVICE COST CENTERS	T T			
	3000 ADULTS & PEDIATRICS				30.0
	3100 I NTENSI VE CARE UNI T				31. 0
	4100 SUBPROVIDER - IRF				41. 0
	4300 NURSERY				43.0
	4400 SKILLED NURSING FACILITY				44. 0
	NCILLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 000000			50.0
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
	5500 RADI OLOGY-THERAPEUTI C	0. 000000			55.0
	5700 CT SCAN	0. 000000			57.0
57. 01 03	3630 ULTRA SOUND	0. 000000			57. 0
58. 00 0	5800 MRI	0. 000000			58.0
59. 00 0	5900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 0
50.00 06	6000 LABORATORY	0. 000000			60.0
50. 01 06	6001 BLOOD LABORATORY	0. 000000			60.0
3.00 0	6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 0
4. 00 0	6400 INTRAVENOUS THERAPY	0. 000000			64. 0
55.00 06	6500 RESPI RATORY THERAPY	0. 000000			65. 0
56.00 06	6600 PHYSI CAL THERAPY	0. 000000			66.0
57. 00 06	6700 OCCUPATIONAL THERAPY	0. 000000			67.0
58. 00 0	6800 SPEECH PATHOLOGY	0. 000000			68.0
59.00 0	6900 ELECTROCARDI OLOGY	0. 000000			69.0
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 0
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 0
	7300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 0
	7400 RENAL DIALYSIS	0. 000000			74.0
	3020 OTHER ANCILLARY	0. 000000			76.0
	3140 CARDI AC REHAB	0. 000000			76.0
	3070 WOMEN' S CENTER	0. 000000			76. 0
	3330 ENDOSCOPY	0. 000000			76.0
_	UTPATIENT SERVICE COST CENTERS	0.00000			70.0
	9000 CLI NI C	0. 000000			90.0
	9001 OUTPATI ENT	0. 000000			90.0
	9002 NEUROPSYCHOLOGY	0. 000000			90.0
	9100 EMERGENCY	0. 000000			91. 0
	9101 SHORT STAY	0. 000000			91.0
- 1	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			91.0
	THER REIMBURSABLE COST CENTERS	0.000000			92.0
	9500 AMBULANCE SERVICES	0.00000			95. 0
200.00	Subtotal (see instructions)	0. 000000			200. 0
	,				200. 0
201.00	Less Observation Beds				201. 0
202. 00	Total (see instructions)	1			J202. C

Heal th Financi	al Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTI ONMENT	OF INPATIENT ROUTINE SERVICE CAN	PITAL COSTS	Provider Co	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/24/2022 5:2	
				XVIII	Hospi tal	PPS	
Co	ost Center Description	Capi tal Rel ated Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 / col. 4)	
		(from Wkst. B,	.,	Related Cost		,	
		Part II, col.		(col. 1 - col.			
		26)		2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI E	NT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS	& PEDI ATRI CS	5, 513, 242	0	5, 513, 242	15, 721	350. 69	30. 00
31. 00 I NTENSI	VE CARE UNIT	847, 485		847, 485	4, 199	201. 83	31. 00
	/IDER - IRF	956, 367	0	956, 367		222. 36	
43. 00 NURSERY		0		(1, 512	0.00	
	NURSING FACILITY	0		(0	0.00	
	(lines 30 through 199)	7, 317, 094		7, 317, 094	25, 733		200. 00
Co	ost Center Description	I npati ent	Inpati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
		6. 00	6) 7. 00	-			
INDATIF	NT ROUTINE SERVICE COST CENTERS	6.00	7.00				
	& PEDIATRICS	3, 853	1, 351, 209				30.00
	VE CARE UNIT	961	193, 959	1			31.00
	IDER - IRF	2, 277	506, 314				41.00
43. 00 NURSERY		2,2,7	000,011				43. 00
	NURSING FACILITY		o o				44. 00
	(lines 30 through 199)	7, 091	2, 051, 482				200. 00

Health Financial Systems	RIVERVIEW HOSPITAL In Lieu			
APPORTIONMENT OF INPATIENT ANCILLARY S	SERVICE CAPITAL COSTS	Provider CCN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/24/2022 5:25 pm
		T \0.01.1.		DDO

Cost Center Description	APPOR	HIONMENT OF ENPATTENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/24/2022 5:2	
Related Cost (From West, C. Part II, col. Part III, col. Part								
Part II. col. 26) 20 3.00 4.00 5		Cost Center Description						
Part II, col. 8) 2)								
ANCILLARY SERVICE COST CENTERS					1,	. Charges	column 4)	
ANCILLARY SERVICE COST CENTERS				8)	2)			
ANCILLARY SERVICE COST CENTERS S. 0.00 Cost				2.00	2.00	4.00	Г 00	
50.00 05000 05000 05000 05000 05000 05000 0500000 0		ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.000000 0.000000 0.54.00 0.5400 0.5400 0.5400 0.5400 0.5400 0.5400 0.5400 0.5400 RADIOLOGY-DIAGNOSTIC 710,765 14,420.099 0.049290 708,117 34,903 54.00 0.5500 RADIOLOGY-THERAPEUTIC 378,844 9,920,884 0.038187 18,957 724 55.00 0.5700 0.5700 CT SCAN 4,168 23,289,011 0.000179 1,460,932 262 57.00 0.5701 0.5630 ULTRA SOUND 4,305 9,376,152 0.000459 287,551 312 57.01 0.5800 MRI 3,859 7,142,711 0.000540 167,428 90 58.00 0.5800 MRI 3,859 7,142,711 0.000540 167,428 90 58.00 0.5800 MRI 3.3859 7,142,711 0.000540 167,428 90 58.00 0.5800 CARDIAC CATHETERIZATION 132,337 27,214,094 0.004863 2,946,228 14,328 59.00 0.50000 0.5000 0.5000 0.5000 0.5000 0.500	50.00		2 690 104	99 356 748	0.02707	5 4 792 085	129 746	50.00
S4 - 00 054-00 RADI OLOGY-DI AGNOSTI C 710, 765 14, 420, 099 0.049290 708, 117 34, 903 54, 00								
55.00 05500 RSD0 RABIOLLOGY-THERAPEUTI C 378, 844 9, 920, 884 0, 038187 18, 957 724 55.00			1	"				
57.00 05700 CT SCAN 4, 168 23, 289, 011 0, 000179 1, 460, 932 262 57.00 57.01 03630 ULTRA SOUND 4, 305 9, 376, 152 0.000459 287, 551 132 57.01 0.000540 0.000459 287, 551 132 57.01 0.000540 0.000459 0.0000459 0.								1
57. 01 03630 ULTRA SOUND 4, 305 9, 376, 152 0, 000459 287, 551 132 57. 01								ł
58. 00 05800 MRI 3,859 7,142,711 0.000540 167,428 90 58.00 59. 00 05900 CARDIAC CATHETERIZATION 132,337 27,214,094 0.004863 2,946,228 14,328 59.00 60. 01 06000 LABORATORY 828,437 69,098,365 0.011989 4,906,220 58,821 60.00 60. 01 06001 BLOOD LABORATORY 0 0.000000 0 0.00000 0 0.60.01 64. 00 06300 BLOOD STORING, PROCESSING & TRANS. 131,068 1,788,889 0.073268 224,199 16,427 63.00 64. 00 06400 INTRAVENOUS THERAPY 95,743 9,853,110 0.009717 2,206,427 21,440 65.00 65. 00 06500 RESPI RATORY THERAPY 326,788 31,283,923 0.010446 1,143,907 11,949 66.00 66. 00 06600 PHYSI CAL THERAPY 326,788 31,283,923 0.010446 1,143,907 11,949 66.00 68. 00 06900 SPEECH PATHOLOGY 0 0 0.000000 0 0.000000								
59.00 05900 CARDI AC CATHETERI ZATI ON 132, 337 27, 214, 094 0.004863 2, 946, 228 14, 328 59.00							•	
60. 00 06000 LABORATORY 828, 437 69, 098, 365 0. 011989 4, 906, 220 58, 821 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0. 000000 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 131, 068 1, 788, 889 0. 073268 224, 199 16, 427 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0. 000000 0 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 95, 743 9, 853, 110 0. 009717 2, 206, 427 21, 440 65. 00 66. 00 06600 PHYSI CAL THERAPY 326, 788 31, 283, 923 0. 010446 1, 143, 907 11, 949 66. 00 67. 00 06600 PHYSI CAL THERAPY 326, 788 31, 283, 923 0. 010446 1, 143, 907 11, 949 66. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0. 000000 0 0 67. 00 69. 00 06900 ELECTROCARDIOLOGY 350, 914 11, 153, 118 0. 031463 795, 054 25, 015 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 429, 561 46, 883, 986 0. 009162 4, 664, 331 42, 735 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 88, 671 22, 357, 956 0. 003966 1, 869, 270 7, 141 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 568, 677 63, 401, 927 0. 008969 4, 180, 801 37, 498 73. 00 74. 00 07400 RENAL DI ALYSIS 50, 482 706, 660 0. 071437 181, 314 12, 953 74. 00 76. 01 03140 CARDIAC REHAB 595, 296 16, 243, 113 0. 036649 160, 125 5, 868 76. 01 76. 02 03070 WOMEN' S CENTER 477, 851 7, 771, 466 0. 061488 2, 049 126 76. 02 76. 03 03330 ENDOSCOPY 0 0 0. 000000 0 0 0 00 00								ł
60. 01 06001 06001 06001 06001 06001 060000 060000 060000 060000 060000 0600000 0600000 0600000 0600000 06000000 06000000 06000000 060000000 060000000 0600000000								
63. 00 06300							l	
64. 00 06400 INTRAVENOUS THERAPY 0 0 0.000000 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 95. 743 9, 853, 110 0.009717 2, 206, 427 21, 440 65. 00 06500 RESPI RATORY THERAPY 95. 743 9, 853, 110 0.009717 2, 206, 427 21, 440 65. 00 06600 PHYSI CAL THERAPY 326, 788 31, 283, 923 0.101446 1, 143, 907 11, 949 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0.000000 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 350, 914 11, 153, 118 0.031463 795, 054 25, 015 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 429, 561 46, 883, 986 0.009162 4, 664, 331 42, 735 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 88, 671 22, 357, 956 0.003966 1, 869, 270 7, 414 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 568, 677 63, 401, 927 0.008969 4, 180, 801 37, 498 73. 00 74. 00 07400 RENAL DI ALYSI S 50, 482 706, 660 0.071437 181, 314 12, 953 74. 00 76. 01 03140 CARDI AC REHAB 595, 296 16, 243, 113 0.036649 160, 125 5, 868 76. 01 76. 02 03070 WOMEN' S CENTER 477, 851 7, 771, 466 0.061488 2, 049 126 76. 02 76. 03 03330 ENDOSCOPY 0 0.000000 0 0 76. 03 79. 00 09000 CLINI C 127, 693 5, 446, 911 0.023443 5, 309 124 90. 00 79. 01 09010 UIPATI ENT SERVI CE COST CENTERS 79. 00 09000 DEUROPSYCHOLOGY 90, 574 1, 812, 692 0.049967 0 0.000000 70 09000 DEUROPSYCHOLOGY 90, 574 1, 812, 692 0.049967 0 0.000000 70 09100 MERINSABLE COST CENTERS 70 009000 DESERVATI ON BEDS (NON-DISTINCT PART 945, 822 6, 886, 315 0.137348 412, 169 56, 611 70 09500 OMBULANCE SERVI CES			Ŭ	·				l
65. 00 06500 RESPI RATORY THERAPY 95, 743 9, 853, 110 0.009717 2, 206, 427 21, 440 65. 00 66. 00 06600 PHYSI CAL THERAPY 326, 788 31, 283, 923 0.010446 1, 143, 907 11, 949 66. 00 67. 00 0.000000 0 0 0.000000 0			131,000					
66. 00 06600 PHYSI CAL THERAPY 320, 788 31, 283, 923 0. 010446 1, 143, 907 11, 949 66. 00 6700 0CCUPATI ONAL THERAPY 0 0 0. 000000 0 0 67. 00 68. 00 06900 06900 SPEECH PATHOLOGY 350, 914 11, 153, 118 0. 031463 795, 054 25, 015 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 429, 561 46, 883, 986 0. 009162 4, 664, 331 42, 735 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATIENT 88, 671 22, 357, 956 0. 003966 1, 869, 270 7, 414 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 568, 677 63, 401, 927 0. 008969 4, 180, 801 37, 498 73. 00 74. 00 07400 RENAL DIALYSIS 50, 482 706, 660 0. 071437 181, 314 12, 953 74. 00 76. 01 03140 CARDI AC REHAB 595, 296 16, 243, 113 0. 036649 160, 125 5, 868 76. 01 03330 ENDOSCOPY 0 0. 0000000 0 0 0. 000000 0			05 742					•
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0.000000 0 0 67. 00 68. 00 69. 00 06800 SPEECH PATHOLOGY 0 0 0.000000 0 0 0.68. 00 0.000000 0 0 0.68. 00 0.000000 0 0 0.000000 0								
68.00 06800 SPEECH PATHOLOGY 0 0.000000 0 0.000000 0 0 68.00 69.00 69.00 69.00 ELECTROCARDI OLOGY 350, 914 11, 153, 118 0.031463 795, 054 25, 015 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 429, 561 46, 883, 986 0.009162 4, 664, 331 42, 735 71.00 7200 IMPL. DEV. CHARGED TO PATI ENTS 88, 671 22, 357, 956 0.003966 1, 869, 270 7, 414 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 568, 677 63, 401, 927 0.008969 4, 180, 801 37, 498 73.00 74.00 07400 RENAL DI ALYSI S 50, 482 706, 660 0.071437 181, 314 12, 953 74.00 76.00 03020 OTHER ANCI LLARY 0 0 0.000000 0 0 0 76.00 76.00 03020 OTHER ANCI LLARY 0 0 0.000000 0 0 0 76.00 76.00 03020 OTHER ANCI LLARY 0 0 0.000000 0 0 0 76.00 76.00 03020 OTHER ANCI LLARY 0 0 0.000000 0 0 0 76.00 76.00 030300 WOMEN'S CENTER 477, 851 7, 771, 466 0.061488 2, 049 126 76.02 76.03 03330 ENDOSCOPY 0 0 0.000000 0 0 0 76.00 000000 0 0 0 76.00 000000 0 0 0 76.00 000000 0 0 0 0 000000 0 0 0 0 000000			320, 700					1
69. 00 06900 ELECTROCARDI OLOGY 350, 914 11, 153, 118 0. 031463 795, 054 25, 015 69. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 429, 561 46, 883, 986 0. 009162 4, 664, 331 42, 735 71. 00 72. 00 70200 IMPL. DEV. CHARGED TO PATI ENTS 88, 671 22, 357, 956 0. 003966 1, 869, 270 7, 414 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 568, 677 63, 401, 927 0. 008969 4, 180, 801 37, 498 73. 00 74. 00 07400 RENAL DI ALYSIS 50, 482 706, 660 0. 071437 181, 314 12, 953 74. 00 76. 00 03020 OTHER ANCI LLARY 0 0 0. 000000 0 0 76. 00 76. 00 76. 00 03140 CARDI AC REHAB 595, 296 16, 243, 113 0. 036649 160, 125 5, 868 76. 01 03300 SCHARGED TO PATI ENT SERVI CE COST CENTERS 0 0. 0000000 0 0 76. 03 0. 0000000 0 0 0. 0000000 0			0					
71. 00			250 014	11 152 110				
72. 00								
73. 00 07300 DRUGS CHARGED TO PATIENTS 568, 677 63, 401, 927 0. 008969 4, 180, 801 37, 498 73. 00 74. 00 07400 RENAL DI ALYSI S 50, 482 706, 660 0. 071437 181, 314 12, 953 74. 00 03020 OTHER ANCI LLARY 0 0 0. 0000000 0 0 0 76. 00 76. 00 03140 CARDI AC REHAB 595, 296 16, 243, 113 0. 036649 160, 125 5, 868 76. 01 03140 CARDI AC REHAB 595, 296 16, 243, 113 0. 036649 160, 125 5, 868 76. 01 03140 CARDI AC REHAB 70. 0 0 0. 000000 0 0 0 0 0 0 0 0 0 0 0								1
74. 00			1					
76. 00			1		•			
76. 01			1	1			l	
76. 02			_	"				
76. 03			1		l .			•
OUTPATI ENT SERVI CE COST CENTERS 90.00 O9000 CLI NI C 127, 693 5, 446, 911 0.023443 5, 309 124 90.00 90.01 O9001 OUTPATI ENT 193, 388 8, 243, 915 0.023458 26, 955 632 90.01 90.02 O9002 NEUROPSYCHOLOGY 90, 574 1, 812, 692 0.049967 0 0 90.02 91.01 O9100 EMERGENCY 1, 285, 957 56, 854, 913 0.022618 1, 925, 544 43, 552 91.00 91.01 SHORT STAY 0 0 0.000000 0 0 91.01 92.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 945, 822 6, 886, 315 0.137348 412, 169 56, 611 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVI CES 95.00 O9500 OMBULANCE SERVI CES 95.00 O0500 OUTPATI ENT OUTPATI			1				l e	1
90. 00	70.03			· · · · · ·	0.00000	0 0		70.00
90. 01 09001 0UTPATI ENT 193, 388 8, 243, 915 0. 023458 26, 955 632 90. 01 90. 02 09002 NEUROPSYCHOLOGY 90, 574 1, 812, 692 0. 049967 0 0 0. 02900 91. 00 09100 EMERGENCY 1, 285, 957 56, 854, 913 0. 022618 1, 925, 544 43, 552 91. 00 91. 01 09101 SHORT STAY 0 0 0. 000000 0 0 0. 000000 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 945, 822 6, 886, 315 0. 137348 412, 169 56, 611 95. 00 09500 AMBULANCE SERVI CES 95. 00	90.00		127, 693	5, 446, 911	0. 02344	3 5, 309	124	90.00
91. 00 09100 EMERGENCY 1, 285, 957 56, 854, 913 0. 022618 1, 925, 544 43, 552 91. 00 91. 01 09101 SHORT STAY 0 0 0. 000000 0 0 0 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 945, 822 6, 886, 315 0. 137348 412, 169 56, 611 92. 00 09500 AMBULANCE SERVI CES 95. 00	90. 01	09001 OUTPATI ENT	193, 388	8, 243, 915	0. 02345	8 26, 955	632	90. 01
91. 00 09100 EMERGENCY 1, 285, 957 56, 854, 913 0. 022618 1, 925, 544 43, 552 91. 00 91. 01 09101 SHORT STAY 0 0 0. 000000 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 945, 822 6, 886, 315 0. 137348 412, 169 56, 611 92. 00 09500 AMBULANCE SERVI CES 95. 00	90. 02	09002 NEUROPSYCHOLOGY	90, 574	1, 812, 692	0. 04996	7 0	0	90. 02
91. 01 09101 SHORT STAY 0 0 0 0 0 0 0 0 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 945, 822 6, 886, 315 0. 137348 412, 169 56, 611 92. 00 071 071 072 073 074 075 07							43, 552	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 945, 822 6, 886, 315 0. 137348 412, 169 56, 611 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 01		0				l	1
0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00			945, 822	6, 886, 315			56, 611	92.00
200. 00 Total (lines 50 through 199) 10,511,304 550,506,958 33,084,972 521,350 200.00	95.00							
	200.00	Total (lines 50 through 199)	10, 511, 304	550, 506, 958		33, 084, 972	521, 350	200. 00

