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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0059 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/25/2023 3: 52 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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 01/01/2022 and ending 12/31/2022 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	SIGNATURE 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 XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	566, 751	16, 323	0	-188, 607	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	50, 092	28		-437, 927	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	616, 843	16, 351	0	-626, 534	200.00
Tho ob	nove amounts represent "due to" or "due from"	the applicable	program for t	he element of	the above comp	lov indicated	

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0059 Period: Worksheet S-2

From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 3:52 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 395 WESTFIELD ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: NOBLESVILLE Zi p Code: 46060-County: HAMILTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal RIVERVIEW HOSPITAL 150059 26900 07/07/1966 Ν Р 0 3.00 1 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF RIVERVIEW HOSPITAL 15T059 26900 5 01/01/1994 N Р 0 5.00 REHAB 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF 7 00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 9 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0059 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 3: 52 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 60.01 23 00 1 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 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 61.02 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 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 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 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 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 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

N

Health Financial Systems	RI VE	ERVIEW HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eri od:	Worksheet S-2	
			To	rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre	
			Unwei ghted	Unwei ghted	5/25/2023 3:5 Ratio (col.	2 pm
			FTĔs	FTEs in	1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after .			This base year	is your cost	reporti ng	
64.00 Enter in column 1, if line 63 is	s yes, or your facili	ty trained residents	0.00	0. 00	0. 000000	64.00
in the base year period, the nur resident FTEs attributable to ro						
settings. Enter in column 2 the	e number of unweighte	d non-primary care				
resident FTEs that trained in you of (column 1 divided by (column						
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te			
65.00 Enter in column 1, if line 63	1. 00	2. 00	3. 00	4. 00	5. 00 0. 000000	65. 00
is yes, or your facility			0.00	0.00	0.00000	00.00
trained residents in the base year period, the program name						
associated with primary care						
FTEs for each primary care program in which you trained						
residents. Enter in column 2,						
the program code. Enter in column 3, the number of						
unweighted primary care FTE						
residents attributable to rotations occurring in all						
non-provider settings. Enter in						
column 4, the number of unweighted primary care						
resident FTEs that trained in						
your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column						
4)). (see instructions)			Unweighted	Unweighted	Ratio (col.	
			FTEs	FTEs in	1/ (col . 1 +	
			Nonprovi der Si te	Hospi tal	col. 2))	
	V 575 D 11 1 1		1.00	2. 00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	jsEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of	unweighted non-prima		0.00	0. 00	0. 000000	66.00
FTEs attributable to rotations of Enter in column 2 the number of						
FTEs that trained in your hospit (column 1 divided by (column 1 -	tal. Enter in column :	3 the ratio of				
(Cordini Farvided by (Cordilli F-	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	позрі таї	COI . 4))	
47 00 Enter in column 1 the program	1. 00	2. 00	3. 00	4. 00	5. 00 0. 000000	47.00
67.00 Enter in column 1, the program name associated with each of			0.00	0.00	0.00000	67.00
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)						

	Financial Systems RIVERVIEW HOSPITAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCM		eri od:		of Form		
		F	rom 01/01/2 o 12/31/2		Part I Date/Ti 5/25/20	me Pre 23 3:5	pared: 2 pm
				-	1. 0	0	
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490 For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	tain permissi	on from you		N		68. 00
				1. 00	2.00	3. 00	
70. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	nin an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachin recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye Column 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	es or "N" for in a new teac es or "N" for cost reportir	no. (see thi ng no.			0	71.00
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it cosubprovider? Enter "Y" for yes and "N" for no.	ntain an IRF		Υ			75. 00
	If line 75 is yes: Column 1: Did the facility have an approved GME teachin recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	"Y" for yes of in accordance column 2 is Y	or "N" for e with 42 ',	N	N	0	76. 00
					1. 0	0	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for n Is this a LTCH co-located within another hospital for part or all of the c "Y" for yes and "N" for no.		period? Er	nter	N N		80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			no.	N		85. 00 86. 00
87. 00	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified u 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			N		87. 00
	Troob(d)(T)(b)(vr): Enter 1 Tor yes or N Tor no.		Approved Permanen Adjustmen (Y/N) 1.00	nt	Number Appro Permar Adjustn 2.0	ved nent ments	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFR amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co 89. (see instructions)		<i>,</i>			0	88. 00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	Effectiv	/P	Appro	ved	
		No.	Date		Permar Adjust Amount Discha	nent ment Per	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2. 00		3. 0		89. 00
07.00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	0. 00				Ü	07.00
	Column 3: Enter the amount of the approved permanent adjustment to the						
	TEFRA target amount per discharge.				V/ I \	(
			1. 00		2. 0		
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En	nter "Y" for					90.00
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report	either in	1.00		2. 0		90.00
91. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati	either in	1. 00 N		2. 0 Y		
91. 00 92. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and	either in on)? (see	1. 00 N		2. 0 Y Y		91.00
91. 00 92. 00 93. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	either in on)? (see I XIX? Enter	1.00 N N		2. 0 Y Y		91.00
91. 00 92. 00 93. 00 94. 00 95. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	either in on)? (see IXIX? Enter o in the	1.00 N N		2. 0 Y Y N	0	91. 00 92. 00 93. 00

118.00

118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	RI VERVI	EW HOSPITAL				In Lie	eu of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provid	Provi der CCN: 15-0059 Peri od: From 01/01/202 To 12/31/202			om 01/01/2022		repared:
							1. 00	\dashv
147.00 Was there a change in the statist	cal basis? Enter "Y"	for ves or "N	" for	no.			N N	147. 00
148.00 Was there a change in the order o							N	148.00
149.00 Was there a change to the simplif	ed cost finding method	d? Enter "Y"	for ye	es or "N"	for r	no.	N	149. 00
		Part		Part		Title V	Title XIX	
		1. 00		2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or								
155. 00 Hospi tal		N		N		N	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								158.00
159. 00 SNF 160. 00 HOME HEALTH AGENCY		N		N N		N N	N	159. 00 160. 00
161. 00 CMHC		N		N N		N N	N N	161.00
TOT. OO CIWITC				- IN		IN		101.00
Mari di samara							1.00	
Multicampus 165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more	campu	uses in di	ffere	ent CBSAs?	N	165. 00
Effect 4 for yes of N for no.	Name	County		State	Zip (Code CBSA	FTE/Campus	
	0	1. 00		2.00	3. (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)							0. (00 166. 00
							1. 00	
Health Information Technology (HI						Act		
167.00 s this provider a meaningful use 168.00 f this provider is a CAH (line 1	05 is "Y") and is a mea	ani ngful user				enter the	Y	167. 00 168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user,	does this pr	ovi der	qualify	for a	a hardshi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")	and is not a	CAH ((line 105	is "N	N"), enter the	9.	99169.00
,						Begi nni ng	Endi ng	
						1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and endi	ing date for	the re	eporti ng				170.00
						1. 00	2.00	
171.00 If line 167 is "Y", does this pro	vider have any days for	r individuals	enrol	led in		N 1. 00	2.00	0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line	2, col	. 6? Ente				