Health Financial Systems	RI VERVI EW				eu of Form CMS-	<u>2552-10</u>
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Peri od: From 01/01/2021 To 12/31/2021		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - IRF 43. 00 04300 NURSERY	0 0	0 0	1		0 0 0 0	31. 00 41. 00
43. 00 044000 SKI LLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0	0		0 0	_	44. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	2001.00
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0	0 0 0 0	15, 72 4, 19 4, 30 1, 5	99 0. 00 01 0. 00	961 2, 277	31. 00 41. 00
44.00 04400 SKILLED NURSING FACILITY		0		0.00		
200.00 Total (lines 30 through 199)		0	25, 73	33	7, 091	200. 00
	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER - I RF	0 0					30. 00 31. 00 41. 00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0 0					43. 00 44. 00 200. 00

ealth Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AITHROUGH COSTS	ICILLARY SERVICE OTHER PAS	S Provider CO		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prep 5/24/2022 5:29	pared: 5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3, 00	

		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
57. 00 05700 CT SCAN	0	0	l	o	0	57. 00
57. 01 03630 ULTRA SOUND	0	0	1	o o	0	57. 01
58. 00 05800 MRI	0	0		o	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1 0	0	l o	59.00
60. 00 06000 LABORATORY	0	0		0	O	60.00
60. 01 06001 BL00D LABORATORY	0	0		0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0			0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	١				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			349, 120	73. 00
74. 00 07400 RENAL DIALYSIS	0	0			0	74.00
76. 00 03020 OTHER ANCI LLARY	0					76.00
76. 01 03140 CARDI AC REHAB	0					76. 01
76. 02 03070 WOMEN' S CENTER	0	0			0	76. 01
76. 03 03330 ENDOSCOPY	0	0			0	76. 02
OUTPATIENT SERVICE COST CENTERS	0	0) 0		70.03
90. 00 09000 CLINIC	0	0			0	90.00
90. 01 09001 OUTPATI ENT	0	0			0	90. 00
90. 02 09002 NEUROPSYCHOLOGY	0				0	90.01
91. 00 09100 EMERGENCY	0	0			0	91.00
91. 00 09100 EMERGENCT 91. 01 09101 SHORT STAY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	U		O O	0	91.01
OTHER REIMBURSABLE COST CENTERS	0			<u> </u>	0	J 92. UU
95. 00 09500 AMBULANCE SERVICES			I			95. 00
· · · · · · · · · · · · · · · · · · ·	_	_		_	349, 120	
200.00 Total (lines 50 through 199)	0	0	(0	349, 120	J200. 00

Health F	Financial Systems	RI VERVI EW	ΗΛΟΟΙ ΤΔΙ		In lie	eu of Form CMS-2	2552_10
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:
			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	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	_		T			4
	05000 OPERATING ROOM	0			0 99, 356, 748	•	
	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0	0.000000	
	D5400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 420, 099	•	1
	D5500 RADI OLOGY-THERAPEUTI C	0	0		0 9, 920, 884		
	D5700 CT SCAN	0	0		0 23, 289, 011		
	03630 ULTRA SOUND	0	0		0 9, 376, 152	1	
	05800 MRI	0	0		0 7, 142, 711	•	
	D5900 CARDI AC CATHETERI ZATI ON	0	0		0 27, 214, 094		
	D6000 LABORATORY	0	0		0 69, 098, 365	•	
	D6001 BLOOD LABORATORY	0	0		0	0.000000	
	D6300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 788, 889		
	06400 I NTRAVENOUS THERAPY	0	0		0	0.000000	
	D6500 RESPI RATORY THERAPY	0	0		0 9, 853, 110		
	D6600 PHYSI CAL THERAPY	0	0		0 31, 283, 923	•	
	06700 OCCUPATI ONAL THERAPY	0	0		0	0.000000	
	D6800 SPEECH PATHOLOGY	0	0		0 0	0.000000	
	D6900 ELECTROCARDI OLOGY	0	0		0 11, 153, 118		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 46, 883, 986		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 22, 357, 956	•	
	D7300 DRUGS CHARGED TO PATIENTS	0	349, 120	349, 12	· · · · · ·	•	
	07400 RENAL DIALYSIS	0	0		0 706, 660		
	03020 OTHER ANCI LLARY	0	0		0	0.000000	
	D3140 CARDI AC REHAB	0	0		0 16, 243, 113		
	03070 WOMEN' S CENTER	0	1		0 7, 771, 466		
	D3330 ENDOSCOPY	0	0		<u>U 0</u>	0.000000	76. 03
	OUTPATIENT SERVICE COST CENTERS	_		I	5 44/ 211	0.000000	00.00
	D9000 CLINIC	0			0 5, 446, 911	•	
			. ()	i .	III X /// UIS		. 90 01

0

0

349, 120

5, 446, 911 8, 243, 915

1, 812, 692

56, 854, 913

6, 886, 315

550, 506, 958

349, 120

0.000000

0.000000

0. 000000 0. 000000

0.000000

90.01

90. 02

91.00

91.01

92.00

95.00

200.00

90. 01 09001 OUTPATIENT

91. 00 | 09100 | EMERGENCY

91. 01 | 09101 | SHORT STAY

09002 NEUROPSYCHOLOGY

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

90. 02

200.00

Heal th	Financial Systems	RI VERVI EW HO	OSPI TAL		In Lie	u of Form CMS-2	2552-1 <u>0</u>
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PASS	Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/24/2022 5:2	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10. 00	11. 00	12.00	13. 00	
	ANCI LLARY SERVI CE COST CENTERS			Т			
50.00	05000 OPERATING ROOM	0. 000000	4, 792, 085	i	0 18, 804, 153		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	708, 117		0 2, 170, 619		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	18, 957		0 2, 696, 349		55. 00
57. 00	05700 CT SCAN	0. 000000	1, 460, 932		0 4, 194, 402		57. 00
57. 01	03630 ULTRA SOUND	0. 000000	287, 551		0 1, 999, 185		57. 01
58. 00	05800 MRI	0. 000000	167, 428		0 1, 498, 013		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 946, 228		0 4, 325, 458		59. 00
60.00	06000 LABORATORY	0. 000000	4, 906, 220		0 3, 990, 064	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	224, 199		0 63, 096		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	2, 206, 427		0 729, 371	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 143, 907		0 174, 229	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	795, 054		0 1, 735, 638	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 664, 331		0 6, 196, 031	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 869, 270		0 4, 595, 102	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 005506	4, 180, 801	23, 01	9 16, 909, 641	93, 104	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	181, 314		0	0	74. 00
76.00	03020 OTHER ANCILLARY	0. 000000	0		0	0	76. 00
76. 01	03140 CARDI AC REHAB	0. 000000	160, 125		3, 941, 403	0	76. 01
76. 02	03070 WOMEN' S CENTER	0. 000000	2, 049		0 562, 624	0	76. 02
76. 03	03330 ENDOSCOPY	0. 000000	0		0	0	76. 03

0.000000

0.000000

0.000000

0. 000000

0.000000

0.000000

5, 309

26, 955

412, 169

1, 925, 544

33, 084, 972

90.00

90. 01

90.02

91. 00

91. 01

92.00

95.00

0

0

0

0

93, 104 200. 00

1, 728, 139

2, 308, 611

1, 026, 813

5, 862, 049

86, 500, 152

989, 162

23, 019

OUTPATIENT SERVICE COST CENTERS

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

Total (lines 50 through 199)

90. 00 09000 CLINIC

92.00

200.00

90. 01 09001 OUTPATI ENT

90. 02 09002 NEUROPSYCHOLOGY

95. 00 09500 AMBULANCE SERVICES

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Co	CN: 15-0059	Peri od:	Worksheet D	
					From 01/01/2021	Part V	
					To 12/31/2021	Date/Time Pre	pared:
			T: ±1 -	V(/	11: 4-1	5/24/2022 5: 2	.5 pm
			IIIIIe	XVIII	Hospi tal	PPS	
	Cook Cooks Books to	C+ +- Ch	DDC Delimbrose ed	Charges	0+	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins (see inst.)	Ded. & Coins. (see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	05000 OPERATING ROOM	0. 140416	18, 804, 153		0 0	2, 640, 404	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0		52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 331443	l .		0 0	719, 436	
	l				0 0		
	05500 RADI OLOGY-THERAPEUTI C	0. 202081	2, 696, 349		0 0	544, 881	
	05700 CT SCAN	0. 023797	4, 194, 402		-	99, 814	1
	03630 ULTRA SOUND	0. 060548			0 0	121, 047	
	05800 MRI	0. 071033	1		0 0	106, 408	1
	05900 CARDI AC CATHETERI ZATI ON	0. 055590			0	240, 452	
	06000 LABORATORY	0. 181832			0	725, 521	
	06001 BLOOD LABORATORY	0. 000000	ł		0	0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 525996	63, 096		0	33, 188	1
	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
1	06500 RESPI RATORY THERAPY	0. 289156		l .	0	210, 902	
	06600 PHYSI CAL THERAPY	0. 289839	174, 229		0	50, 498	66. 00
	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
	06900 ELECTROCARDI OLOGY	0. 141534	1, 735, 638		0	245, 652	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 238064	6, 196, 031		0	1, 475, 052	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 575755	4, 595, 102		0	2, 645, 653	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 295895	16, 909, 641	9, 72	76, 805	5, 003, 478	73. 00
74. 00	07400 RENAL DIALYSIS	0. 744120	0		0 0	0	74.00
76. 00	03020 OTHER ANCILLARY	0. 000000	0		0 0	0	76. 00
76. 01	03140 CARDI AC REHAB	0. 178963	3, 941, 403		0 0	705, 365	76. 01
76. 02	03070 WOMEN'S CENTER	0. 198477	562, 624		0 0	111, 668	76. 02
76. 03	03330 ENDOSCOPY	0. 000000	0		0 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 150305	1, 728, 139		0 0	259, 748	90.00
90. 01	09001 OUTPATI ENT	0. 230222	2, 308, 611		0 0	531, 493	90. 01
90. 02	09002 NEUROPSYCHOLOGY	0. 370898	1, 026, 813		0 0	380, 843	90. 02
91. 00	09100 EMERGENCY	0. 479775	5, 862, 049		0 0	2, 812, 465	91. 00
91. 01	09101 SHORT STAY	0. 000000	0		0 0	ĺ	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 687958	989, 162		0 0	680, 502	92.00
	OTHER REIMBURSABLE COST CENTERS			•			
	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
200.00	Subtotal (see instructions)		86, 500, 152	9, 72	76, 805	20, 344, 470	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges					1	
202.00			86, 500, 152	9, 72	76, 805	20, 344, 470	202. 00
	· · · · · · · · · · · · · · · · · · ·	•		•	•		-

In Lieu of Form CMS-2552-10 Health Financial Systems RI VERVI EW HOSPI TAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0059 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 5/24/2022 5:25 pm 12/31/2021 Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000000 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 55. 00 | 05500 | RADI OLOGY-THERAPEUTI C 0 55.00 57. 00 05700 CT SCAN 0 57.00 57. 01 03630 ULTRA SOUND 0 57.01 05800 MRI 0 58.00 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 60.00 06001 BLOOD LABORATORY 0 60 01 60 01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2,878 22, 726 73.00 07400 RENAL DIALYSIS 74.00 0 0 74.00 03020 OTHER ANCILLARY 0 76.00 0 76.00 76. 01 03140 CARDI AC REHAB 0 0 76.01 03070 WOMEN'S CENTER 0 76.02 0 76.02 76.03 03330 ENDOSCOPY 0 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 OUTPATI ENT 90. 01 0 0 0 90.01