Health Financial Systems RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0059 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/25/2023 3:52 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 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) Was the cost report prepared using the PS&R Report for 04/09/2023 04/09/2023 17.00 Υ Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

dealth Financial Systems RIVERVIEW				u of Form CM				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0059	Peri od: From 01/01/2022 To 12/31/2022	Date/Time F 5/25/2023 3	repared:			
		i pti on	Y/N	Y/N				
20 00 16 15 - 17 - 17 5 - 17 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 - 17 5 -		0	1. 00 N	3.00	20.00			
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	N	20.00			
Report data for other, beserve the other dajustillents.	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	CEPT CHILDRENS	HOSPI TALS)		1.00				
Capital Related Cost		,						
22.00 Have assets been relifed for Medicare purposes? If yes, se 23.00 Have changes occurred in the Medicare depreciation expense			ring the cost		22. 00 23. 00			
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases enter	red into durino	this cost r	eporting period?		24.00			
If yes, see instructions 25.00 Have there been new capitalized leases entered into during	g the cost repo	orting period	? If yes, see		25. 00			
instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during 1	the cost report	ing period?	If yes, see		26.00			
instructions. 27.00 Has the provider's capitalization policy changed during the copy.	ne cost reporti	ng period? I	f yes, submit		27. 00			
Interest Expense 28.00 Were new Loans, mortgage agreements or Letters of credit 6	entered into du	ring the cos	t reporting		28. 00			
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or		29. 00						
treated as a funded depreciation account? If yes, see inst	treated as a funded depreciation account? If yes, see instructions							
	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see							
instructions. Purchased Services								
32.00 Have changes or new agreements occurred in patient care se	ervices furnish	ed through c	ontractual		32.00			
arrangements with suppliers of services? If yes, see instr 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap	ructi ons.	· ·		-	33.00			
no, see instructions. Provider-Based Physicians								
34.00 Were services furnished at the provider facility under an	arrangement wi	th provider-	based physicians?		34.00			
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		ents with the	provi der-based		35. 00			
physicians during the cost reporting period: if yes, see i	mstructions.		Y/N	Date				
			1. 00	2. 00				
Home Office Costs								
36.00 Were home office costs claimed on the cost report?					36.00			
37.00 If line 36 is yes, has a home office cost statement been p	prepared by the	home office	?		37.00			
If yes, see instructions. 88.00 If line 36 is yes , was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end of the home of the provider?			f		38.00			
39.00 If line 36 is yes, did the provider render services to other see instructions.			S,		39. 0			
40.00 If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see			40.00			
	1.00 2.							
Cost Report Preparer Contact Information								
Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41.00			
Irachactivalv	1		1		II.			
respectively. 42.00 Enter the employer/company name of the cost report preparer.	BLUE & CO., L	_C			42. 0			

Health Financial Systems	N HOSPITAL In Lieu of Form					2552-10		
HOSPITAL AND HOSPITAL HE	ALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0059		01/01/2022	Worksheet S- Part II Date/Time Pr 5/25/2023 3:	epared:
				3. 00				
Cost Report Prepar	er Contact Information			3. 00				
41.00 Enter the first na			MANAGER					41. 00
	report preparer in colum	nns 1, 2, and 3,						
respectively.	,							10.00
42.00 Enter the employer	c/company name of the co	ost report						42. 00
preparer.	so number and small adds	soon of the cost						43.00
43.00 Enter the telephor	ne number and email addr n columns 1 and 2, respe							43.00
preport preparer ri	i corumnis i and 2, respe	ectivery.			ı			1

 Health Financial Systems
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-0059

					Т	o 12/31/2022	Date/Time Pre 5/25/2023 3:5	
					<u>'</u>		I/P Days /	
							0/P Visits /	
	C	W	NI-	-E DI-	Dad Davis	CALL Havena	Trips Title V	
	Component	Worksheet A Line No.	NO.	of Beds	Bed Days Available	CAH Hours	ii tie v	
		1. 00		2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		106	38, 690	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2. 00	for the portion of LDP room available beds)							2.00
3. 00	HMO and other (see instructions) HMO IPF Subprovider							3.00
4. 00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7. 00	Total Adults and Peds. (exclude observation			106	38, 690	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31.00		15	5, 475	0.00	0	8.00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			121	44, 165	0.00	0	14.00
15.00	CAH visits						0	15.00
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	41. 00		1.4	5, 110		0	16. 00 17. 00
18.00	SUBPROVIDER - TRE	41.00		14	5, 110	,	Ü	18.00
19. 00	SKILLED NURSING FACILITY	44.00		o	C	,	0	19.00
20. 00	NURSING FACILITY	44.00		ď			O	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	26. 25
27. 00	Total (sum of lines 14-26)			135				27.00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29.00
30. 00 31. 00	Employee discount days (see instruction)							30. 00 31. 00
31.00	Employee discount days - IRF Labor & delivery days (see instructions)			0	C			31.00
32. 00	Total ancillary labor & delivery room			٩	C	,		32.00
JZ. UI	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days			ļ				33.00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	C)	0	34.00

Provi der CCN: 15-0059

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				'	0 12/31/2022	5/25/2023 3: 5	pareu. 2 pm
		I/P Days	/ O/P Visits	/ Trins	Full Time I	Equi val ents	Z piii
		171 bays	7 071 113113	, 111 ps	Turr rime	Equi vai onto	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	55p5.115111			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 873	466	12, 716			1.00
1.00	8 exclude Swing Bed, Observation Bed and	0,070	100	12,710			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	3, 835	2, 642				2.00
3. 00	HMO IPF Subprovider	0,000	2, 012				3.00
4. 00	HMO IRF Subprovider	683	398				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0,0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	٩	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	3, 873	466	12, 716			7.00
7.00	beds) (see instructions)	3,073	400	12,710			7.00
8. 00	INTENSIVE CARE UNIT	878	0	3, 181			8.00
9. 00	CORONARY CARE UNIT	070	U	3, 101			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
							1
12.00	OTHER SPECIAL CARE (SPECIFY)		1.11	1 510			12.00
13.00	NURSERY	4 751	141	1, 518		1 010 00	13.00
14.00	Total (see instructions)	4, 751	607	17, 415		1, 012. 80	
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - I PF	0.00/	4.0	0.007	0.00	4, 04	16.00
17. 00	SUBPROVIDER - IRF	2, 096	10	3, 987	0. 00	16. 04	
18. 00	SUBPROVI DER		_	_			18.00
19. 00	SKILLED NURSING FACILITY	0	0	0	0. 00	0.00	
20.00	NURSI NG FACI LI TY						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)			70			24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	1, 028. 84	27. 00
28. 00	Observation Bed Days		0	2, 697			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	O	133	271			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	O					33.00
33. 01	LTCH site neutral days and discharges	O					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

					12/31/2022	5/25/2023 3: 5	
		Full Time Equivalents		Di sch	arges		·
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	968	82	4, 309	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)			664	605		2.00
3. 00	HMO IPF Subprovi der			004	0		3.00
4. 00	HMO IRF Subprovider				33		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				99		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)						/.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	968	82	4, 309	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	189	1	344	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 outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			o			33.00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansi on COVID-19 PHE Acute Care						34.00
31.00	1. Simportal of Zaparisi on Covid 17 The Moute Care	ı I		1	'		, 51.50