0

0

2,878

2,878

0

0

0

22, 726

22, 726

90.02

91.00

91.01

92.00

95.00

200.00

201.00

202.00

09002 NEUROPSYCHOLOGY

09500 AMBULANCE SERVICES

Only Charges

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

OTHER REIMBURSABLE COST CENTERS

09100 EMERGENCY

09101 SHORT STAY

90.02

91.00

91.01

92.00

95.00

200.00

201.00

202.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0059	Peri od:	Worksheet D	
			Component	CCN: 15-T059	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/24/2022 5:2	
			Title	: XVIII	Subprovi der – I RF	PPS	<u> </u>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	· ·	1,	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)			1.00		
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2.00	3. 00	4. 00	5. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS	0 (00 101	00.05/.740	0.0070	100 100	4 004	F0 00
50.00	05000 OPERATI NG ROOM	2, 690, 104			·	4, 931	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	710, 765					1
55. 00	05500 RADI OLOGY-THERAPEUTI C	378, 844				1, 181	1
57. 00	05700 CT SCAN	4, 168		l .		11	1
57. 01	03630 ULTRA SOUND	4, 305				111	57. 01
58. 00	05800 MRI	3, 859		l .		5	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	132, 337		l .		250	
60.00	06000 LABORATORY	828, 437		l .		6, 270	
60. 01	06001 BLOOD LABORATORY	0				0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	131, 068		l .		875	
64. 00	06400 I NTRAVENOUS THERAPY	0		0.0000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY	95, 743		l .		2, 507	65. 00
66. 00	06600 PHYSI CAL THERAPY	326, 788				27, 502	
67. 00	06700 OCCUPATI ONAL THERAPY	0	_			0	
68. 00	06800 SPEECH PATHOLOGY	0				0	
69. 00	06900 ELECTROCARDI OLOGY	350, 914	,	l .		692	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	429, 561				6, 250	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	88, 671		l .	·	263	
73.00	07300 DRUGS CHARGED TO PATIENTS	568, 677				5, 108	
74.00	07400 RENAL DIALYSIS	50, 482			·	5, 001	74.00
76. 00	03020 OTHER ANCI LLARY	0	_			0	
76. 01	03140 CARDI AC REHAB	595, 296			·	148	
76. 02	03070 WOMEN' S CENTER	477, 851				5	76. 02
76. 03	03330 ENDOSCOPY	0	0	0. 00000	00 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	127, 693		l .		17	90.00
90. 01	09001 OUTPATI ENT	193, 388				205	1
90. 02	09002 NEUROPSYCHOLOGY	90, 574		l .		0	90. 02
91.00	09100 EMERGENCY	1, 285, 957				540	1
91. 01	09101 SHORT STAY	0		0.00000		0	
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	6, 886, 315	0.00000	00 0	0	92.00
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
95. 00	09500 AMBULANCE SERVICES	0 545 400	FEO EO/ 050		F F00 000	44 200	95. 00
200.00	Total (lines 50 through 199)	9, 565, 482	550, 506, 958	1	5, 500, 802	J 64, 288	200. 00

	Financial Systems	RI VERVI EW		N. 45 0050			u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	Provi der CO	CN: 15-0059	Per	riod: om 01/01/2021	Worksheet D Part IV	
TTROOG	11 00313		· ·	CCN: 15-T059	То		Date/Time Pre 5/24/2022 5:2	pared: 5 pm
			Title	XVIII	Sı	ubprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
		Anesthetist	Program	Program		Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
		1.00	Adjustments 2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZN	2.00		5A	3.00	
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55. 00
57.00	05700 CT SCAN	0	0		0	0	0	57. 00
57. 01	03630 ULTRA SOUND	0	0		0	0	0	57. 01
58. 00	05800 MRI	0	0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59. 00
60. 00	06000 LABORATORY	0	0		0	0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0	0	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	349, 120	
74. 00	07400 RENAL DIALYSIS	0	0		0	Ö	0 17, 120	74. 00
76. 00	03020 OTHER ANCI LLARY	0	0		0	0	0	76. 00
76. 01	03140 CARDI AC REHAB	0	0		0	O	0	76. 01
76. 02	03070 WOMEN'S CENTER	0	0		0	0	0	76. 02
76. 03	03330 ENDOSCOPY	0	0		0	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	0		0	0	0	90. 00
90. 01	09001 OUTPATI ENT	0	0		0	0	0	90. 01
90. 02	09002 NEUROPSYCHOLOGY	0	0		0	0	0	90. 02
91. 00	09100 EMERGENCY	0	0		0	0	0	91. 00
91. 01	09101 SHORT STAY	0	0		0	0	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
05.00	OTHER REIMBURSABLE COST CENTERS							05.00
95.00	09500 AMBULANCE SERVICES	1		l				95.00
200.00	l l	0	0		0	0	349, 120	200 00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	Component (CCN: 15-T059	Period: From 01/01/2021 To 12/31/2021	5/24/2022 5: 2	pared: 5 pm
			Title	XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3,	Total Charges (from Wkst. C,	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			ŕ	and 4)		(see instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			0 99, 356, 748 0 0		
52. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0 14, 420, 099	0. 000000 0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 9, 920, 884	0.000000	
57. 00	05700 CT SCAN	0	0		0 23, 289, 011	0.000000	
57. 01	03630 ULTRA SOUND	o o	Ö		0 9, 376, 152		
58.00	05800 MRI	0	0		0 7, 142, 711	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 27, 214, 094	0.000000	59. 00
60.00	06000 LABORATORY	0	0		0 69, 098, 365	0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 788, 889		
64. 00	06400 INTRAVENOUS THERAPY	0	0		0	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	0	0		9, 853, 110		
66.00	06600 PHYSI CAL THERAPY	0	0		0 31, 283, 923 0 0	0.000000	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	1
69. 00	06900 ELECTROCARDI OLOGY		0		0 11, 153, 118	0. 000000 0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 46, 883, 986		1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö		0 22, 357, 956		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	349, 120	349, 12		0. 005506	1
74. 00	07400 RENAL DI ALYSI S	0	0		0 706, 660		
76.00	03020 OTHER ANCILLARY	0	0		0 0	0.000000	
76. 01	03140 CARDI AC REHAB	0	0		0 16, 243, 113		76. 01
76.02	03070 WOMEN'S CENTER	0	0		0 7, 771, 466	0. 000000	76. 02
76. 03	03330 ENDOSCOPY	0	0		0 0	0.000000	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	1		0 5, 446, 911	0. 000000	
90. 01	09001 OUTPATI ENT	0	0		0 8, 243, 915		1
90. 02 91. 00	09002 NEUROPSYCHOLOGY	0	0		0 1, 812, 692 0 56 854 913		
91.00	O9100 EMERGENCY	0	0		0 56, 854, 913 0 0	0. 000000 0. 000000	
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		0 6, 886, 315		
12.00	OTHER REIMBURSABLE COST CENTERS		<u> </u>		0,000,313	0.000000	72.00
95. 00	09500 AMBULANCE SERVICES						95.00

Health Financial Systems	RI VERVI EW H	_			u of Form CMS-	2002 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provi der Co		Peri od: From 01/01/2021	Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
		Title	XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col . 6 ÷ col .		Costs (col. 8	3	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col . 12)	
ANOLLI ADV. CEDVI CE. COCT. CENTEDO	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000	100 100			0	
50. 00 05000 OPERATING ROOM	0. 000000	182, 109		0	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0.000000	49, 006		0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	30, 927		0	0	
57. 00 05700 CT SCAN	0.000000	62, 690		0	0	
57. 01 03630 ULTRA SOUND	0.000000	241, 714		0	0	
58. 00 05800 MRI	0.000000	9, 977		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	51, 317		0	0	
60. 00 06000 LABORATORY	0. 000000	522, 961		0	0	
60. 01 06001 BLOOD LABORATORY	0.000000	0		0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	11, 938		0	0	
64. 00 06400 NTRAVENOUS THERAPY	0.000000	0.57 007		0	0	
65. 00 06500 RESPIRATORY THERAPY	0.000000	257, 997		0	0	
66. 00 06600 PHYSI CAL THERAPY	0.000000	2, 632, 808		0	0	
67. 00 06700 OCCUPATIONAL THERAPY	0.000000	0		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0.000000	-		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0.000000	21, 981		٥	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	682, 136 66, 293		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 005506			-	0	
74. 00 07400 RENAL DI ALYSI S	0. 000000	569, 495 70, 002		0 0	0	
74. 00 07400 RENAL DI ALTSIS 76. 00 03020 OTHER ANCILLARY	0. 000000	70, 002		0 0	0	
76. 01 03140 CARDI AC REHAB	0. 000000	4, 025		0 0	0	
76. 02 03070 WOMEN' S CENTER	0. 000000	4, 025		0 0	0	
76. 03 03330 ENDOSCOPY	0. 000000	04		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000			0 0	U	76.03
90. 00 09000 CLINI C	0. 000000	744		0 0	0	90.00
90. 01 09000 CETNI C 90. 01 09001 OUTPATI ENT	0. 000000			0 0	0	
90. 02 09001 001PATTENT 90. 02 09002 NEUROPSYCHOLOGY	0. 000000	8, 745 0		0 0	0	1
91. 00 09100 MERGENCY	0. 000000	23, 853		0 224	0	1
91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY	0. 000000	23, 853		0 224	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	
OTHER REIMBURSABLE COST CENTERS	0.000000	0		0	0	92.00
95. 00 09500 AMBULANCE SERVICES						95. 00
73. OU U730U AWBULANCL 3LKVI CE3	1 1		1	1		1 7J. UU

		Component (CCN: 15-T059	To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
		Title	· XVIII	Subprovi der - I RF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(
	Part I, col. 9	,	Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATING ROOM	0. 140416	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		ol ol	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 331443	0		o	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 202081	0		o o	0	
57. 00 05700 CT SCAN	0. 023797	0		o o	0	
57. 01 03630 ULTRA SOUND	0. 060548	0	•	0	0	
58. 00 05800 MRI	0. 071033	0		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 071033	0			0	
60. 00 06000 LABORATORY	0. 181832	0			0	
60. 01 06001 BLOOD LABORATORY	0. 181832	0			0	
	1	0		0	0	
	0. 525996	0		0		
64. 00 06400 I NTRAVENOUS THERAPY	0.000000	0		0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 289156	0		0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 289839	0		0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 141534	0		이	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 238064	0		이	0	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0. 575755	0		0 0	0	1 - 1 - 0 - 0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 295895	0		0 436	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 744120	0		0 0	0	74. 00
76. 00 03020 OTHER ANCI LLARY	0.000000	0		0 0	0	76. 00
76. 01 03140 CARDI AC REHAB	0. 178963	0		o o	0	76. 01
76. 02 03070 WOMEN' S CENTER	0. 198477	0		ol ol	0	76. 02
76. 03 03330 ENDOSCOPY	0. 000000	0		ol ol	0	76. 03
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 150305	0		0 0	0	90.00
90. 01 09001 OUTPATI ENT	0. 230222	0		ol ol	0	90. 01
90. 02 09002 NEUROPSYCHOLOGY	0. 370898	0		ol ol	0	1
91. 00 09100 EMERGENCY	0. 479775	224		o o	107	
91. 01 09101 SHORT STAY	0. 000000	0		o o	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 687958	0			0	
OTHER REIMBURSABLE COST CENTERS	0.007700			<u> </u>		72.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95. 00
200.00 Subtotal (see instructions)	0.000000	224		0 436	107	200.00
201.00 Less PBP Clinic Lab. Services-Program		224	i e	0 430	107	201.00
Only Charges				~		201.00
202.00 Net Charges (line 200 - line 201)		224		0 436	107	202. 00
202.00 Net Glarges (Title 200 - Title 201)	1 1	224	I '	∪ 430	107	1202.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0059	Peri od:	Worksheet D	
		Component	CCN: 15-T059	From 01/01/2021 To 12/31/2021	Date/Time Pre	
					5/24/2022 5: 2	5 pm
		Title	e XVIII	Subprovi der -	PPS	
				I RF		
	Cos	ts				
Cost Contor Doscription	Coct	Coct	1			

			Title	e XVIII	Subprovi der -	PPS	
		Costs			IKF		
	Cost Center Description	Cost	Cost				
	2001 30mtor 2000 r p t r c m		Rei mbursed				
			ervices Not				
		Subject To	Subject To				
			ed. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	LLARY SERVICE COST CENTERS						
1	O OPERATING ROOM	0	0				50. 00
	O DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
	O RADI OLOGY-DI AGNOSTI C	0	0	1			54. 00
1	O RADI OLOGY-THERAPEUTI C	0	0	1			55. 00
	O CT SCAN	0	0	1			57. 00
1	O ULTRA SOUND	0	0	1			57. 01
	O MRI	0	0	1			58. 00
	O CARDI AC CATHETERI ZATI ON	0	0	1			59. 00
	O LABORATORY	0	0				60.00
	1 BLOOD LABORATORY	0	0				60. 01
	O BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
	O I NTRAVENOUS THERAPY	0	0	1			64. 00
	O RESPI RATORY THERAPY		0	1			65. 00
	O PHYSI CAL THERAPY	0	0	1			66.00
	O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY		0				67. 00 68. 00
	O ELECTROCARDI OLOGY		0				69.00
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0				71.00
	O IMPL. DEV. CHARGED TO PATIENTS		0				71.00
	O DRUGS CHARGED TO PATIENTS		129				73.00
	O RENAL DIALYSIS		0				74.00
	O OTHER ANCILLARY		0				76.00
	O CARDI AC REHAB		0				76. 00
	O WOMEN' S CENTER		0	1			76. 01
4	O ENDOSCOPY		0				76. 02
	ATIENT SERVICE COST CENTERS	<u> </u>		1			70.00
	O CLINIC	0	0				90. 00
	1 OUTPATI ENT	0	0	1			90. 01
1	2 NEUROPSYCHOLOGY	l ol	0	,			90. 02
1	O EMERGENCY	o	0	,			91. 00
	1 SHORT STAY	0	0)			91. 01
	O OBSERVATION BEDS (NON-DISTINCT PART	0	0)			92.00
	R REIMBURSABLE COST CENTERS	·	-				
	O AMBULANCE SERVICES	0					95. 00
200. 00	Subtotal (see instructions)	0	129				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	129	1			202. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Prep 5/24/2022 5: 2	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XVIII	Hospi tal	5/24/2022 5: 2 PPS	5 pm
	Cost Center Description	THE ATTE	nospi tui	'	
	DADT I ALL DDOWLDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		15, 721	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			15, 721	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		13, 024	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				, ,,,,
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December .	31 OF the COST	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
0.00	reporting period				0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 853	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)		
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18. 00
16.00	reporting period	es arter becember 51 or	THE COST	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng poriod (line	27, 615, 134 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost reporti	ng perrou (rine	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost reportion	na period (line	0	24. 00
24.00	7 x line 19)	31 of the cost reportin	ig period (Title	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) 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)		27, 615, 134	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	- line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	27, 615, 134	37. 00
57.00	27 minus line 36)	pri vato room cost ur	. S. Girti di (i i ile	27,010,104	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	$\label{prop:prop:cont} \mbox{Adjusted general inpatient routine service cost per diem (see} $	•		1, 756. 58	
39. 00	Program general inpatient routine service cost (line 9 x line	•		6, 768, 103	
40. 00	Medically necessary private room cost applicable to the Program	,		0 4 749 103	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ ITTIE 40)	l	6, 768, 103	41.00

	,	eu of Form CMS-2	2552-10
COMPUT	FATION OF INPATIENT OPERATING COST Provider CCN: 15-0059 Period: From 01/01/2021	Worksheet D-1	
	To 12/31/2021	Date/Time Prep 5/24/2022 5:2	
	Cost Center Description Total Total Average Per Program Days	PPS Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷	(col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 0 0 0.00 0 Intensive Care Type Inpatient Hospital Units	0	42. 00
43. 00	INTENSIVE CARE UNIT 7, 199, 310 4, 199 1, 714. 53 961	1, 647, 663	43. 00
44. 00 45. 00	CORONARY CARE UNIT		44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT		46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47. 00
49.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 8, 033, 479	48. 00
48. 00 49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	16, 449, 245	
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	1, 545, 168	50.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	544, 369	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	2, 089, 537	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14, 359, 708	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION		F.4.00
55.00	Program di scharges Target amount per di scharge	0.00	54. 00 55. 00
56. 00 57. 00		0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61. 00
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	o	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)	Ö	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitation		81.00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
84. 00 85. 00			84. 00 85. 00
86. 00			86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	2, 697	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 756. 58	88. 00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4, 737, 496	89.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/24/2022 5: 2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	5, 513, 242	27, 615, 134	0. 19964	6 4, 737, 496	945, 822	90.00
91.00 Nursing Program cost	0	27, 615, 134	0.00000	4, 737, 496	0	91.00
92.00 Allied health cost	0	27, 615, 134	0.00000	4, 737, 496	0	92.00
93.00 All other Medical Education	0	27, 615, 134	0. 00000	4, 737, 496	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 15-T059	To 12/31/2021	Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Subprovi der -	PPS

		litie XVIII	I RF	PPS	
	Cost Center Description		1100		
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		4, 301	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			4, 301	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		21 -6 +6	4, 301	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	er 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei s	or the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 277	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-	nly (including private r	room days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	V only (including privat	o room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			U	13.00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	of the cost	0.00	17. 00
17.00	reporting period	es through becember 51 c	in the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
	reporting period				
21.00	Total general inpatient routine service cost (see instructions			5, 377, 344	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December :	21 of the cost reporting	noried (line 9	0	25. 00
25.00	x line 20)	of the cost reporting	perrou (Trie 8	U	25.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 377, 344	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had sh	orgos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	d and observation bed cr	iai yes)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	aus lino 22)(soo instruc	rtions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)		,(10115)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 377, 344	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 250. 25	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			2, 846, 819	
40.00	Medically necessary private room cost applicable to the Progra	,		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	l	2, 846, 819	41. 00