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0059

					Ť	o 12/31/2022	Date/Time Pre 5/25/2023 3:5	
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	, p
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	93, 594, 978	108, 770	93, 703, 748	2, 139, 985. 00	43. 79	1.00
	instructions)			·				
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4.00
	Admi ni strati ve		_	_				
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	0. 00 0. 00	
	Physician-Part B		_	_				
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0. 00	6.00
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)		C					
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44.00	0	0	0	0. 00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		29, 251, 315	436, 959	29, 688, 274	504, 955. 50	58. 79	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		6, 369, 950	0	6, 369, 950	46, 283. 97	137. 63	11.00
12. 00	Contract Labor: Top Level		0	0	О	0.00	0. 00	12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		494, 312	0	494, 312	2, 368. 00	208. 75	13. 00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0. 00	14.00
	organization salaries and							
14. 01	wage-related costs Home office salaries		0	0	0	0. 00	0. 00	14. 01
14. 02	Related organization salaries		0	0	0	0.00	0. 00	
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	0	0	0. 00	0. 00	16.00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
	- Teaching		_	_				
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
47.00	WAGE-RELATED COSTS		10 110 005		10 110 005			1
17. 00	Wage-related costs (core) (see instructions)		13, 143, 235	0	13, 143, 235			17.00
18. 00	Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		4, 932, 987	0	4, 932, 987			19.00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	О			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
	Physician Part B		0	0	ő			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
	approved program)		O					
25. 50	Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization		0	0	0			25. 51
	wage-related (core)							
25 52			Λ	^	_			25 52
25. 52	, ,		0	0	0			25. 52

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION RI VERVI EW HOSPI TAL Provi der CCN: 15-0059

					11	0 12/31/2022	5/25/2023 3:5	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
				A-6)	ŕ		ŕ	
		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)							
	OVERHEAD COSTS - DIRECT SALARI							
26. 00	Employee Benefits Department	4. 00	622, 650	l .	622, 650		39. 34	
27.00	Administrative & General	5. 00	7, 528, 708	-219, 036	7, 309, 672		27. 56	
28. 00	Administrative & General under		217, 901	0	217, 901	1, 068. 79	203. 88	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	2, 357, 346	l .	2, 357, 346		34. 11	
31.00	Laundry & Linen Service	8. 00	82, 569	l .	82, 569		18. 06	
32.00	Housekeepi ng	9. 00	1, 181, 088	0	1, 181, 088	55, 093. 50	21. 44	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10.00	1, 299, 416	-961, 328	338, 088	15, 919. 75		34.00
35.00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
	instructions)							
36.00	Cafeteria	11. 00	0	805, 780	805, 780			36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37.00
38. 00	Nursing Administration	13.00	552, 063	0	552, 063	11, 693. 50	47. 21	38. 00
39.00	Central Services and Supply	14. 00	777, 394	0	777, 394	27, 778. 50	27. 99	39.00
40.00	Pharmacy	15. 00	2, 700, 041	-281, 411	2, 418, 630	57, 502. 50	42. 06	40.00
41.00	Medical Records & Medical	16. 00	796, 689	0	796, 689	29, 041. 75	27. 43	41.00
	Records Li brary							
42.00	Social Service	17. 00	714, 588	0	714, 588	17, 054. 75	41. 90	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provi der CO	CN: 15-0059	Peri od:	Worksheet S-3	
					From 01/01/2022	Part III	
					To 12/31/2022	Date/Time Pre	pared:
						5/25/2023 3: 5	2 pm
	Worksheet A	Amount	Recl assi fi cat		Paid Hours	Average	

							5/25/2023 3: 5	2 pm
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		93, 812, 879	108, 770	93, 921, 649	2, 141, 053. 79	43. 87	1.00
	instructions)							
2.00	Excluded area salaries (see		29, 251, 315	436, 959	29, 688, 274	504, 955. 50	58. 79	2.00
	instructions)							
3.00	Subtotal salaries (line 1		64, 561, 564	-328, 189	64, 233, 375	1, 636, 098. 29	39. 26	3.00
	minus line 2)							
4.00	Subtotal other wages & related		6, 864, 262	0	6, 864, 262	48, 651. 97	141. 09	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		13, 143, 235	0	13, 143, 235	0. 00	20. 46	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		84, 569, 061	-328, 189	84, 240, 872	1, 684, 750. 26	50.00	6.00
7.00	Total overhead cost (see		18, 830, 453	-655, 995	18, 174, 458	607, 854. 54	29. 90	7.00
	instructions)							

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-1		
HOSPITAL WAGE RELATED COSTS		Peri od: Worksheet S-3 From 01/01/2022 Part IV To 12/31/2022 Date/Time Prep		

	10 12/31/2022	5/25/2023 3:5:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		l
	RETI REMENT COST		l
1.00	401K Employer Contributions	1, 738, 586	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	
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	0.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	0.0.
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	9, 043, 212	
8.03	Heal th Insurance (Purchased)	0	0.00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	220, 481	1
	Life Insurance (If employee is owner or beneficiary)	34, 399	
		0	1
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)	277, 007	14.00
15. 00		256, 784	1
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ative portion)		1
	TAXES		
	FICA-Employers Portion Only	6, 483, 358	•
	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unempl oyment Insurance	-12, 000	1
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
	<pre>instructions))</pre>	_	
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	34, 395	
24. 00		18, 076, 222	24.00
25 62	Part B - Other than Core Related Cost		25.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	ı ,	25. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-1		
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0059	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/25/2023 3:52 pm	

			0 12/31/2022	Date/IIme Pre 5/25/2023 3:5	
	Cost Center Description	·	Contract	Benefit Cost	
			Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		6, 369, 950	18, 076, 222	1. 00
2.00	Hospi tal		6, 369, 950	18, 076, 222	2.00
3.00	SUBPROVI DER - I PF				3.00
4. 00	SUBPROVI DER - I RF		0	0	4. 00
5. 00	Subprovi der - (Other)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	SKILLED NURSING FACILITY		0	0	8. 00
9. 00	NURSING FACILITY				9. 00
10.00					10.00
11. 00	· ·				11. 00
12. 00	· /				12.00
13. 00	1				13.00
14. 00	· ·				14.00
15. 00	· •				15. 00
16. 00	· ·				16. 00
17. 00			0	0	17. 00
18. 00	0ther		0	0	18. 00