	Financial Systems	RI VERVI EW I		ON 45 0050		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-0059	Period: From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
			·	: XVIII	Subprovi der -	5/24/2022 5: 2 PPS	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost				(col . 3 x col . 4)	
42.00	MUDSERV (+i +l o V * VIV only)	1.00	2.00	3.00	4. 00 00	5. 00	42. 00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	l o		<u> </u>	00 0	<u>, </u>] 42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	O	0.	00 0	0	43. 00 44. 00
45. 00							45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk:	st D-3 col 3	line 200)			1. 00 1, 445, 393	48. 00
49. 00				ns)		4, 292, 212	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, su	m of Parts I and	506, 314	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	67, 424	51.00
52. 00	Total Program excludable cost (sum of lines					573, 738	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anest	hetist, and	3, 718, 474	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operation	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	pdated and c	ompounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.00
61. 00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61. 00
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the c	ost reportin	a period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (iine	64 prus rine 6	5)(title XVI	ii oniy). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	f the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00						0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	·		(line 14 x li	ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•		lorkshoot R	Dart II column		74. 00 75. 00
	26, line 45)		COSTS (TIOIII II	orksneet b,	art II, corumn		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	·						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on			,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (:						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	1 Jugii 100/				
87. 00 88. 00	Total observation bed days (see instructions	•	Line 2)			0 00	87. 00 88. 00
	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see		1111e 2)			1	89.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5:2	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
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	956, 367	5, 377, 344	0. 17785	1 0	0	90. 00
91.00 Nursing Program cost	0	5, 377, 344	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	5, 377, 344	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	5, 377, 344	0. 00000	0 0	0	93. 00

RIVERVIEW HOSPITAL	In Lie	u of Form CMS-	2552-10
Provider CCN: 15-0059	Peri od: From 01/01/2021	Worksheet D-1	
	To 12/31/2021		
Title XIX	Hospi tal	Cost	
		1. 00	
	Provi der CCN: 15-0059	Provider CCN: 15-0059 Period: From 01/01/2021 To 12/31/2021	Provider CCN: 15-0059

		Title XIX	Hospi tal	5/24/2022 5: 2 Cost	5 pm
	Cost Center Description	II tie xix	поѕрі таі	COST	
	3330 7 50 30			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS			45 704	
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			15, 721	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day		vato room days	15, 721 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	vate 100iii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		13, 024	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December :	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through Dosombor	21 of the cost	0	7. 00
7.00	reporting period	ii days) tili odgir beceiliber	31 Of the Cost	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	375	9. 00
40.00	newborn days) (see instructions)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instructions)		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Join days) arter		11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	iii (excidding swing-bed t	uays)		15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	3 through becomber 31 of	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			27, 615, 134	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)		9		
24. 00	Swing-bed cost applicable to NF type services through December	and 31 of the cost reportion	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		27, 615, 134	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			, , , , , ,	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 26)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x lin		•	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 a	and private room cost di	fferential (line	27, 615, 134	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 756. 58	38. 00
39. 00	Program general inpatient routine service cost per drem (see			658, 718	
40. 00	Medically necessary private room cost applicable to the Progra	-		0	40. 00
41.00	Total Program general inpatient routine service cost (line 39			658, 718	41. 00

	•	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0059 Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prep 5/24/2022 5:29	
	Title XIX Hospital	Cost	э рііі
	Cost Center Description Total Total Average Per Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)	Program Cost (col. 3 x col. 4)	
	1.00 2.00 3.00 4.00	5. 00	
42. 00	NURSERY (title V & XIX only) 0 1,512 0.00 0 Intensive Care Type Inpatient Hospital Units	0	42. 00
43.00	INTENSIVE CARE UNIT 7, 199, 310 4, 199 1, 714. 53 0	0	43.00
44. 00	CORONARY CARE UNIT		44. 00
46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	317, 340	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	976, 058	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50.00
51. 00	III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
31.00	and IV)		
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	52. 00 53. 00
55.00	medical education costs (line 49 minus line 52)	l o	55.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges		F4 00
55. 00	1 3	0 0. 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0.00	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62. 00	Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	О	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	o	66. 00
67. 00	CAH (see instructions)	0	67. 00
	(line 12 x line 19)		
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74. 00 75. 00
	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00
81. 00	Inpatient routine service costs for comparison to the cost frim tation (fine 78 minus fine 79)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Passonable inpatient routine service costs (see instructions)		82.00
83.00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		83. 00 84. 00
85.00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87.00	Total observation bed days (see instructions)	2, 697	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 756. 58 4, 737, 496	

Health Financial Systems	RI VERVI EW	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 Pre 5/24/2022 5:2	
		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 (COST					
90.00 Capital -related cost	5, 513, 242	27, 615, 134	0. 19964	6 4, 737, 496	945, 822	90.00
91.00 Nursing Program cost	0	27, 615, 134	0.00000	0 4, 737, 496	0	91.00
92.00 Allied health cost	0	27, 615, 134	0.00000	0 4, 737, 496	0	92.00
93.00 All other Medical Education	0	27, 615, 134	0. 00000	0 4, 737, 496	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 15-T059	To 12/31/2021	Date/Time Prepared: 5/24/2022 5:25 pm
	Title XIX	Subprovi der -	Cost

Detr. 1.1 PROTOTIES COMPANY IS 1.00 Impatient days (including private room days and saing-bed days, excluding neatorn) Impatient days (including private room days, sectualing seing-bed and neatorn days) 1.00 Impatient days (including private room days, sectualing seing-bed and neatorn days) 2.00 1.00			II the XIX	I RF	COST	
NAME ALL PROVIDER COMPONENTS		Cost Center Description				
INPARTIENT DAYS		DADT I ALL DDOVIDED COMPONENTS			1. 00	
Inpatient days (Including private room days and swing-bed days, excluding needorn)						
2.00 Orivate room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 4.00	1.00		, excluding newborn)		4, 301	1. 00
do not complete this line. 4.00 Selephivate room days (secluding swing-bed and observation bed days) 5.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 7.00 Room December 31 of the cost reporting period (see instruction) 8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 8.00 Total swing-bed SW type inpatient days applicable to swing-bed SW type inpatient days appli						
Semi-private room days (excluding swing-bed and observation bed days) To the swing-bed SRF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (includ	3. 00		s). If you have only pri	vate room days,	0	3. 00
Total xwing-bed SNF 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	4 00		d days)		4 301	4 00
1 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11ne) 7.00				31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Totals swing-bed MF type inpatient days (including private room days) through December 31 of the cost 8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost 9.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost 10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 11.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed MF type inpatient days applicable to the Program (excluding swing-bed days) 13.00 Swing-bed MF type inpatient days applicable to the Program (excluding swing-bed days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Miscrey days (title V or XIX only) 17.00 Medically necessary private room days applicable to services through December 31 of the cost 18.00 Medical rote for swing-bed SMF services applicable to services after December 31 of the cost 18.00 Medical rote for swing-bed SMF services applicable to services after December 31 of the cost 18.00 Medical rote for swing-bed SMF services applicable to services through December 31 of the cost 18.00 Swing-bed cost applicable to SMF type services through December 31 of the cost reporting period (line 6 x x line 18) 18.00 Medical rote for swing-bed SMF services after December 31 of the cost reporting period (line 6 x x line 18) 18.00 Swing-bed cost applicable to SMF type services through			3 7			
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 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) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 13 0,00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 10,00 Swing-bed SNF type inpatient days applicable to the Ital XVII in unjust to the program (excluding private room days) 10,00 Swing-bed SNF type inpatient days applicable to the Ital XVII in unjust (including private room days) after 11,00 Swing-bed SNF type sapplicable to Ital EXVII in unjust (including private room days) 12,00 Swing-bed WF type inpatient days applicable to Ital EXVII in unjust (including private room days) 12,00 Swing-bed WF type inpatient days applicable to Ital EXVII in unjust (including private room days) 12,00 Swing-bed WF type inpatient days applicable to Ital EXVII in unjust (including private room days) 13,00 Swing-bed WF type inpatient days applicable to Ital EXVII in unjust (including private room days) 14,00 15,00 Total nursery days (Itile V or XIX only) 15,00 Total nursery days (Itile V or XIX only) 16,00 Swing-bed WF type inpatient days applicable to services through December 31 of the cost reporting period 16,00 17	6. 00		om days) after December 3	1 of the cost	0	6. 00
reporting period 7. 00 Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Suing-bed Ni type inpatient days applicable to title XVIII only (including private room days) 8. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Suing-bed Ni't type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed Ni't type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (including private room days) after 12. 00 Swing-bed Ni't type inpatient days applicable to title XVIII only (including private room days) after 13. 00 Swing-bed Ni't type inpatient days applicable to title XVIII only (including private room days) 0 12. 00 Introduce December 31 of the cost reporting period (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 14. 00 Nedically necessary private room days applicable to title X or XIX only (including private room days) 0 14. 00 Nedically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 00 Nedical inverse years (inter V or XIX only) 1. 1.512 15. 00 Nedical room of the cost reporting period (inter see the xing-bed SNF services applicable to services through December 31 of the cost reporting period (including triperiod reporting period Nedical drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including triperiod Nedical drate for swing-bed SNF services after December 31 of the cost reporting period (line 5 x I including triperiod Nedical drate for swing-bed SNF services through December 31 of the cost reporting period (line 6 x I including triperiod Nedical drate for swing-bed SNF services after December 31 of the cost reporting period (line 8 x I includi	7 00		days) through December	31 of the cost	0	7 00
reporting period (if calendar year, énter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 8.00 Swing-bed SNF type inpatient days applicable to tittle XVIII only (including private room days) on through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to tittle XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to tittle XVIII only (including private room days) after through December 31 of the cost reporting period (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to tittle XVIII only (including private room days) after 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 title XV or XIX only (including private room days) after 1.512 is 1	7.00		r days) till odgir becember	or or the cost	O	7.00
10.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 10.00 10.0	8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
newborn days) (see Instructions) 0 10.00 00 10.00 00 00 10.00 00	0.00				4.0	0.00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Interpretation of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Namise December 31 of the cost reporting period (if calendar year, enter 0 on this line) 17.00 Namise Bor ADUSTINENT 17.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (if calendar year) 18.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (if calendar year) 19.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (if calendar year) 19.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (if calendar year) 19.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (if calendar year) 19.00 Medical drate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (if calendar year) 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (if calendar year) 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (if the SMF year) 19.00 Medical drate f	9.00		the Program (excluding	swing-bed and	13	9.00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.01 Across the cost reporting period (if calendar year, enter 0 on this line) 1.02 Across the cost reporting period (if calendar year, enter 0 on this line) 1.03 Across the cost reporting period (if calendar year, enter 0 on this line) 1.04 OW Medically increasy days (title V or XIX only) 1.05 ON Total nursery days (title V or XIX only) 1.06 OW Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 8 x line 18) 2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 8 x line 18) 2.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 18) 2.02 Swing-bed cost applicable to NF type services through December 31 of the cost reporting pe	10. 00		nly (including private ro	om days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00		through December 31 of the cost reporting period (see instruct	ions)			
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room 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 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line Reporting period) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line days) 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line days) 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line for swing-bed NF services applicable to services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line for X line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for X line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for X line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for X line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for X line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for X line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for X line 29)	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	lly (including private ro	om days) after	0	11. 00
through December 31 of the cost reporting period after December 31 of the cost reporting period (if callendar year, enter 0 on this line) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 16.00 Nursery days (title V or XIX only) 16.00 Normary days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost cost cost reporting period (line decorting period cost applicable to SNF type services after December 31 of the cost cost cost services after December 31 of the cost cost cost services after December 31 of the cost cost cost services after December 31 of the cost cost cost services after December 31 of the cost cost cost services cost services after 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 after December 31 of the cost reporting period (line 6 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 26.00 Total swing-bed cost sephicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Total swing-bed cost sphicable to NF type services after Decem	12 00			room days)	0	12 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 14.00 15	12.00		t only (the daring private	room days)	G	12.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 Total nursery days (title V or XIX only) 1.512 15.00 16.00 Nursery days (title V or XIX only) 1.512 15.00 17.00 SINING BED ADJUSTMENT	13.00				0	13. 00
15.00 Total nursery days (title V or XIX only) 1.512 15.00 16.00 16.00 17.00 18.00 18.00 18.00 19.00 18.00 19.00 1	14 00	1 91 \		, i	0	14 00
16.00 Nursery days (title v or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period reporting period medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period (line 1.00 19.00 swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 1.00 19.00 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 1.00 19.00 19.00 19.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 1.00 19.00 1			ill (excluding Swing-bed d	ays)		
SWING BED ADJUSTMENT 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period medicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1.00 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost (see instructions) Open 25.00 Swing-bed cost (see instructions) Open 26.00 Total swing-bed cost (see instructions) Open 26.00 Total swing-bed cost (see instructions) Open 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) Sying-bed cost (see instructions) Open 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) Sying-bed cost (see instructions) Open 27.00 General inpatient routine service cost (see x line 21 minus line 26) Sying-bed charges) Open 27.00 General inpatient routine service cost for Swing-bed charges) Open 27.00 General inpatient routine service cost for Swing-bed cost (see instructions) Open 27.00 Sying-bed cost (see instructions) Open 27.00 Sying-bed cost (see instr						
reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 5.377.344 21.00 22.00 Sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5.377.344 21.00 22.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6.3 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6.3 x line 18) 24.00 7.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8.3 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8.3 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8.3 x line 20) 25.00 Total swing-bed cost (see instructions) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8.3 x line 20) 25.00 Total swing-bed cost (see instructions) 25.00 Swing-bed cost (see instructions)		SWING BED ADJUSTMENT				
Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 18.00 19.	17. 00		es through December 31 of	the cost	0. 00	17. 00
reporting period Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 21.00 Total general inpatient routine service cost (see instructions) 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 after 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) 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 Total swing-bed cost (see instructions) 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 Average per invate room per diem charge (line 29 + line 3) 30.00 Average per invate room per diem charge (line 30 + line 4) 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 35) 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 35) 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 35) 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 35) 30.00 Average per diem private room cost differenti	18 00	' 3 '	s after December 31 of t	he cost	0.00	18 00
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 1.00 Total general inpatient routine service cost (see instructions) 2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17) 3.00 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 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 26.00 Total 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) 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 charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 31.00 Average per diem private room per diem charge (line 30 + line 4) 32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 33.00 Average per diem private room cost differential (line 32 minus line 33) 34.00 Average per diem private room cost differential (line 32 minus line 33) 35.00 Program general inpatient routine service cost per diem (see instructions) 36.00 Program general inpatient routine service cost per diem (see instructions) 37.00 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 per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instruct	10.00		S arter becomber or or t	110 0031	0.00	10.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10tal general inpatient routine service cost (see instructions) 5, 377, 344 21.00 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) 4 line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 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) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost (see instructions) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost (see instructions) 25.00 Private room charges (excluding swing-bed charges) 25.00 Private room charges (excluding swing-bed charges) 25.00 Swing-bed cost (see instructions) 25.00 Swing-bed room charge (sexcluding swing-bed charges) 25.00 Swing-bed charges) 25.00 Swing-bed charges (sexcluding swing-bed charges) 25.00 Swing-bed cost (see instructions) 25.00 Swing-bed cost (see instructions) 25.00 Swing-bed cost (see instructions) 25.00 Swing-bed swing-bed swing-bed cost (see	19. 00		through December 31 of	the cost	0.00	19. 00
reporting period Total general inpatient routine service cost (see instructions) 22.00 23.00 3wing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 24.00 3wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 25.00 3wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 3wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 26.00 27.00 28.00 29.00 20.00 2	20.00	, , , , , , , , , , , , , , , , , , , ,	after December 21 of th	o cost	0.00	20 00
22.00 Total general inpatient routine service cost (see instructions) 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) 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) 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 27.00 Semi-private room charges (excluding swing-bed charges) 28.00 Semi-private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 20.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per jivate room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 31.00 Average per diem private room cost differential (line 3 x line 35) 32.00 Average per diem private room cost differential (line 3 x line 35) 33.00 Private room cost differential adjustment (line 3 x line 35) 34.00 Average per diem private room cost differential (line 3 x line 35) 35.00 Adjusted general inpatient routine service cost (line 9 x line 35) 36.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 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)	20.00		arter becember 31 or th	e cost	0.00	20.00
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 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed charges) 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 29 ÷ line 3) 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 32 minus line 33)(see instructions) 36.00 Private room cost differential adjustment (line 3 x line 31) 37.00 General inpatient routine service cost reporting period (line 14 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost of the Program (line 14 x line 35) 40.00 Medically necessary private room cost of the Program (line 14 x line 35) 5 x line 17) 5 x line 18) 5 x line 19) 5 x line 19) 5 x line 10 5 x line					5, 377, 344	
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 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) 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) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 36.00 Private room cost differential djustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Agiusted 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) 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)	22. 00		er 31 of the cost reporti	ng period (line	0	22. 00
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 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions)	23 00	l	31 of the cost reporting	neriod (line 6	0	23 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 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 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 Frivate room charges (excluding swing-bed charges) 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 29 ÷ line 3) 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 adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 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) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		or the cost reporting	perrou (rine o	O	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) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 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) 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 per diem private room 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 32 minus line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 37.00 And Inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35) 0 40.00	24. 00	, , , , , , , , , , , , , , , , , , , ,	31 of the cost reportin	g period (line	0	24. 00
x line 20) Total swing-bed cost (see instructions) 26. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 Perivate room charges (excluding swing-bed and observation bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 Semi-private room charges (excluding swing-bed charges) 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 34 x line 31) 35. 00 Average per diem private room cost differential (line 3 x line 35) 37. 00 Seneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 37. 00 Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special cost and private room cost differential (line 5, 377, 344) Average per diem private room cost differential (special c	25 00		11 of the cost reporting	noriad (line 0	0	25 00
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) 27.00 Fivate ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 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) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 37.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 37.00 Average per diem private room cost differential (line 5, 377, 344) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 5, 377, 344) 37.00 Average per diem private room cost differential (line 5, 377, 344) 37.00 Average per diem private room cost differential (line 5, 377, 344) 37.00 Average per diem private room cost differential (line 5, 377, 344) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 5, 377, 344) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost d	23.00	1 3	of the cost reporting	perrou (Trile 6	U	25.00
PRI VATE 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) 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) 32. 00 Average semi-private room per diem charge (line 30 + line 4) 33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 3 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 5, 377, 344) 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) 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 28. 00 29. 00 29. 00 20. 00 31. 00 0 .00 32. 00 32. 00 34. 00 34. 00 35. 00 40. 00	26. 00					
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 34 x line 31) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Private room cost differential adjustment (line 3 x line 35) 30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344) 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) 0 28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 34. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 37. 00 38. 00 39. 00 Average per diem private room cost differential (line 5, 377, 344) 37. 00 38. 00 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per	27. 00		line 21 minus line 26)		5, 377, 344	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) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 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) 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 5, 377, 344) 37.00 PART II - HOSPITAL AND SUBPROVI DERS 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 30.00 30.00 30.00 31.00 32.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 38.00 39.00 Average per diem private room cost differential (line 5, 377, 344) 37.00 38.00 39.00 Average per diem private room cost per diem (see instructions) 38.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 0 40.00	28 00		l and observation had cha	rae)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 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 5, 377, 344) 37.00 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			and observation bed cha	i ges)		
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 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) 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 5, 377, 344) 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 5, 377, 344) 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 34.00 37.00 35.00 38.00 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) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 40.00	31. 00	,	line 28)		0. 000000	
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 5, 377, 344) 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 0 34.00 35.00 35.00 36.00 37.00 37.00 1.00 38.00 37.00 38.00 37.00 39.00 Program general inpatient routine service cost per diem (see instructions) 1, 250.25 38.00 40.00						
35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 377, 344 37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 250. 25 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00			1: 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 5, 377, 344 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) 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) 36.00 36.00 37.00 37.00		, , , , , , , , , , , , , , , , , , , ,	, ,	ions)		
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) 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 Adv. 00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38) 40.00 deciral inpatient routine service cost (line 9 x line 38)		9	ic 31 <i>)</i>			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 250. 25 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			nd private room cost dif	ferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 250. 25 38.00 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) 0 40.00		27 minus line 36)	· · · · · · · · · · · · · · · · · · ·	` '		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,250.25 38.00 Program general inpatient routine service cost (line 9 x line 38) 16,253 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			CTMENTS			
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) 16,253 39.00 40.00	38 00				1 250 25	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 16,253 41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		16, 253	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW 1		CN: 15-0059	Peri od:	eu of Form CMS-2 Worksheet D-1	
				CCN: 15-T059	From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
			Titl	e XIX	Subprovi der -	5/24/2022 5: 2 Cost	5 pm
					IRF		1
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	I	1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.	00 0	<u> </u>	42.00
43. 00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT			•			46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	. line 200)			1. 00	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ns)		26, 993	
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, su	m of Parts I and	0	50.00
51. 00	<pre> </pre>	atient ancillar	v services (fr	om Wkst D	sum of Parts II	0	51.00
	and IV)		, 55. 11 555 (11	ot. D,	0. 14110 11		
52.00	Total Program excludable cost (sum of lines		lated non abo	ololon oncot	hatiat and	0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		iateu, non-phy	sıcıdı anest	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	·					ļ
	Program discharges Target amount per discharge					0 00	54. 0 55. 0
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions)		andina 1007 .	undated and a	ampaundad by tha	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	borting period	enarng 1996, t	ipuateu anu c	ompounded by the	0.00	59. 0
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61.0
	amount (line 56), otherwise enter zero (see	nstructions)	S (TITIES 54 X	60), 01 1% 0	i the target		
62.00 Relief payment (see instructions)							62. 0
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63. 0
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 0
65. 00	instructions)(title XVIII only)	to often Decemb	on 21 of the c	ant monomitim	a nonind (Coo	0	45.0
33.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after beceilib	er 31 or the C	ost reportin	g perrou (see	ا	65. 0
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66. 0
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost r	enorting period	0	67. 0
37.00	(line 12 x line 19)	c costs till ough	December 31 c	inc cost i	epor tring perrou		07.0
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 0
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 0
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.0
71. 00	Adjusted general inpatient routine service c				,		71. 0
	Program routine service cost (line 9 x line			>			72. 0
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv		•	,			73.0
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 0
. ,	26, line 45)	0)					7, 0
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 0 77. 0
	Inpatient routine service cost (line 74 minus						78. 0
	Aggregate charges to beneficiaries for exces						79. 0
30. 00 31. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	ı (line 78 mi	nus line 79)		80. 0 81. 0
32. 00	Inpatient routine service cost per drem from)				82. 0
83. 00	Reasonable inpatient routine service costs (see instruction	•				83. 0
84.00	Program inpatient ancillary services (see in		ma)				84. 0
35. 00 36. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 0 86. 0
.0.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		i Jugii 00)				30.0
						0	87.00
37. 00 38. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per						88. 0

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5: 2	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	956, 367	5, 377, 344	0. 17785	51 0	0	90.00
91.00 Nursing Program cost	0	5, 377, 344	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 377, 344	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 377, 344	0. 00000	00 0	0	93. 00

Health Financial Systems	RIVERVIEW HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2021	Worksheet D-3	pared:
	Ti tl e	e XVIII	Hospi tal	PPS	•
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1 00	2.00	2.00	\vdash

	Title XVIII	Hospi tal	PPS	.o piii
Cost Center Description	Ratio of Cos		Inpatient	
cost center bescription	To Charges	Program	Program Costs	
	To charges		(col. 1 x col.	
		Charges	2)	
	1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		8, 148, 094		30.00
31. 00 03100 NTENSI VE CARE UNI T		2, 888, 794		31.00
			1	1
41. 00 04100 SUBPROVI DER - I RF		1, 374, 611		41. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS				43. 00
50. 00 05000 OPERATING ROOM	0.1404	4 702 005	672, 885	FO 00
			1	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0.00000		1	
54. 00 05400 RADI OLOGY -DI AGNOSTI C	0. 33144	•	1	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 20208			
57. 00 05700 CT SCAN	0. 02379			
57. 01 03630 ULTRA SOUND	0. 06054			
58. 00 05800 MRI	0. 07103			
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 05559			
60. 00 06000 LABORATORY	0. 18183			
60. 01 06001 BL00D LABORATORY	0.00000		1	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 52599		117, 928	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0.00000	00 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 28915	2, 206, 427	638, 002	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 28983	1, 143, 907	331, 549	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.00000	00	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0.00000	00 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 14153	795, 054	112, 527	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 23806	4, 664, 331		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 57575			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 29589		1	
74. 00 07400 RENAL DIALYSIS	0. 74412		1	
76. 00 03020 OTHER ANCI LLARY	0.00000		1	1
76. 01 03140 CARDI AC REHAB	0. 17896			
76. 02 03070 WOMEN' S CENTER	0. 1984			1
76. 03 03330 ENDOSCOPY	0. 00000		1	
OUTPATIENT SERVICE COST CENTERS	0.0000		<u> </u>	7 0. 00
90. 00 09000 CLI NI C	0. 15030	5, 309	798	90.00
90. 01 09001 0UTPATI ENT	0. 23022		1	1
90. 02 09002 NEUROPSYCHOLOGY	0. 37089		0, 200	1
91. 00 09100 EMERGENCY	0. 47977			
91. 01 09101 SHORT STAY	0.00000		1	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 68795		1	
OTHER REIMBURSABLE COST CENTERS	1 0.00773	712, 107	200, 000	1 /2.00
95. 00 09500 AMBULANCE SERVICES				95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		33, 084, 972	8, 033, 479	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(lino 61)	33,004,972	0,033,479	200.00
202.00 Net charges (line 200 minus line 201)	S (TITIE OI)	33, 084, 972	[]	201.00
202.00 Met charges (Title 200 millias Title 201)	I	33,004,972	·I	1202.00

ealth Financial Systems RIVERVIEW F NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-3	
		CCN: 15-T059	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 5:2	pared
	Title	xVIII	Subprovi der - I RF	PPS	о рііі
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			4
0. 00 03000 ADULTS & PEDI ATRI CS					30.0
11. 00 03100 I NTENSI VE CARE UNI T 11. 00 04100 SUBPROVI DER - I RF			2 274 070		31. (
3. 00 04300 NURSERY			3, 376, 970		43.0
ANCI LLARY SERVI CE COST CENTERS					1 45. 0
0. 00 05000 OPERATING ROOM		0. 14041	16 182, 109	25, 571	50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 33144	49, 006	16, 243	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 20208		6, 250	
7. 00 05700 CT SCAN		0. 02379		1, 492	
7. 01 03630 ULTRA SOUND		0.06054		14, 635	
8. 00 05800 MRI 9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07103 0. 05559		709 2, 853	1
0. 00 06000 LABORATORY		0. 05559		95, 091	
0. 01 06001 BLOOD LABORATORY		0. 00000		0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 52599		6, 279	
4. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.
5. 00 06500 RESPI RATORY THERAPY		0. 28915	56 257, 997	74, 601	
6. 00 06600 PHYSI CAL THERAPY		0. 28983		763, 090	1
7. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	
8. 00 06800 SPEECH PATHOLOGY		0.00000		0	
9.00 06900 ELECTROCARDIOLOGY 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 14153 0. 2380 <i>6</i>		3, 111 162, 392	1
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23600		38, 169	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29589		168, 511	
4. 00 07400 RENAL DI ALYSI S		0. 74412		52, 090	
6. 00 03020 OTHER ANCILLARY		0.00000	00	0	76.
6. 01 03140 CARDI AC REHAB		0. 17896	4, 025	720	76.
6. 02 03070 WOMEN' S CENTER		0. 19847		17	
6. 03 03330 ENDOSCOPY		0.00000	00 0	0	76.
OUTPATIENT SERVICE COST CENTERS		0.15000	744	110	1
0. 00 09000 CLI NI C 0. 01 09001 OUTPATI ENT		0. 15030		112	1
0. 01 09001 001PATENT 0. 02 09002 NEUROPSYCHOLOGY		0. 23022 0. 37089		2, 013 0	1
1. 00 09100 EMERGENCY		0. 47977		11, 444	
11. 01 09101 SHORT STAY		0.00000		0	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 68795		0	
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95.
Total (sum of lines 50 through 94 and 96 through 98)			5, 500, 802	1, 445, 393	
Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.
02.00 Net charges (line 200 minus line 201)			5, 500, 802		202.