Heal th	Financial Systems RIVERVIEW HO	ISPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C	CN: 15-0059	Peri od:	Worksheet S-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared: 2 pm
	ht				1. 00	
1 00	Uncompensated and indigent care cost computation	البياط مطاميا	ine 202 celum	on (I)	0.275420	1 00
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 Medicaid (see instructions for each line)	divided by i	THE 202 COLU	III 8)	0. 275428	1. 00
2. 00	Net revenue from Medicaid				7, 396, 733	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 supplement	ental paymen	ts from Medic	cai d?	Υ	4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medica	i d		0	5.00
6.00	Medi cai d charges				76, 793, 628	
7.00	Medicaid cost (line 1 times line 6)			0 1 5 . 1 6	21, 151, 115	
8. 00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	m (line / mii	nus sum ot II	nes 2 and 5; IT	13, 754, 382	8. 00
	Children's Health Insurance Program (CHIP) (see instructions	for each li	ne)			
9. 00	Net revenue from stand-alone CHIP		10)		0	9. 00
10.00	Stand-alone 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 CHI	P (line 11 mi	inus line 9;	if < zero then	0	12.00
	enter zero)	notrusti ono t	For sook line	.)		
13. 00	Other state or local government indigent care program (see in Net revenue from state or local indigent care program (Not in				0	13. 00
14. 00	Charges for patients covered under state or local indigent care				Ö	14.00
	10)					
15. 00	State or local indigent care program cost (line 1 times line				0	15.00
16. 00	Difference between net revenue and costs for state or local	indigent car	e program (li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, (CHIP and sta	te/local indi	gent care progra	ıms (see	
	instructions for each line)					
17. 00	1				0	
18. 00 19. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Lo			ne (sum of lines	13, 754, 382	
17.00	8, 12 and 16)	car margent	care program	is (sum of fiftes	15, 754, 562	17.00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts for the entire	facility	6, 271, 1	36 1, 093, 409	7, 364, 545	20.00
	(see instructions)					
21. 00	Cost of patients approved for charity care and uninsured dis	counts (see	1, 727, 2	1, 093, 409	2, 820, 655	21. 00
22. 00	instructions) Payments received from patients for amounts previously write	en off as		0 0	0	22. 00
22.00	charity care	cii oii us				22.00
23. 00	Cost of charity care (line 21 minus line 22)		1, 727, 2	1, 093, 409	2, 820, 655	23.00
					1.00	
24 00	Does the amount on line 20 column 2, include charges for pat	iont dove bo	uand a Langth	of atou limit	1. 00 N	24.00
24. 00	imposed on patients covered by Medicaid or other indigent ca		yond a rengtr	1 OF Stay ITHII t	IN	24. 00
25. 00	If line 24 is yes, enter the charges for patient days beyond stay limit	. 0	t care progra	am's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see	instructions)		16, 808, 671	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital comp				42, 913	
27. 01	Medicare allowable bad debts for the entire hospital complex	(see instru	ctions)		66, 020	27. 01
28. 00	Non-Medicare bad debt expense (see instructions)	_			16, 742, 651	28. 00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt	expense (see	i nstructi ons	s)	4, 634, 502	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus	line 20)			7, 455, 157 21, 209, 539	
31.00	Trotal and elimbal sea and uncompensated calle cost (fille 19 plus	11116 30)			21, 209, 339	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	RIVERVIEW H	Provider CO	°N: 15_0059 P	In Lie eriod:	u of Form CMS-: Worksheet A	2552-10
KLULAS	STITCATION AND ADJUSTMENTS OF TRIAL BALANCE O	I LAFLINGES	FI OVI dei Co	F	rom 01/01/2022		
				T	o 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared: 2 pm
	Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	OO100 CAP REL COSTS-BLDG & FIXT OO400 EMPLOYEE BENEFITS DEPARTMENT	422 450	21, 779, 438 8, 178, 228			21, 287, 660 9, 667, 729	1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	622, 650 7, 528, 708	40, 836, 501			48, 856, 987	5.00
7. 00	00700 OPERATION OF PLANT	2, 357, 346	7, 088, 116			9, 445, 462	1
8. 00	00800 LAUNDRY & LINEN SERVICE	82, 569	1, 422, 453			1, 505, 022	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 181, 088 1, 299, 416	1, 152, 351 2, 159, 183			2, 333, 439 894, 249	
11. 00	01100 CAFETERI A	1, 299, 410	2, 134, 163	0, 450, 577	2, 144, 710	2, 144, 710	1
13.00	01300 NURSING ADMINISTRATION	552, 063	89, 201		0	641, 264	13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	777, 394	198, 632			8, 708, 580	
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	2, 700, 041 796, 689	19, 223, 576 535, 278		-309, 411 0	21, 614, 206 1, 331, 967	
17. 00	01700 SOCIAL SERVICE	714, 588	239, 708			954, 296	
23. 00	02300 PARAMED ED PRGM PHARMACY	0	0			296, 162	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	40 774 054	0.005.444	44.400.775	F00 0F4	40 545 744	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	10, 774, 051 2, 975, 944	3, 335, 614 1, 546, 095			13, 515, 714 4, 277, 588	
41. 00	04100 SUBPROVI DER - I RF	1, 528, 814	1, 033, 048			2, 489, 978	
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	4, 582, 059	10, 221, 921	14, 803, 980	-4, 176, 932	10, 627, 048	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 027	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 219, 802	774, 370			2, 983, 921	
55. 00	05500 RADI OLOGY-THERAPEUTI C	508, 954	593, 293		845	1, 103, 092	1
57. 00 57. 01	05700 CT SCAN 03630 ULTRA SOUND	469, 787 448, 660	221, 857 50, 752			580, 564 493, 321	
58. 00	05800 MRI	332, 689	48, 647			374, 437	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	927, 536	1, 598, 807			1, 785, 444	
60. 00 60. 01	06000 LABORATORY	3, 392, 101	6, 825, 224	10, 217, 325	-2, 913	10, 214, 412	60.00
63.00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	533, 314	533, 314	0	0 533, 314	
64.00	06400 I NTRAVENOUS THERAPY	Ö	0	0	Ö	0	64.00
65.00	06500 RESPI RATORY THERAPY	1, 654, 638	651, 830			2, 177, 757	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	5, 127, 607	1, 513, 946	6, 641, 553	-7, 091 0	6, 634, 462 0	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	602, 834	187, 190	790, 024	-213	789, 811	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	9, 491, 902	9, 491, 902	0	9, 491, 902 0	1
	07400 RENAL DIALYSIS	0	355, 633	355, 633	-2, 082	353, 551	
	03020 OTHER ANCI LLARY	0	0	0	0	0	76. 00
76. 01	03140 CARDI AC REHAB 03070 WOMEN' S CENTER	796, 262	350, 619			1, 010, 353	1
76. 02 76. 03	03330 ENDOSCOPY	477, 213 0	164, 637 0	641, 850 0	-73, 684 0	568, 166 0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	O	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS	077 000	407.040	F. 4 504	0= =00	500.000	
90. 00 90. 01	09000 CLI NI C 09001 OUTPATI ENT	377, 203 606, 534	187, 318 843, 803			528, 932 1, 157, 882	1
90. 01	09002 NEUROPSYCHOLOGY	398, 572	131, 703			530, 275	
91.00	09100 EMERGENCY	9, 058, 665	23, 020, 739			30, 714, 671	1
91. 01	09101 SHORT STAY	0	0	0	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	41, 802	34, 043	75, 845	0	75, 845	95.00
102.00	10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
110 00	SPECIAL PURPOSE COST CENTERS	4E 014 270	1// /10 070	232, 533, 249	140.024	222 (04 172	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	65, 914, 279	166, 618, 970	232, 533, 249	160, 924	232, 694, 173] 18.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	118, 547	133, 541	252, 088	0	252, 088	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	21, 987, 162	10, 962, 616			32, 377, 333	
	19201	192, 673	23, 445			216, 118	
	19202 CLINICS 19206 HOME HEALTH PARTNERSHIP	972, 896 0	202, 946 1, 617	1, 175, 842 1, 617		1, 175, 100 1, 617	192. 02
192. 04	19207 WESTFI ELD SCHOOLS	1, 192, 253	169, 076			1, 360, 862	
	19203 PRACTI CE MANAGEMENT	411, 136	672, 921	1, 084, 057		1, 084, 057	1
	19204 MOB - NOBLESVILLE SQUARE 19208 PHYSICIANS' PRIVATE OFFICES	0	59, 166 0	59, 166 0	0		192. 06 192. 07
	19205 RI VERVI EW MEDI CAL ARTS	0	151, 554		-	151, 554	
	19209 BEHAVI OR CARE	503, 969	182, 852		o	686, 821	
_							

Health Financial Systems	RI VERVI EW H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Period: From 01/01/2022	Worksheet A	
				To 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared: 2 pm
Cost Center Description	Sal ari es	0ther	,	Recl assi fi cat		
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
193. 00 19300 NONPAI D WORKERS	0	0		0	0	193. 00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	267	26	7 0	267	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	47, 634	4, 921	52, 55	5 0	52, 555	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	520, 739	81, 363	602, 10	2 0	602, 102	193. 03
193.04 19304 OB/GYN SPEC GATHERS	117, 491	22, 409	139, 90	0	139, 900	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	768, 142	103, 190	871, 33	2 0	871, 332	193. 05
193. 06 19306 OUTPATIENT PHARMACY	576, 634	4, 266, 395	4, 843, 02	9 -72	4, 842, 957	193. 06
194. 00 07950 WORKMED	271, 423	283, 566	554, 98	9 -1, 214	553, 775	194. 00
194. 01 07951 MEALS ON WHEELS	O	0		0 414, 016	414, 016	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	93, 594, 978	183, 940, 815	277, 535, 79	3 0	277, 535, 793	200. 00

 Health Financial
 Systems
 RIVERVI

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0059

Period: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm

			5/25/2023 3: 52	ma
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00 00100 CAP REL COSTS-BLDG & FLXT	-31, 742	21, 255, 918		1.00
4. 00 O0400 EMPLOYEE BENEFITS DEPARTMENT	-53, 824	9, 613, 905		4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-20, 421, 895	28, 435, 092		5. 00
7.00 00700 OPERATION OF PLANT	0	9, 445, 462		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	1, 505, 022		8.00
9. 00 00900 HOUSEKEEPI NG	0	2, 333, 439		9.00
10. 00 01000 DI ETARY	-108, 685	785, 564		10. 00
11. 00 01100 CAFETERI A	-703, 990	1, 440, 720		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	641, 264		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	59 0	8, 708, 639		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-1, 411	21, 614, 206 1, 330, 556		16. 00
17. 00 01700 SOCIAL SERVICE	0	954, 296		17. 00
23. 00 02300 PARAMED ED PRGM PHARMACY	o	296, 162		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	- '			
30. 00 03000 ADULTS & PEDI ATRI CS	0	13, 515, 714	3	30.00
31.00 03100 INTENSIVE CARE UNIT	0	4, 277, 588		31. 00
41. 00 04100 SUBPROVI DER - I RF	0	2, 489, 978		41. 00
43. 00 04300 NURSERY	0	0		43.00
44. 00 04400 SKILLED NURSING FACILITY	0	0		44. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	-2, 527, 767	8, 099, 281		50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-2, 327, 707	0, 044, 201		52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	-3, 153	2, 980, 768		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 103, 092		55. 00
57.00 05700 CT SCAN	-2, 891	577, 673		57. 00
57. 01 03630 ULTRA SOUND	-316	493, 005	Ę	57. 01
58. 00 05800 MRI	0	374, 437		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	-735, 000	1, 050, 444		59. 00
60. 00 06000 LABORATORY	-91, 455	10, 122, 957		60.00
60. 01 06001 BLOOD LABORATORY	0	0		60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	533, 314		63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	2, 177, 757		64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	-78, 489	6, 555, 973		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	70, 407	0, 333, 773		67. 00
68. 00 06800 SPEECH PATHOLOGY	Ö	o		68. 00
69. 00 06900 ELECTROCARDI OLOGY	-105, 604	684, 207		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 491, 902	7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
74. 00 07400 RENAL DI ALYSI S	0	353, 551		74. 00
76. 00 03020 OTHER ANCI LLARY	0	0		76. 00
76. 01 03140 CARDI AC REHAB	-686	1, 009, 667		76. 01
76. 02 03070 WOMEN' S CENTER 76. 03 03330 ENDOSCOPY	0	568, 166 0		76. 02 76. 03
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	- 1		70. 03 77. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		77.00
90. 00 09000 CLINIC	0	528, 932		90. 00
90. 01 09001 OUTPATI ENT	-14, 311	1, 143, 571		90. 01
90. 02 09002 NEUROPSYCHOLOGY	-265, 019	265, 256		90. 02
91. 00 09100 EMERGENCY	-13, 393, 409	17, 321, 262		91. 00
91. 01 09101 SHORT STAY	0	0		91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	105	75 720		95. 00
95. 00 09500 AMBULANCE SERVI CES 102. 00 10200 OPI OI D TREATMENT PROGRAM	-125 0	75, 720 0		95. 00 02. 00
SPECIAL PURPOSE COST CENTERS	U _I	U _I		02.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-38, 539, 713	194, 154, 460	11	18. 00
NONREI MBURSABLE COST CENTERS	00,007,710	17171017100		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	252, 088	19	90.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	32, 377, 333	19	92.00
192. 01 19201 FOUNDATI ON	0	216, 118	19	92. 01
192. 02 19202 CLI NI CS	0	1, 175, 100		92. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	1, 617		92. 03
192. 04 19207 WESTFI ELD SCHOOLS	0	1, 360, 862		92.04
192. 05 19203 PRACTI CE MANAGEMENT	0	1, 084, 057		92.05
192. 06 19204 MOB - NOBLESVILLE SQUARE	0	59, 166		92.06
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES 192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	151 554		92. 07 92. 08
192. 08 19205 RI VERVI EW MEDICAL ARTS 192. 09 19209 BEHAVI OR CARE	0	151, 554 686, 821		92. 08 92. 09
193. 00 19300 NONPALD WORKERS	0	080, 821		92. 09 93. 00
		<u> </u>	10.	