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTION		Peri od: Worksheet D-3 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/24/2022 5: 25 pm

INFAIL	LIVI ANCILLARI SERVICE COSI AFFORTIONIMENT	riovidei C	CN. 13-0039	From 01/01/2021	WOLKSHEET D-3)
				To 12/31/2021		
		Ti +1	e XIX	Hospi tal	5/24/2022 5: 2 Cost	25 pm
	Cost Center Description	11 (1	Ratio of Cos		Inpatient	
	oust defiter bescription		To Charges	Program	Program Costs	
			l onar goo	Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			706, 577		30.00
	03100 INTENSIVE CARE UNIT			150, 548	3	31. 00
	04100 SUBPROVI DER - I RF			0	1	41. 00
	04300 NURSERY			0)	43. 00
	ANCILLARY SERVICE COST CENTERS		,			
	05000 OPERATING ROOM		0. 1404	·	•	
	05200 DELIVERY ROOM & LABOR ROOM		0.0000) C	
	05400 RADI OLOGY-DI AGNOSTI C		0. 3314		1	1
	05500 RADI OLOGY-THERAPEUTI C		0. 2020) C	
	05700 CT SCAN		0. 0237	·		
	03630 ULTRA SOUND		0. 0605	·	•	
	05800 MRI		0. 0710		1	
	05900 CARDI AC CATHETERI ZATI ON		0. 0555			
	06000 LABORATORY		0. 1818			1
	06001 BLOOD LABORATORY		0.0000		1	
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 5259	·		1
	06400 I NTRAVENOUS THERAPY		0.0000		10.000	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 2891 0. 2898			
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY		0. 2898	·		
	06800 SPEECH PATHOLOGY		0.0000			
	06900 ELECTROCARDI OLOGY		0.0000		1	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1413		•	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5757			
	07300 DRUGS CHARGED TO PATIENTS		0. 3757			1
	07400 RENAL DI ALYSI S		0. 7441	·		1
	03020 OTHER ANCI LLARY		0.0000		1	1
	03140 CARDI AC REHAB		0. 1789			
	03070 WOMEN'S CENTER		0. 1984		1	1
	03330 ENDOSCOPY		0.0000			
	OUTPATIENT SERVICE COST CENTERS				-	1
	09000 CLI NI C		0. 1503	05 47	7	90.00
90. 01	09001 OUTPATI ENT		0. 2302		ol c	90. 01
90. 02	09002 NEUROPSYCHOLOGY		0. 3708	98 0) c	90. 02
91.00	09100 EMERGENCY		0. 4797	75 59, 873	28, 726	91.00
91. 01	09101 SHORT STAY		0.0000	00) c	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 6879	58 0) C	92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES				1	95. 00
200.00				1, 371, 546	317, 340	
201.00		(line 61)		0)	201. 00
202. 00	Net charges (line 200 minus line 201)		1	1, 371, 546	1	202. 00

Health Financial Systems RIVERVIEW F INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0059	Peri od:	u of Form CMS-3 Worksheet D-3	
THE ATTENT AND LEART SERVICE COST ATTORTONIMENT	Trovider o	ON. 15 0057	From 01/01/2021	WOI KSHEEL D 3	
	Component	CCN: 15-T059	To 12/31/2021	Date/Time Pre 5/24/2022 5:2	pared: 5 pm
	Ti tl	e XIX	Subprovi der – I RF	Cost	•
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		1			30. 0
31. 00 03100 NTENSI VE CARE UNI T					31.00
41. 00 04100 SUBPROVI DER - RF			177, 906		41.00
43. 00 04300 NURSERY			177, 700		43.00
ANCI LLARY SERVI CE COST CENTERS					10.0
50. 00 05000 OPERATING ROOM		0.1404	16 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000	00	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 33144		0	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 20208		0	55. 0
57. 00 05700 CT SCAN		0. 02379	97 0	0	57.0
57.01 03630 ULTRA SOUND		0. 06054	18 0	0	57.0
58. 00 05800 MRI		0. 07103	33 0	0	58. 0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05559	90 0	0	59.00
60. 00 06000 LABORATORY		0. 18183	32 2, 207	401	60.0
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 0°
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 52599		0	63.00
64.00 O6400 INTRAVENOUS THERAPY		0.00000		0	64. 0
65. 00 06500 RESPI RATORY THERAPY		0. 28915		0	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 28983		5, 145	
67. 00 06700 0CCUPATI ONAL THERAPY		0.00000		0	67.0
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	68. 0
69. 00 06900 ELECTROCARDI OLOGY		0. 14153		178	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 23806		5, 016	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 57575 0. 29589		0	
74. 00 07400 RENAL DI ALYSI S		0. 74412		0	
74. 00 07400 KENAL BIALISIS 76. 00 03020 OTHER ANCI LLARY		0. 00000		0	
76. 01 03140 CARDI AC REHAB		0. 17896		0	
76. 02 03070 WOMEN' S CENTER		0. 19847		0	
76. 03 03330 ENDOSCOPY		0.00000		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	50 0		70.0
90. 00 09000 CLI NI C		0. 15030	05 0	0	90.00
90. 01 09001 0UTPATI ENT		0. 23022		0	
90. 02 09002 NEUROPSYCHOLOGY		0. 37089		0	90.0
91. 00 09100 EMERGENCY		0. 4797		0	91. 0
91. 01 09101 SHORT STAY		0.00000		0	1
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 68795		0	
OTHER REIMBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVICES					95.0
200 00 Total (sum of Lines 50 through 94 and 96 through 98)		1	42 283	10 740	lann no

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

10, 740 200. 00 201. 00 202. 00

42, 283

0 42, 283

200.00

201. 00 202. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared:

			10 12/31/2021	5/24/2022 5: 2	
		Title XVIII	Hospi tal	PPS	
	DADT A LANDATI FAIT HOODI TAL CERVILOFO LINDER LIDE			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1. 00
1. 00 1. 01	DRG amounts other than outlier payments for discharges occurring	g prior to October 1 (s	see	7, 207, 636	1. 00
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring	g on or after October	(see	2, 558, 847	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring	orior to October	0	1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring o	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount	`		0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction			0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (s			333, 798	2. 03
2.04	Outlier payments for discharges occurring on or after October 1	(see instructions)		121, 935	2. 04
3. 00 4. 00	Managed Care Simulated Payments	ing pariod (see instru	stions)	111 15	3. 00 4. 00
4.00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	ing perrou (see mstruc	, ti ons)	111. 15	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	criteria for an add-o	n to the cap for	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified un ACA § 5503 reduction amount to the IME cap as specified under 4			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions.			0.00	8. 00
8.00	Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79			0.00	8.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a closed teachi	ng hospital	0. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02) (s	see	0. 00	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the curren	it year from your record	ls	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12. 00	Current year allowable FTE (see instructions)			0. 00	
13. 00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year	ended on or after Sep	ember 30, 1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital closu	ıre			17. 00
	Adjusted rolling average FTE count			0.00	
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19. 00
	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE residen		R 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the Lo	ower of line 23 or line	24 (see	0. 00	
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruc	ions)	1. 18	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	33,3 (300 11131140	55,	19. 60	
32. 00	Sum of Lines 30 and 31			20. 78	
	Allowable disproportionate share percentage (see instructions)				33. 00
34.00	Disproportionate share adjustment (see instructions)			155, 288	34.00

ALCULATI	ON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre	pared
				5/24/2022 5: 2	
		Title XVIII	Hospi tal Pri or to 10/1	PPS On/After 10/1	
			1.00	2.00	
Und	compensated Care Adjustment				
1	tal uncompensated care amount (see instructions)		0	0	
1	ctor 3 (see instructions)	+bi- li> (0. 000000000	0. 000000000	1
	ospital uncompensated care payment (Ifline 34 is zero, ente distructions)	er zero on this line) (see	1, 682, 889	1, 478, 064	35.
	o rata share of the hospital uncompensated care payment amo	ount (see instructions)	1, 258, 708	372, 553	35.
	tal uncompensated care (sum of columns 1 and 2 on line 35.0		1, 631, 261		36.
	ditional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throug			
1	otal Medicare discharges (see instructions) otal ESRD Medicare discharges (see instructions)		0		40.
- 1	otal ESRD Medicare discharges (see first detrons) tal ESRD Medicare covered and paid discharges (see instruct	ions)	0		41.
1	vide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.
3. 00 To	otal Medicare ESRD inpatient days (see instructions)	,	0		43.
	tio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
	ıys) verage weekly cost for dialysis treatments (see instructions	-1	0.00		45.
- 1	otal additional payment (line 45 times line 44 times line 41	· ·	0.00		46.
	ubtotal (see instructions)		12, 008, 765		47.
	ospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48
on	ly. (see instructions)			Amount	
				Amount 1.00	
. 00 To	tal payment for inpatient operating costs (see instructions	s)		12, 008, 765	49
	yment for inpatient program capital (from Wkst. L, Pt. I ar			916, 191	
	cception payment for inpatient program capital (Wkst. L, Pt.			0	
- 1	rect graduate medical education payment (from Wkst. E-4, li ursing and Allied Health Managed Care payment	ne 49 see instructions).		0 20, 610	
	pecial add-on payments for new technologies			204, 016	
	slet isolation add-on payment			0	1
	et organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	
1	ost of physicians' services in a teaching hospital (see intr	•	1 05)	0	
1	outine service other pass through costs (from Wkst. D, Pt. I acillary service other pass through costs from Wkst. D, Pt.		rough 35).	0 23, 019	
- 1	otal (sum of amounts on lines 49 through 58)	1V, Col. 11 1111e 200)		13, 172, 601	
	imary payer payments			9, 797	
. 00 To	tal amount payable for program beneficiaries (line 59 minus	s line 60)		13, 162, 804	61
1	eductibles billed to program beneficiaries			1, 140, 132	
- 1	insurance billed to program beneficiaries			17, 066	
	lowable bad debts (see instructions) liusted reimbursable bad debts (see instructions)			20, 958 13, 623	
	lowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
. 00 Su	ubtotal (line 61 plus line 65 minus lines 62 and 63)	,		12, 019, 229	
	redits received from manufacturers for replaced devices for			0	
- 1	utlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instructions	5)	0	
4	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Iral Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (soci	nstructions)	0	
	emonstration payment adjustment amount before sequestration	daj astilierit (see 1	noti deti onoj	0	1
	CH or MDH volume decrease adjustment (contractor use only)			Ö	1
. 89 Pi	oneer ACO demonstration payment adjustment amount (see inst	ructions)			70.
	SP bonus payment HVBP adjustment amount (see instructions)			0	
- 1	P bonus payment HRR adjustment amount (see instructions)			0	
	ndled Model 1 discount amount (see instructions) (BP payment adjustment amount (see instructions)			0 13, 723	
۱۱۱۷ د ۰	1 3 3				
. 94 HR	R adjustment amount (see instructions)		l	-9, 545	1 / 0

	73)		011,011	, 1. 0
74.01	Balance due provider/program-PARHM (see instructions)			74. 0
75. 00	Protested amounts (nonallowable cost report items) in accordance with		146, 474	
	CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.0
	plus 2.04 (see instructions)			
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	
94. 00	The rate used to calculate the time value of money (see instructions)		0.00	
95. 00	Time value of money for operating expenses (see instructions)		0	
96. 00	Time value of money for capital related expenses (see instructions)			96. 0
			On/After 10/1	
		1. 00	2. 00	
	HSP Bonus Payment Amount			ļ
100.00	HSP bonus amount (see instructions)	0	0	100. 0
	HVBP Adjustment for HSP Bonus Payment			ļ
	HVBP adjustment factor (see instructions)	0. 0000000000	0.0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 0
	HRR Adjustment for HSP Bonus Payment			ļ
	HRR adjustment factor (see instructions)	0. 0000		
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 0
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 0
	Century Cures Act? Enter "Y" for yes or "N" for no.			ļ
	Cost Reimbursement			
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 0
	Medicare discharges (see instructions)			202. 0
203.00	Case-mix adjustment factor (see instructions)			203. 0
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-year demonst	ration	
204.00	peri od)			204 0
	Medicare target amount			204. 0
	Case-mix adjusted target amount (line 203 times line 204)			205. 0
206.00				1206. U
207.00				207.0
	,			209. 0
211.00				1211.0
				212 0
212 00				
213.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218.0
207. 00 208. 00 209. 00 210. 00	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)			210 211 212 213

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2021 | Part A Exhibit 4 | To 12/31/2021 | Date/Time Prepared: | 5/24/2022 5:25 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0059

						0 12/31/2021	5/24/2022 5: 2	
		l			XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior to 10/01	Period	Total (Col 2 through 4)	
		line 0	E, Part A) 1.00	Entitlement 2.00	3.00	0n/After 10/01 4.00	5. 00	
1. 00	DRG amounts other than outlier		0	0	3.00		0.00	1. 00
	payments			-				
1. 01	DRG amounts other than outlier payments for discharges	1. 01	7, 207, 636	0	7, 207, 636	b	7, 207, 636	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	2, 558, 847	0		2, 558, 847	2, 558, 847	1. 02
	payments for discharges occurring on or after October							
1. 03	DRG for Federal specific operating payment for Model 4	1. 03	0	0	()	0	1. 03
	BPCI occurring prior to October 1							
1. 04	DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for	2. 00						2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	(0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	333, 798	0	333, 798	3	333, 798	2. 02
2. 03	October 1 (see instructions) Outlier payments for	2. 04	121, 935	0		121, 935	121, 935	2. 03
	discharges occurring on or after October 1 (see							
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	(0	0	3. 00
4. 00	Managed care simulated payments	3. 00	O	0	(0	0	4. 00
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.000000	0. 000000		5. 00
	A, line 21 (see instructions)							
6. 00	IME payment adjustment (see instructions)	22.00	0	0	(0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	(0	0	6. 01
	instructions) Indirect Medical Education Adju	etment for the	Add-on for Sec	ction 122 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0.000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0.00000	0. 000000	0.00000	0. 000000	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0			0	8. 01
0.01	for managed care (see instructions)	20.01	ď	0		,	0	0.01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	O	0	(0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	O	0	(0	0	9. 01
	8. 01)	L						
10. 00	Disproportionate Share Adjustme Allowable disproportionate	ant 33.00	0. 0636	0. 0636	0. 0636	0. 0636		10.00
10.00	share percentage (see instructions)	33.00	0.0030	0.0030	0.0036	0.0030		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	155, 288	0	114, 602	40, 686	155, 288	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00 rcentage of ESF	1,631,261 RD beneficiary o	0 di scharges	1, 258, 708	372, 553	1, 631, 261	11. 01
12. 00	Total ESRD additional payment	46. 00	ol	0	(0	0	12. 00
	(see instructions)							
13. 00	Subtotal (see instructions)	47. 00	12, 008, 765	0	8, 914, 744	3, 094, 021	12, 008, 765	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	C	0	0	14. 00
15. 00	(see instructions) Total payment for inpatient	49. 00	12, 008, 765	0	8, 914, 744	3, 094, 021	12, 008, 765	15. 00
	operating costs (see instructions)		,		, .		,	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	916, 191	O	C	916, 191	916, 191	16. 00
	1 appi i cabi <i>e)</i>	1	ı l			ı I		ı

LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC		From 01/01/2021 To 12/31/2021	Part A Exhibi Date/Time Pre 5/24/2022 5:2	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	<u> </u>	0	1. 00	2.00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	204, 016	0		204, 016	204, 016	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	0	0		0	0	17. 02
10.00	devices for applicable MS-DRGs	02.00		0				10 00
18. 00	Capital outlier reconciliation adjustment amount (see	93. 00	U	Ü	'	0	0	18. 00
19. 00	instructions) SUBTOTAL			0	8, 914, 74	4, 214, 228	13, 128, 972	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	741, 471	0		741, 471	741, 471	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	142, 837	0		142, 837	142, 837	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	,	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0430	0. 0430	0. 043	0. 0430		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	31, 883	0		31, 883	31, 883	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	916, 191	0		916, 191	916, 191	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000	0.00000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96				o O	0	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line)		Y					100.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0059 Peri od: Worksheet E From 01/01/2021 Part A Exhibit 5 Date/Time Prepared: 5/24/2022 5:25 pm 12/31/2021 Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 7, 207, 636 1.01 1.01 7, 207, 636 7, 207, 636 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2, 558, 847 2, 558, 847 2, 558, 847 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 333, 798 333, 798 333, 798 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 121, 935 121, 935 121, 935 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 C 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0636 0.0636 0.0636 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 155, 288 114, 602 40.686 155, 288 11.00 instructions) 11.01 1, 631, 261 Uncompensated care payments 36, 00 1, 258, 708 372, 553 1, 631, 261 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 12, 008, 765 13 00 12, 008, 765 8, 914, 744 3, 094, 021 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 12, 008, 765 8, 914, 744 3, 094, 021 12, 008, 765 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 916, 191 683.247 232, 944 916, 191 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 204, 016 204, 016 204, 016 0 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions)

9, 597, 991

3, 530, 981

13, 128, 972 19. 00

19.00

SUBTOTAL

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CO	F		Worksheet E Part A Exhibi Date/Time Pre 5/24/2022 5:2	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	741, 471	551, 723	189, 748	741, 471	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01

			11 11 0	AVIII	nospi tai		
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	741, 471	551, 723	189, 748	741, 471	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	o	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	142, 837	107, 800	35, 037	142, 837	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	o	0	0	21. 01
22.00	Indirect medical education percentage (see	5. 00	0.0000	0.0000	0.0000		22. 00
	instructions)						
23.00	Indirect medical education adjustment (see	6. 00	l o	l o	0	l 0	23. 00
	instructions)				-		
24.00	Allowable disproportionate share percentage	10.00	0. 0430	0. 0430	0.0430		24. 00
	(see instructions)						
25.00	Di sproporti onate share adjustment (see	11.00	31, 883	23, 724	8, 159	31, 883	25. 00
	instructions)						
26.00	Total prospective capital payments (see	12.00	916, 191	683, 247	232, 944	916, 191	26. 00
	instructions)						
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	13, 723	o	13, 723	13, 723	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0	o	0	0	30. 01
	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-9, 545	-5, 884	-3, 661	-9, 545	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70, 91	l	l o	0	0	31. 01
	instructions)						
	•					(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see	70. 99		95, 921	35, 410	131, 331	32. 00
	instructions)						
100.00	Transfer HAC Reduction Program adjustment to		Y				100. 00
	Wkst. E, Pt. A.						
				·			