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 01/01/2023

From 01/01/2022	
To 12/31/2022	Date/Time Prepared:
	5/25/2023 3:52 pm

			37 237 2023 3. 32 pili
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	267	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	52, 555	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	602, 102	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	139, 900	193. 04
193.05 19305 OB SPECIALISTS DAVENPORT	0	871, 332	193. 05
193. 06 19306 OUTPATIENT PHARMACY	0	4, 842, 957	193. 06
194. 00 07950 WORKMED	0	553, 775	194. 00
194.01 07951 MEALS ON WHEELS	0	414, 016	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-38, 539, 713	238, 996, 080	200.00

| Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | Dat

					10	12/31/2022	5/25/2023 3:52 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - CAFETERIA RECLASS						
00	CAFETERI A	1100	<u>805, 7</u> 80	1, 338, 930			1.
	TOTALS		805, 780	1, 338, 930			
	B - MEALS ON WHEELS RECLASS						
00	MEALS ON WHEELS	194. 01	155, 548	258, 468			1.
	TOTALS		155, 548	258, 468			
	C - INSURANCE RECLASS		· · · · ·				
00	ADMINISTRATIVE & GENERAL	5. 00		491, 778			1.
	TOTALS	+		491, 778			
	D - MEDICAL SUPPLY RECLASS		٩	17.17.70			
00	CENTRAL SERVICES & SUPPLY	14. 00		7, 732, 554			1.
00	RADI OLOGY-THERAPEUTI C	55. 00		845			2.
00	INADI OLOGI - MENAI LOTT C	0.00	o	0			3.
00		· · · · · · · · · · · · · · · · · · ·	o	0			1
		0.00	- 1				4.
00		0. 00	0	0			5.
00		0.00	0	0			6.
00		0.00	0	0			7.
00		0. 00	0	0			8.
00		0. 00	0	0			9.
. 00		0.00	0	0			10.
.00		0.00	O	0			11.
00		0.00	o	0			12.
00		0. 00	ol	0			13
. 00		0.00	ő	0			14
. 00		0.00	o	0			15.
. 00		0.00	0	0			16.
							•
. 00		0. 00	0	0			17.
. 00		0.00	0	0			18.
. 00		0. 00	0	0			19.
. 00		0. 00	0	0			20.
. 00		0. 00	0	0			21.
. 00		0.00	0	0			22.
. 00		0.00	0	0			23.
. 00		0.00	o	0			24.
00		0.00	0	0			25.
. 00		0.00	0	0			26
. 00		0.00	0	0			27.
00	TOTALS — — — —	+		7, 733, 399			
	E - RSMA RECLASS		<u> </u>	7, 733, 377			
00	OPERATING ROOM	50.00	327, 806				1.
00		4. 00	321,000	10 220			
JU	EMPLOYEE BENEFITS DEPARTMENT			10, 228			2.
	TOTALS		327, 806	10, 228			
	F - PARAMED ED RECLASS	00.00	004 444	44.754			
00	PARAMED ED PRGM PHARMACY	2300	281, 411	14, 751			1.
	TOTALS		281, 411	14, 751			
	G - COMMUNITY RELATIONS RECLAS	SS					
00	ADMINISTRATIVE & GENERAL	5. 00		219, 036			1.
	TOTALS	+		219, 036			
	H - ALLOCATED BENEFITS RECLASS	<u> </u>	31	,			
00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	857, 588			1.
,,,	TOTALS			857, 588			'
			U	037, 300			

Provider CCN: 15-0059

Period: Worksheet A-o From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm

						5/25/2023 3: 5	52 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10.00	805, 780	1, 338, 930	0		1.00
	TOTALS		805, 780	1, 338, 930			1
	B - MEALS ON WHEELS RECLASS	<u>'</u>	<u> </u>		<u> </u>		1
1.00	DI ETARY	10.00	155, 548	258, 468	0		1.00
00	TOTALS	 _	155, 548	258, 468			1
	C - INSURANCE RECLASS		100, 010	200, 100			1
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00		491, 778	12		1.00
1.00	TOTALS			491, 778			1.00
	D - MEDICAL SUPPLY RECLASS			471, 770			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		965	0		1.00
						•	
2.00	DIETARY	10.00		5, 624		•	2.00
3.00	PHARMACY	15. 00		13, 249		•	3.00
4.00	ADULTS & PEDIATRICS	30. 00		593, 951	0		4.00
5. 00	INTENSIVE CARE UNIT	31. 00		244, 451	0		5.00
6.00	SUBPROVI DER - I RF	41. 00		71, 884			6.00
7.00	OPERATI NG ROOM	50. 00		4, 166, 704	0		7.00
8. 00	RADI OLOGY-DI AGNOSTI C	54. 00		10, 251	0		8. 00
9.00	CT SCAN	57. 00		111, 080	0		9. 00
10.00	ULTRA SOUND	57. 01		6, 091	0		10.00
11.00	MRI	58. 00		6, 899	0		11.00
12.00	CARDI AC CATHETERI ZATI ON	59. 00		740, 899	0		12.00
13.00	LABORATORY	60.00		2, 913	0		13.00
14.00	RESPI RATORY THERAPY	65. 00		128, 711	0		14.00
15. 00	PHYSI CAL THERAPY	66. 00		7, 091	0		15.00
16. 00	ELECTROCARDI OLOGY	69. 00		213			16.00
17. 00	RENAL DI ALYSI S	74. 00		2, 082			17. 00
18. 00	CARDI AC REHAB	76. 01		136, 528			18.00
19. 00	WOMEN' S CENTER	76. 02		73, 684			19.00
20.00	CLI NI C	90.00		35, 589		•	20.00
	OUTPATI ENT	90.00				•	1
21. 00				292, 455			21.00
22.00	EMERGENCY	91.00		507, 145		•	22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192. 00		572, 445		•	23.00
24. 00	CLINICS	192. 02		742		•	24.00
25.00	WESTFIELD SCHOOLS	192. 04		467			25. 00
26.00	OUTPATI ENT PHARMACY	193. 06		72			26. 00
27.00	WORKMED	1 <u>94.</u> 00		<u>1, 2</u> 14			27. 00
	TOTALS		0	7, 733, 399			l
	E - RSMA RECLASS						l
1.00	OPERATING ROOM	50.00		338, 034	0		1.00
2.00		0.00	o	0	0		2.00
	TOTALS			338, 034			1
	F - PARAMED ED RECLASS		-1				1
1.00	PHARMACY	15. 00	281, 411	14, 751	0		1.00
1.00	TOTALS		281, 411	1 1, 7 51		1	1.00
	G - COMMUNITY RELATIONS RECLA	100	201, 411	14, 731			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	219, 036		0		1.00
1.00						•	1.00
	TOTALS		219, 036	0			1
	H - ALLOCATED BENEFITS RECLAS		,1				
1. 00	EMERGENCY	<u>91.</u> 00	•	85 <u>7, 5</u> 88			1.00
	TOTALS		0	857, 588			
500.00	Grand Total: Decreases		1, 461, 775	11, 032, 948			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RIVERVIEW HOSPITAL Provi der CCN: 15-0059