Health Financial Systems	RI VERVI EW HOSPI TAL		u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2021	Worksheet E Part B

To 12/31/2021 Part B
Date/Time Prepared:
5/24/2022 5: 25 pm
Hospital PPS

	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	25, 604	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	20, 251, 366	
3. 00 4. 00	OPPS payments	17, 048, 261	3. 00 4. 00
4.00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	286, 991 0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	5. 00
6.00	Line 2 times line 5	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0. 00	
8.00	Transitional corridor payment (see instructions)	02 104	8. 00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	93, 104 0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	25, 604	
	COMPUTATION OF LESSER OF COST OR CHARGES	·	
	Reasonable charges		
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	86, 530 0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	86, 530	
00	Customary charges	00,000	00
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)	0. 000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)	86, 530	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	60, 926	
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)	25, 604	21. 00
22. 00	Interns and residents (see instructions)	25, 664	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	17, 428, 356	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0 3, 057, 388	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	14, 396, 572	
	instructions)		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	14 204 572	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments	14, 396, 572 3, 025	
32. 00	Subtotal (line 30 minus line 31)	14, 393, 547	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	48, 766 31, 698	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	-261	
37. 00	Subtotal (see instructions)	14, 425, 245	
38. 00	MSP-LCC reconciliation amount from PS&R	-141	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40. 00	Subtotal (see instructions)	14, 425, 386	
40. 01	Sequestration adjustment (see instructions)	0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs	14 550 204	40. 03
41. 00 41. 01	Interim payments Interim payments-PARHM	14, 559, 304	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)	0	
42. 01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-133, 918	
43. 01	Balance due provider/program-PARHM (see instructions)	0	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44. 00
	TO BE COMPLETED BY CONTRACTOR		
90. 00	Original outlier amount (see instructions)	0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)	0	91. 00
92.00	The rate used to calculate the Time Value of Money		92.00
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0	
, 1. 00		0	, 50

Health Financial Systems	RIVERVIEW HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Period: Worksheet E From 01/01/2021 Part B
	Component CCN: 15-T059	To 12/31/2021 Date/Time Prepared: 5/24/2022 5:25 pm

Title XVIII Subprovi der -1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 129 2.00 Medical and other services reimbursed under OPPS (see instructions) 107 2.00 3 00 OPPS payments 80 3 00 4.00 Outlier payment (see instructions) 0 4.00 4.01 Outlier reconciliation amount (see instructions) 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.00 Line 2 times line 5 0 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) Ω 8.00 9 00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 0 10.00 Organ acquisitions 10.00 0 11.00 Total cost (sum of lines 1 and 10) (see instructions) 129 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 436 12.00 13 00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 13.00 14.00 14.00 Total reasonable charges (sum of lines 12 and 13) 436 Aggregate amount actually collected from patients liable for payment for services on a charge basis 15.00 0 15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis Ω 16.00 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17 00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17 00 18.00 Total customary charges (see instructions) 436 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 307 19.00 instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20.00 0 20.00 instructions) 21.00 Lesser of cost or charges (see instructions) 129 21.00 22. 00 Interns and residents (see instructions) 0 22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 80 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 26.00 26 00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 209 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 209 30.00 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 0 31.00 209 32.00 Subtotal (line 30 minus line 31) 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33 00 Allowable bad debts (see instructions) 34.00 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 35.00 36, 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 209 37.00 MSP-LCC reconciliation amount from PS&R 38.00 38.00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 39.97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 39.99 209 40.00 Subtotal (see instructions) 40.00 40.01 Sequestration adjustment (see instructions) 40.01 0 40.02 Demonstration payment adjustment amount after sequestration 40.02 40 03 Sequestration adjustment-PARHM pass-throughs 40 03 41.00 Interim payments 254 41.00 Interim payments-PARHM 41.01 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 Tentative settlement-PARHM (for contractor use only) 42 01 42 01 43.00 Balance due provider/program (see instructions) -45 43.00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44 00 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 0 90.00 91 00 Outlier reconciliation adjustment amount (see instructions) 91.00 92.00 92.00 0.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 94.00 Total (sum of lines 91 and 93) 94.00 0

| Period: | Worksheet E-1 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/24/2022 5:25 pm Health Financial Systems

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

					5/24/2022 5: 25	5 pm
			XVIII	Hospi tal	PPS	
		I npati en	it Part A	Par	rt 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		11, 215, 341		14, 301, 502	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
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	12/31/2021	132, 424	12/31/2021	257, 802	3. 01
3. 02	ABSOSTWENTS TO TROVIDER	12/31/2021	132, 424		0	3. 02
3. 02						3. 03
3. 04						3. 04
3. 05						3. 05
3.03	Provider to Program	l .		1		3. 03
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51					l ol	3. 51
3. 52					l ol	3. 52
3. 53					0	3. 53
3.54			l c		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		132, 424		257, 802	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		11, 347, 765		14, 559, 304	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	I	ı	1		
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER	I			1 0	5. 01
5. 01	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
5.05	Provider to Program				0	5. 03
5. 50	TENTATI VE TO PROGRAM				I 0	5. 50
5. 51	TENTATIVE TO TROOKAW					5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
0. , ,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		544, 311		0	6. 01
6.02	SETTLEMENT TO PROGRAM		C		133, 918	6. 02
7.00	Total Medicare program liability (see instructions)		11, 892, 076		14, 425, 386	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se	(0	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Health Financial Systems	RIVERVIEW H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED)	Provi der Co	CN: 15-0059	Peri od:	Worksheet E-1	
			45 Tota			
		Component	CCN: 15-T059	To 12/31/2021		
					5/24/2022 5: 2	5 pm
		Title	: XVIII	Subprovider -	PPS	
				IRF		
		I npati en	it Part A	Par	t B	
		mm/dd/\\\\\	Amount	mm/dd/\\\\\\	Amount	

				IRF		
		Inpatien	nt 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	1.00	4, 348, 710		254	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
2.00	submitted or to be submitted to the contractor for				Ĭ	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		T	T		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Dravidar to Dragram		0		U	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		1 0		0	3. 50
3. 51	ADJUSTINIENTS TO FROGRAM				0	3. 51
3. 52			0		Ö	3. 52
3. 53			1 0		0	3. 53
3. 54			0		o o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 348, 710		254	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 02	TENTATIVE TO PROVIDER				0	5. 01
5. 02					0	5. 02
3.03	Provider to Program		0		0	5. 05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			l o		o l	5. 51
5. 52			0		o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		l 0		o	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		46, 772		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		45	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 395, 482		209	7. 00
				Contractor	NPR Date	
		,	0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		U	1.00	2.00	8. 00
5. 00	Thame of contractor	l		II .		0.00

Heal th	Financial Systems RIVERVIEW HOS	SPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0059 Period: From 01/01/2021 To 12/31/2021 E					
	Title XVIII Hospital					
	TO DE COMPLETED DV CONTRACTOR FOR MONOTANDARD COST REPORTS			1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-	
1. 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst.		. 14		1. 00	
					2.00	
2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)				2.00		
3.00					3.00	
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1 and 8 through 12 and	nlus for cost		4. 00	
1. 00	reporting periods beginning on or after 10/01/2013, line 32)	i, and o through 12, and	prus roi cost		1.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31. 00	
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00	

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2021	Worksheet E-3 Part III
	Component CCN: 15-T059	To 12/31/2021	Date/Time Prepared: 5/24/2022 5:25 pm
	Title XVIII	Subprovi der -	PPS

	THE AVIII	IRF	113	
			1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		1. 00	
1. 00	Net Federal PPS Payment (see instructions)		4, 163, 370	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0. 0182	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		134, 477	3. 00
4.00	Outlier Payments		142, 577	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period end	ding on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)			
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were		0. 00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustr	nent under 42		
6. 00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions)		0. 00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth pe	arind of a "new	0.00	7. 00
7.00	teaching program" (see instructions)	sirou or a new	0.00	7.00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth pe	eriod of a "new	0.00	8. 00
	teaching program" (see instructions)			
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)		11. 783562	
11. 00	, , ,		0. 000000	
12. 00	3 3		0	
	Total PPS Payment (see instructions)		4, 440, 424	
14.00			0	
15.00				15.00
16. 00 17. 00	9 (4 440 424	
18. 00			4, 440, 424 0	18.00
19. 00	1 . 3 1. 3 . 1. 3		4, 440, 424	
20. 00			35, 464	
21. 00			4, 404, 960	
22. 00	,		12, 614	ı
23. 00	Subtotal (line 21 minus line 22)		4, 392, 346	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24. 00
25. 00	· · · · · · · · · · · · · · · · · · ·		0	1
26. 00	,		0	
27. 00			4, 392, 346	
28. 00			0	
	Other pass through costs (see instructions)		3, 136	
30.00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
31. 50			0	
31. 98			0	
	Demonstration payment adjustment amount before sequestration		0	
32. 00			4, 395, 482	
32. 01	Sequestration adjustment (see instructions)		0	
32. 02			0	32. 02
33.00	Interim payments		4, 348, 710	33.00
34.00	Tentative settlement (for contractor use only)		0	34. 00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		46, 772	35. 00
36. 00		chapter 1,	0	36. 00
	§115. 2			
EO 00	TO BE COMPLETED BY CONTRACTOR		140 577	E0 00
50. 00 51. 00			142, 577 0	50. 00 51. 00
51.00	,		0. 00	
53. 00			0.00	•
55. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END	I O OF THE COVID-19		33.00
99. 00			0. 000000	99. 00
	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0. 000000	
		'		•

Health Financial Systems	RIVERVIEW HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: Worksheet E-3

Title XIX

		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		976, 058		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		O		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		976, 058	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		976, 058	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		857, 125		8.00
9.00	Ancillary service charges		1, 371, 546	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 228, 671	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for ser	vices on a charge	0	0	13.00
	basis	Ç .			
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 42 CF	R §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)		2, 228, 671	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if	Fline 16 exceeds	1, 252, 613	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	fline 4 exceeds line	0	0	18.00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		976, 058	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	leted for PPS provide	rs.		
22. 00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		976, 058	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		976, 058	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		976, 058	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38. 00	Subtotal (line 36 ± line 37)		976, 058	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		976, 058	0	40.00
41.00	Interim payments		992, 912	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-16, 854	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance w	vith CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems	RIVERVIEW HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059		Worksheet E-3
		From 01/01/2021	Part VII
	Component CCN: 15-T059	To 12/31/2021	Date/Time Prepared:
			5/24/2022 5: 25 pm
	T1.11 V1.V	0 1 1 1	0 1

		Title XIX	Subprovi der -	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		26, 993	_	1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	0	3. 00
4. 00 5. 00	Subtotal (sum of lines 1, 2 and 3)		26, 993	0	4. 00 5. 00
6.00	Inpatient primary payer payments Outpatient primary payer payments		٥	0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		26, 993	0	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		20, 773		7.00
	Reasonable Charges				
8.00	Routine service charges		177, 906		8. 00
9.00	Ancillary service charges		42, 283	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		220, 189	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				4.00
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 4 Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR §413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		220, 189	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	193, 196	0	17. 00
17.00	line 4) (see instructions)	y II IIIle To exceeds	173, 170	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		26, 993	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	0	
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00 25. 00
26. 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	26. 00 26. 00
27. 00				0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		26, 993	0	29. 00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		20, 770		27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	26, 993	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	26, 993	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
	Subtotal (line 36 ± line 37)		26, 993	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	_	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		26, 993	0	40.00
41. 00 42. 00	Interim payments Balance due provider/program (line 40 minus line 41)		81, 719 -54, 726	0	41. 00 42. 00
42.00	Protested amounts (nonallowable cost report items) in accordan	ace with CMS Pub 15-2	-54, 726	0	42.00
73.00	chapter 1, §115.2	ISS WITTI OND TUD 13-2,		O	73.00
	- - - - - - - -		1		ı

	Financial Systems RIVERVIEW HOS		ON 45 0050		u of Form CMS-2	2552-1
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT LE EDUCATION COSTS	Provi der Co	CN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prep	
		T: +1 o	N/// I	Hooni tal	5/24/2022 5: 25	5 pm
		ı ii ti e	e XVIII	Hospi tal	PPS	
					1. 00	
1.00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for all opathic and osteopathic	programs for	cost reporti	ng peri ods	0.00	1.00
. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see instr	ructions)	0.00	2. 0 3. 0
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MM. Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m).	(see	0. 00 0. 00	3. 00 3. 0°
1. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4. 00
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0.00	4. 0
. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0. 00	4. 0
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	0. 00	5. 0
5. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0. 00	6. 00
7. 00	Enter the lesser of line 5 or line 6		Dri maru Cara	O+box	0.00	7. 00
			Primary Care	0ther 2.00	<u>Total</u> 3. 00	
3. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	0.0		0.00	8. 0
0. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.0	0.00	0. 00	9. 0
0. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent year		0.00		10.0
0. 01	Unweighted dental and podiatric resident FTE count for the cu	irrent year		0.00		10. 0
1. 00 2. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	g year (see	0.0			11. 0 12. 0
3. 00	<pre>instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions)</pre>	porting	0.0	0.00		13. 0
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	0.0	0.00		14. 0
5. 00	Adjustment for residents in initial years of new programs		0.0			15.0
5. 01	Unweighted adjustment for residents in initial years of new p		0.0			15.0
6. 00 6. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0.0			16. C
0. 01	closure	iospi tai	0.0	0.00		10.0
7.00	Adjusted rolling average FTE count		0.0			17.0
8. 00 9. 00	Per resident amount Approved amount for resident costs		0.0	0.00	0	18. 0 19. 0
20.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	can slots rec	rei ved under 42	1.00	20. 0
.0. 00	Sec. 413.79(c) (4)	TE TOST GOTT	cup siots rec	or ved dilder 12	0.00	20.0
21. 00	Direct GME FTE unweighted resident count over cap (see instru	,				21.0
2. 00 2. 00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a		netrueti encl		0. 00 0. 00	
4. 00	Multiply line 22 time line 23	illourit (see i	ristructions)		0.00	24.0
5. 00	1 . 3				0	
			Inpatient Par A	rt Managed Care	Total	
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X, line	7, 09	91 4, 793		26. 00
26. 00				21 702		27. 0
	3.02, column 2) Total Inpatient Days (see instructions)		1 21 79	5.51 / 1 / 2 51		
27. 00	3.02, column 2) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		21, 78 0. 32552			
26. 00 27. 00 28. 00 29. 00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount				0	28. 00 29. 00
27. 00 28. 00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days			0. 220034	0	28. 0

DI RECT GRADUATE MEDI CAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0059 Peri od: From 01/01/2021 To 12/31/2021 To 12/31/2021 To 12/31/2021 Provider CCN: 15-0059 Peri od: From 01/01/2021 To 12/31/2021 To 12/31/2021 To 12/31/2021 To 12/31/2021 To 12/31/2021 To 12/31/2021 Provider CCN: 15-0059 P	Heal th	Financial Systems RIVERVIEW HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS) 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 35.00 Medicare outpatient ESRD charges (see instructions) 36.00 Medicare outpatient ESRD direct medical education costs (line 32 * line 33) 37.00 Reasonable cost (see instructions) 38.00 Reasonable cost (see instructions) 39.00 Cost of physicians' services in a teaching hospital (see instructions) 40.00 Primary payer payments (see instructions) 40.00 Primary payer payments (see instructions) 40.00 Part B reasonable cost 42.00 Reasonable cost (see instructions) 43.00 Reasonable cost (see instructions) 44.00 Total Part A reasonable cost (line 42 minus line 43) 45.00 Total Part B reasonable cost to total reasonable cost (line 44 * line 45) 46.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 * line 45) 47.00 Ratio of Part B reasonable REC GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31)			Provi der CCN: 15-0059	Peri od:		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS) 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 ond 94) 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 34.00 Ratio of direct medical education costs to total charges (line 32 + line 33) 35.00 Medicare outpatient ESRD charges (see instructions) 36.00 Medicare outpatient ESRD charges (see instructions) 37.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 39.00 Cost of physicians' services in a teaching hospital (see instructions) 40.00 Primary payer payments (see instructions) 41.00 Part B Reasonable cost (sem of lines 37 through 39 minus line 40) 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 43.00 Primary payer payments (see instructions) 43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total Part B reasonable cost to total reasonable cost (line 41 + line 45) 46.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45) 48.00 Total payer Bayment (line 31) 48.00 Total payer Bayment (line 31)	MEDI CA	L EDUCATION COSTS				
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS) 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74			Title XVIII	Hospi tal	PPS	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS) 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74						
EDUCATION COSTS) 32. 00 Renal dial ysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) 33. 00 Renal dial ysis and home dial ysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 33. 00 Renal dial ysis and home dial ysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 36. 00 Ratio of direct medical education costs to total charges (line 32 + line 33) 37. 00 Medicare outpatient ESRD charges (see instructions) 38. 00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 37. 00 Reasonable cost (see instructions) 37. 00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 39. 00 Cost of physicians' services in a teaching hospital (see instructions) 40. 00 Primary payer payments (see instructions) 41. 00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 42. 00 Reasonable cost (see instructions) 42. 00 Reasonable cost (see instructions) 43. 00 Primary payer payments (see instructions) 44. 00 Total Part B reasonable cost (line 42 minus line 43) 45. 00 Total Part A reasonable cost total reasonable cost (line 41 + line 45) 46. 00 Ratio of Part A reasonable cost total reasonable cost (line 44 + line 45) 47. 00 Ratio of Part B reasonable cost total reasonable cost (line 44 + line 45) 48. 00 Total program GME payment (line 31)						
and 94) 33. 00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 706, 660 34. 00 Ratio of direct medical education costs to total charges (line 32 ÷ line 33) 80. 000 Medicare outpatient ESRD charges (see instructions) 80. 00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 73. 00 Reasonable cost (see instructions) 90. 00 10.		EDUCATION COSTS)	`		OI CAL	
Ratio of direct medical education costs to total charges (line 32 ÷ line 33) 0.000000 35.00 Medicare outpatient ESRD charges (see instructions) 0 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost Reasonable cost (see instructions) 0 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) 0 Primary payer payments (see instructions) 1 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable cost (see instructions) 1 20, 370, 310 2 20, 370, 310 2 3, 3025 4 00 Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 + line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B Total program GME payment (line 31)	32. 00		Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) 10 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable cost (see instructions) Reasonable cost (see instructions) Primary payer payments (see instructions) Reasonable cost (see instructions) Total Part B reasonable cost (see instructions) Reasonable cost (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B Total program GME payment (line 31)	33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	706, 660	33. 00
Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Primary payer payments (see instructions) Operate B Reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Reasonable cost (see instructions) Primary payer payments (see instructions) Reasonable cost (see instructions) 70 Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B Total program GME payment (line 31)			e 32 ÷ line 33)		0. 000000	34. 00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 37.00 Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 39.00 Cost of physicians' services in a teaching hospital (see instructions) 40.00 Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost 42.00 Reasonable cost (see instructions) Reasonable cost (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31)	35.00	Medicare outpatient ESRD charges (see instructions)			0	
Part A Reasonable Cost 37. 00 Reasonable cost (see instructions) 38. 00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 39. 00 Cost of physicians' services in a teaching hospital (see instructions) 40. 00 Primary payer payments (see instructions) 41. 00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost 42. 00 Reasonable cost (see instructions) 43. 00 Primary payer payments (see instructions) 44. 00 Total Part B reasonable cost (line 42 minus line 43) 45. 00 Total reasonable cost (sum of lines 41 and 44) 46. 00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) AtloCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48. 00 Total program GME payment (line 31)	36.00					36. 00
Reasonable cost (see instructions) Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Ocot of physicians' services in a teaching hospital (see instructions) Originary payer payments (see instructions) Originary payer payments (see instructions) Part B Reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable cost (see instructions) Reasonable cost (see instructions) Primary payer payments (see instructions) Alough Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B Total program GME payment (line 31)			ONLY			
38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 39.00 Cost of physicians' services in a teaching hospital (see instructions) 40.00 Primary payer payments (see instructions) 70.777 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost total reasonable cost (line 44 ÷ line 45) 48.00 Total program GME payment (line 31)						
39.00 Cost of physicians' services in a teaching hospital (see instructions) 40.00 Primary payer payments (see instructions) 41.00 Part B reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost total reasonable cost (line 44 ÷ line 45) 48.00 Total program GME payment (line 31)						
40.00 Primary payer payments (see instructions) 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 43.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31)					-	38. 00
41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total Part B reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31)			ructions)		•	39. 00
Part B Reasonable Cost 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 43.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (line 42 minus line 43) 46.00 Ratio of Part A reasonable cost total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 48.00 Total program GME payment (line 31) 48.00 Total program GME payment (line 31)		31313 \	11 (0)			1
42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) 45.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31)	41.00		IS II ne 40)		20, 731, 660	41.00
43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost total reasonable cost (line 44 ÷ line 45) 48.00 Total program GME payment (line 31) 48.00 Total program GME payment (line 31)	42.00				20 270 210	42.00
44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 20, 367, 285 41, 098, 945 0. 504433 0. 495567						
45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 41,098,945 0.504433 0.495567						
46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 0.504433 0.495567						
47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 0.495567			ne 41 ÷ line 45)			
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 0						
48.00 Total program GME payment (line 31) 0	50				33007	1 55
	48. 00				0	48. 00
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		1 9 1 9 1	(see instructions)		0	ł
					0	50.00

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 15-0059 Period From

| Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared: | 5/24/2022 5:25 pm

oni y)				1270172021	5/24/2022 5: 2	5 pm
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS	15.010.571	T a	1		
1. 00 2. 00	Cash on hand in banks Temporary investments	15, 019, 571		0	0	1. 00 2. 00
3. 00	Notes receivable			0	0	3.00
4. 00	Accounts receivable	89, 603, 928	·	0	0	
5.00	Other recei vable	13, 874, 067	C	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-58, 621, 658	C	0	0	6. 00
7. 00	Inventory	6, 202, 782		0	0	7. 00
8.00	Prepai d expenses	2, 448, 802		0	0	
9. 00 10. 00	Other current assets Due from other funds	0	C	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	68, 527, 492		_		11.00
11.00	FIXED ASSETS	00, 327, 472		0	0	11.00
12.00	Land	16, 050, 414	C	0	0	12. 00
13.00	Land improvements	3, 231, 090	C	0	0	13. 00
14. 00	Accumulated depreciation	-4, 139, 492	C	0		14. 00
15. 00	Bui I di ngs	166, 173, 303		_	0	15. 00
16.00	Accumulated depreciation	-82, 061, 686		0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	1, 399, 855	C	0	0	17. 00 18. 00
19. 00	Fi xed equi pment	50, 300, 481		0	0	19.00
20. 00	Accumulated depreciation	-36, 449, 806	1	0	0	20.00
21. 00	Automobiles and trucks	00,117,000	ĺ	0	0	21.00
22. 00	Accumul ated depreciation	0	C	0	0	22. 00
23. 00	Major movable equipment	122, 055, 242	C	0	0	23. 00
24. 00	Accumulated depreciation	-90, 025, 240	C	0	0	24. 00
25. 00	Mi nor equipment depreciable	0	C	0	0	25. 00
26. 00	Accumulated depreciation	0	C	0	0	26. 00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0		0	0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e			0	0	
30. 00	Total fixed assets (sum of lines 12-29)	146, 534, 161		_		30.00
	OTHER ASSETS					
31.00	Investments	82, 772, 034	C	0	0	31. 00
32. 00	Deposits on leases	0	C	_	0	32. 00
33. 00	Due from owners/officers	0	C	0	0	33. 00
34. 00	Other assets	79, 827		0	0	34. 00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	82, 851, 861 297, 913, 514	0	0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	271, 713, 514		0	0	30.00
37. 00	Accounts payable	11, 065, 550	C	0	0	37. 00
38.00	Salaries, wages, and fees payable	11, 328, 351		0	0	38. 00
39. 00	Payroll taxes payable	0	C	0	0	39. 00
40. 00	Notes and Loans payable (short term)	15, 517, 716	C	0	0	40. 00
41.00	Deferred income	0	C	0	0	41.00
42.00	Accel erated payments	110 202 024	1	0		42.00
43. 00 44. 00	Due to other funds Other current liabilities	110, 303, 826 10, 257, 533		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	158, 472, 976	•	_		
101.00	LONG TERM LIABILITIES	100/1/2///				10.00
46.00	Mortgage payable	0	C	0	0	46. 00
47. 00	Notes payable	50, 770, 000	C	0	0	47. 00
48. 00	Unsecured Loans	0	C	_	-	48. 00
49. 00	Other long term liabilities	1, 886, 070		_	0	1
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	52, 656, 070 211, 129, 046				
51.00	CAPITAL ACCOUNTS	211, 129, 040		0	0	31.00
52. 00	General fund balance	86, 784, 468				52. 00
53.00	Specific purpose fund		l c			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	86, 784, 468		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	297, 913, 514		0	0	60.00
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES RI VERVI EW HOSPI TAL

Provider CCN: 15-0059

					To 12/31/2021	Date/Time Prep 5/24/2022 5: 2	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	у ріп
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		100, 776, 794		C)	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-13, 992, 326				2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	86, 784, 468		0	0	3. 00 4. 00
5.00	Additions (credit adjustments) (specify)	0			0		5. 00
6.00					Ö		6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0		C)	10.00
11. 00	Subtotal (line 3 plus line 10)	_	86, 784, 468		C)	11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13. 00 14. 00		0			0	0	13. 00 14. 00
15. 00					0		15. 00
16. 00					0		16. 00
17. 00		o			o	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		C		18. 00
19. 00	Fund balance at end of period per balance		86, 784, 468		C)	19. 00
	sheet (line 11 minus line 18)		51	L			
		Endowment Fund	PI ant	Funa 			
		6.00	7. 00	8.00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5. 00 6. 00			0				5. 00 6. 00
7. 00			0				7. 00
8. 00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12. 00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15. 00 16. 00			0				15. 00 16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	U		0		18.00
19. 00	Fund balance at end of period per balance				ő		19. 00
	sheet (line 11 minus line 18)						
		·					

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0059

			10	12/31/2021	Date/IIme Prep 5/24/2022 5:25	
	Cost Center Description	Inpa	tient	Outpati ent	Total	<u>у р</u>
			00	2.00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal	51,	900, 501		51, 900, 501	1.00
2.00	SUBPROVI DER - I PF		·			2.00
3.00	SUBPROVI DER - I RF	7,	522, 180		7, 522, 180	3.00
4.00	SUBPROVI DER		·			4.00
5.00	Swing bed - SNF		0		o	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY		0		0	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)	59,	422, 681		59, 422, 681	10.00
	Intensive Care Type Inpatient Hospital Services	•	<u> </u>	,		
11.00	INTENSIVE CARE UNIT	17,	049, 477		17, 049, 477	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines 17,	049, 477		17, 049, 477	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	76,	472, 158		76, 472, 158	17.00
18.00	Ancillary services	108,	534, 540	347, 382, 737	455, 917, 277	18.00
19.00	Outpati ent servi ces	6,	282, 634	73, 576, 731	79, 859, 365	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES		0	0	0	23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27. 00	OTHER OUTPATIENT		0	46, 244, 458	46, 244, 458	27.00
27. 01	PROF FEES		0	28, 458, 897	28, 458, 897	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 191,	289, 332	495, 662, 823	686, 952, 155	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			261, 657, 380		29. 00
30. 00	ADD (SPECIFY)		0			30.00
31. 00			0			31.00
32. 00			0			32.00
33. 00			0			33.00
34. 00			0			34.00
35. 00			0			35.00
36. 00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00			0	_		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		261, 657, 380		43.00
	to Wkst. G-3, line 4)	1			I	

				6.5	
	Financial Systems RIVERVIEW MENT OF REVENUES AND EXPENSES	HOSPITAL Provider CCN: 15-0059	Period:	eu of Form CMS-2 Worksheet G-3	
STATE	INTO TREVENUES AND EXICUSES	110V1 del 1 con. 13 0037	From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
			1	5/24/2022 5: 2	5 pm
				1.00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	Line 28)		686, 952, 155	1. 00
2.00	Less contractual allowances and discounts on patients' acc			464, 692, 081	2. 00
3.00	Net patient revenues (line 1 minus line 2)			222, 260, 074	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		261, 657, 380	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-39, 397, 306	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			10, 296, 260	
8.00	Revenues from telephone and other miscellaneous communicat	tion services		0	0.00
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	12.00
13. 00	Revenue from Laundry and Linen service			0	1
14. 00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to other	er than patients		0	
17. 00	Revenue from sale of drugs to other than patients			0	
18. 00	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	OTHER OPERATING INCOME			13, 160, 988	
24. 01	OTHER OPERATING REVENUE			167, 017	
24. 50	COVI D-19 PHE Fundi ng			1, 780, 715	
25. 00	Total other income (sum of lines 6-24)			25, 404, 980	
26. 00	Total (line 5 plus line 25)			-13, 992, 326	
27. 00	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			12 002 224	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28	3)		-13, 992, 326	29.00

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/24/2022 5:2	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT]
1.00	Capital DRG other than outlier			741, 471	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1
2.00	Capital DRG outlier payments			142, 837	1
2. 01	Model 4 BPCI Capital DRG outlier payments	the east reporting period (ass inst	runti ana)	0	
3. 00 4. 00	Total inpatient days divided by number of days in Number of interns & residents (see instructions)	the cost reporting period (see inst	ructions)	47. 90 0. 00	
5. 00	Indirect medical education percentage (see instru	ictions)		0.00	1
6.00	Indirect medical education adjustment (multiply I		columns 1 and	0.00	
0.00	1.01) (see instructions)	The end the earn of this transfer and the	, 001 411110 1 4114		0.00
7. 00	Percentage of SSI recipient patient days to Medic 30) (see instructions)	are Part A patient days (Worksheet E	, part A line	1. 18	7. 00
8.00	Percentage of Medicaid patient days to total days	(see instructions)		19. 60	8. 00
9.00	Sum of lines 7 and 8			20. 78	
10. 00	Allowable disproportionate share percentage (see				10. 00
11.00	Disproportionate share adjustment (see instruction			31, 883	
12. 00	Total prospective capital payments (see instructi	ons)		916, 191	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instr			0	
2.00	Program inpatient ancillary capital cost (see ins			0	
3.00	Total inpatient program capital cost (line 1 plus	s line 2)		0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x li	ne 4)		0	5. 00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS	`		0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions Program inpatient capital costs for extraordinary			0	
3.00	Net program inpatient capital costs for extraordinary	,		0	
4. 00	Applicable exception percentage (see instructions			0.00	
5. 00	Capital cost for comparison to payments (line 3 x			0	
6.00	Percentage adjustment for extraordinary circumsta			0.00	6.00
7.00	Adjustment to capital minimum payment level for e	extraordinary circumstances (line 2 >	(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7			0	
9.00	Current year capital payments (from Part I, line			0	
10.00	Current year comparison of capital minimum paymen	1 1 3 `	,	0	
11. 00	Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)		•	0	
12.00	Net comparison of capital minimum payment level t			0	
13.00	Current year exception payment (if line 12 is pos			0	
14. 00	Carryover of accumulated capital minimum payment (if line 12 is negative, enter the amount on this		orrowing period	0	14. 00
	Current year allowable operating and capital paym			0	15. 00
15. 00					
15. 00 16. 00	Current year operating and capital costs (see ins			0	