				To	12/31/2022	Date/Time Pre 5/25/2023 3:5:	
				Acqui si ti ons		3/23/2023 3. 3.	Z DIII
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	16, 050, 414	0	0	0	0	1.00
2.00	Land Improvements	3, 231, 090	99, 218	0	99, 218	0	2. 00
3.00	Buildings and Fixtures	166, 173, 303	513, 468	0	513, 468	0	3. 00
4.00	Building Improvements	1, 399, 855	17, 434, 328	0	17, 434, 328	0	4.00
5.00	Fixed Equipment	50, 300, 481	2, 383, 386	0	2, 383, 386	0	5. 00
6.00	Movable Equipment	122, 055, 242	3, 588, 268	0	3, 588, 268	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	359, 210, 385	24, 018, 668	0	24, 018, 668	0	1 0.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	359, 210, 385	24, 018, 668	0	24, 018, 668	0	10.00
		Endi ng	Fully				
		Bal ance	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, 330, 308	0				2.00
3.00	Buildings and Fixtures	166, 686, 771	0				3. 00
4.00	Building Improvements	18, 834, 183	0				4. 00
5. 00	Fixed Equipment	52, 683, 867	0				5.00
6.00	Movable Equipment	125, 643, 510	0				6. 00
7. 00	HIT designated Assets	0	0				7.00
8. 00	Subtotal (sum of lines 1-7)	383, 229, 053	0				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	383, 229, 053	0				10.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0059	Peri od: From 01/01/2022 To 12/31/2022		pared:	
			Sl	JMMARY OF CAP	PITAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10. 00	11.00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	21, 779, 438	0		0 0	0	1.00	
3.00	Total (sum of lines 1-2)	21, 779, 438	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	21, 779, 438				1.00	
3.00	Total (sum of lines 1-2)	0	21, 779, 438				3.00	

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre		
		COME	PUTATION OF RAT	ALLOCATION OF	5/25/2023 3: 5: OTHER CAPITAL	2 pm		
		33						
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio (col. 1 -	instructions)			
				col . 2)				
		1. 00	2.00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00	CAP REL COSTS-BLDG & FIXT	383, 229, 053		383, 229, 053			1.00	
3.00	Total (sum of lines 1-2)	383, 229, 053		383, 229, 053			3.00	
		ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY 0	F CAPI TAL		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
			Capi tal -Rel at					
			ed Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(21, 779, 438		1.00	
3.00	Total (sum of lines 1-2)	0	0	(21, 779, 438	0	3. 00	
			SL	JMMARY OF CAPI	IAL			
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
			(see	instructions)	Capi tal -Rel at	(sum of cols.		
			instructions)		ed Costs (see	9 through 14)		
					instructions)			
		11. 00	12. 00	13. 00	14. 00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C			1	_1			
1.00	CAP REL COSTS-BLDG & FIXT	-31, 742	· ·	1	0	21, 255, 918	1.00	
3.00	Total (sum of lines 1-2)	-31, 742	-491, 778	(0	21, 255, 918	3.00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0059

				Fr To	rom 01/01/2022 12/31/2022	Date/Time Pre	
				Expense Classification on	Worksheet A	5/25/2023 3: 5	2 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
	discounts (chapter 8)		0				
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5.00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A 0 2	0 257 044		0. 00	0	9.00
	adj ustment	A-8-2	-20, 357, 046				10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	254, 925			0	12.00
13. 00	Laundry and linen service	_	0		0. 00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-476, 914 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than		0		0.00	0	10.00
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
	abstracts		0				
19. 00	Nursing and allied health education (tuition, fees,		Ü		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20.00
	Income from imposition of		0		0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	U	RESPIRATORY THERAPY	65. 00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	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 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30.00	therapy costs in excess of	A 0-3	0	SOCOLATIONAL ITEMALI	07.00		30.00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)						

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0059 Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm Peri od: Worksheet A-8

						5/25/2023 3:5	2 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31.00
31.00		7, 0, 3	0	SI ELGII I ATTIOLOGI	00.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0. 00	0	32.00
	Depreciation and Interest						
33.00	HAF EXPENSE	Α	-14, 549, 852	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	ADMI NI STRATI ON	Α	-8, 987	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
	RECRUI TMENT/SPECI AL E		,				
33. 02	OTHER REV MEDICAL REPORT	В	_1 /11	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 02
		В				0	
33. 03	OTHER REVENUES ->PURCHASE	В	-12, 356	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
	DI SCOUNTS						
33. 04	RADI OLOGY- OTHER REVENUE-CDS	В	-3, 153	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 04
	FOR LEG						
33. 05	AMBULANCE OTHER REVENUE	В	-125	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	1
	al .					_	l
33. 08	INFORMATION SYSTEMS OTHER REV	В		WOMEN'S CENTER	76. 02	0	
33. 09	ADMINISTRATION LEAN TEAM	В		EMERGENCY	91. 00	0	33. 09
33. 10	EDUCATION -> OTHER REVENUE	В	-16, 263	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 11	OP PHARMACY REVENUE	Α	0	PHARMACY	15. 00	0	33. 11
33. 12	DIETARY SALES PR DEDUCT	В	-227 076	CAFETERI A	11. 00	0	33. 12
33. 13	WELLNESS SERVICES -	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 13
55. 15	EXTERNAL->-OTHER	ь	-10, 312	LWI LOTEL DEIVELTTS DEI AKTIMENT	4.00	0	33. 13
00.44			_	OFNITRAL CERVILOGO A CURRILY	44.00		00.44
33. 14	OTHER REV PREMIER PROGRAM	В		CENTRAL SERVICES & SUPPLY	14. 00	0	
33. 15	WESTFIELD BISTRO-OTHER REVENUE	В	-108, 685		10. 00	0	
33. 16	NON-OP REV -> MI SCELLANEOUS	В	-31, 742	CAP REL COSTS-BLDG & FLXT	1. 00	11	33. 16
	INTEREST						
33. 17	COMMUNITY RELATIONS	Α	-2.097.304	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	COMMUNITY RELATIONS BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1
33. 19	CRNA	A		OPERATING ROOM	50. 00	0	•
	4					_	ł
33. 20	I HA LOBBYI NG EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 21	CV SERVICES-OTHER REVENUE	В		ELECTROCARDI OLOGY	69. 00	0	
33. 22	CT SCAN-OTHER REVENUE	В	-2, 891	CT SCAN	57. 00	0	33. 22
33. 23	FISCAL SERVICES COMMERCE BANK	В	-114, 234	ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
	REBATE		·				
33. 24	ULTRASOUND - OTHER REVENUE	В	_316	ULTRA SOUND	57. 01	0	33. 24
33. 25	WOUND CARE-OTHER REVENUE	В		OUTPATI ENT	90. 01	0	
	4					_	
33. 26	NON-OP EXPENSE INVESTMENT FEES			ADMINISTRATIVE & GENERAL	5. 00	0	
33. 27	OTHER MISC REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 28	NEUROPSYCHOLOGY OTHER REVENUE	В	-1, 023	NEUROPSYCHOLOGY	90. 02	0	33. 28
33. 29	OTHER REV RADIOLOGY FILM	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 29
33. 30	ADMIN DONATIONS	В		ADMINISTRATIVE & GENERAL	5. 00	0	ı
33. 31	CENTRAL PROCESSING OTHER	В		CENTRAL SERVICES & SUPPLY		0	33. 31
აა. ა I		Ď	59	CLIVIKAL SERVICES & SUPPLY	14. 00	U	33.31
	REVENUE						
50.00	TOTAL (sum of lines 1 thru 49)		-38, 539, 713				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) Do	scription - all chapter referen	cos in this co	lump portain t	o CMC Dub. 1E 1			

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELA	FED 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	51.00	O. C	0	6. 00
7.00			0. 00	0.0	0	7.00
8.00			0. 00	0.0	0	8.00
9. 00			0.00	0.0	0	9.00
10.00			0.00	0.0	0	10.00
100.00	G. Other (financial or				1	100.00
	non-financial) specify:					

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

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syst	ems			RIVERVIEW HOS	SPITAL			1	n Li eu	ม of Form CMS-	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED O	RGANI ZATI O	NS AND HOME	Provi der	CCN:	15-0059	Peri od:		Worksheet A-	8-1
OFFICE	COSTS								From 01/01.		Date/Time Pr	epared.
										, 2022	5/25/2023 3:	52 pm
		Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
		RED AND ADJUST	MENTS REQU	RED AS A	RESULT OF TRA	ANSACTI ONS	SWIT	H RELATED	ORGANI ZATI O	NS OR	CLAIMED HOME	
	OFFICE COSTS:											
1. 00	254, 925	0										1.00
2. 00	0	0										2.00
3. 00	0	0										3.00
4. 00	0	0										4.00
5. 00	254, 925											5.00
* The	amounts on lin	es 1-4 (and sul	oscripts as	s appropria	ate) are trar	sferred i	n de	tail to Wo	rksheet A, d	col umn	6, lines as	
appropr	i ate. Posi ti ve	amounts increas	se cost and	l negative	amounts decr	ease cost	. For	related o	rgani zati on	or ho	me office cos	t which
has not	been posted t	o Worksheet A,	columns 1	and/or 2,	the amount a	ıllowable	shoul	ld be indi	cated in col	umn 4	of this part	
	Related Orga	ani zati on(s)										
	and/or Ho	ome Office										
	Type of	Busi ness										
		00										

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	9.00
10.00	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100.00

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

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

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

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

Provi der CCN: 15-0059

| Peri od: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

						0 12/31/2022	5/25/2023 3:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov) <u> </u>
		I denti fi er	Remuneration	Component	Component	1102 711104111	ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	13, 942	13, 942	0	0	0	1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	3, 859, 228			0	0	2.00
3.00	50. 00	OPERATING ROOM	1, 906, 692	1, 906, 692	0	0	0	3.00
4.00	59. 00	CARDIAC CATHETERIZATION	735, 000	735, 000	0	0	0	4.00
5. 00	66. 00	PHYSI CAL THERAPY	78, 489	78, 489	0	0	0	5. 00
6. 00	69. 00	ELECTROCARDI OLOGY	105, 604	105, 604	0	0	0	6. 00
7. 00		CARDI AC REHAB	686	686	0	0	0	7. 00
8. 00	90. 02	NEUROPSYCHOLOGY	263, 996	263, 996	0	0	0	8. 00
9. 00	91. 00	EMERGENCY	13, 393, 409	13, 393, 409	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			20, 357, 046	20, 357, 046	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		EMPLOYEE BENEFITS DEPARTMENT	0	0	_	-	0	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	0	0		0	0	2.00
3.00		OPERATING ROOM	0	0	0	0	0	3.00
4.00	59. 00	CARDIAC CATHETERIZATION	0	0	0	0	0	4.00
5. 00	66. 00	PHYSI CAL THERAPY	0	0	0	0	0	5.00
6.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	6.00
7. 00	76. 01	CARDI AC REHAB	0	0	0	0	0	7.00
8. 00	90. 02	NEUROPSYCHOLOGY	0	0	0	0	0	8. 00
9. 00	91. 00	EMERGENCY	0	0	0	0	0	9.00
10.00	0. 00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	17.00	10.00		
1 00	1.00	2.00	15. 00	16. 00	17. 00	18. 00		4.00
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	0				1.00
2.00		ADMINISTRATIVE & GENERAL	0	0		3, 859, 228		2.00
3.00		OPERATING ROOM	0	0		1, 906, 692		3.00
4. 00		CARDI AC CATHETERI ZATI ON	0	0	· ·	735, 000	•	4.00
5.00		PHYSI CAL THERAPY	0	0	0	78, 489	•	5.00
6.00		ELECTROCARDI OLOGY	0]	0	105, 604	•	6.00
7. 00		CARDI AC REHAB	0	0				7.00
8. 00		NEUROPSYCHOLOGY	0	0		263, 996		8. 00
9.00		EMERGENCY	0	0		13, 393, 409	1	9.00
10.00	0. 00		0	0	0	0	1	10.00
200.00			0	0	0	20, 357, 046	I	200.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0059

					Ť	0 12/31/2022	Date/Time Pre 5/25/2023 3:5	
				CAPI TAL			372372023 3.3	z piii
				RELATED COSTS				
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI V	
			Allocation		DEPARTMENT		E & GENERAL	
			(from Wkst A					
			col . 7)	1.00			5.00	
	GENER	AL SERVICE COST CENTERS	0	1.00	4. 00	4A	5. 00	
1. 00		CAP REL COSTS-BLDG & FIXT	21, 255, 918	21, 255, 918				1. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	9, 613, 905					4. 00
5.00		ADMINISTRATIVE & GENERAL	28, 435, 092				30, 809, 396	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	9, 445, 462 1, 505, 022			· · ·	2, 498, 806 231, 295	7. 00 8. 00
9. 00		HOUSEKEEPI NG	2, 333, 439			2, 496, 301	369, 425	9. 00
10.00		DI ETARY	785, 564	l '			185, 254	10. 00
11. 00 13. 00		CAFETERI A	1, 440, 720	l e			225, 627 103, 407	11.00
14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	641, 264 8, 708, 639	l e	,		1, 335, 688	13. 00 14. 00
15. 00	01500	PHARMACY	21, 614, 206	294, 317			3, 279, 490	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	1, 330, 556				220, 773	16.00
17. 00 23. 00		SOCIAL SERVICE PARAMED ED PRGM PHARMACY	954, 296 296, 162				160, 475 48, 942	17. 00 23. 00
23.00		IENT ROUTINE SERVICE COST CENTERS	270, 102	5, 252	29, 302	330, 710	40, 742	23.00
30.00	03000	ADULTS & PEDIATRICS	13, 515, 714	3, 175, 678		·	2, 636, 164	30.00
31.00		INTENSIVE CARE UNIT	4, 277, 588				749, 758	31.00
41. 00 43. 00		SUBPROVIDER - IRF NURSERY	2, 489, 978	506, 261 0			466, 968 0	41. 00 43. 00
44. 00		SKILLED NURSING FACILITY	0				0	44. 00
	ANCI L	LARY SERVICE COST CENTERS		-				
50.00		OPERATING ROOM	8, 099, 281	1, 710, 194			1, 527, 352	50.00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0 2, 980, 768	0 450, 251	1	-	0 541, 959	52. 00 54. 00
55. 00		RADI OLOGY-THERAPEUTI C	1, 103, 092				207, 072	55. 00
57.00	05700	CT SCAN	577, 673				92, 728	
57. 01		ULTRA SOUND	493, 005	l e		539, 722	79, 873	
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	374, 437 1, 050, 444	0 79, 966			60, 539 181, 581	58. 00 59. 00
60.00		LABORATORY	10, 122, 957	491, 318			1, 623, 066	60.00
60. 01		BLOOD LABORATORY	0	0	0	-	0	60. 01
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	533, 314	83, 694	0	617, 008	91, 310 0	63. 00 64. 00
65. 00	1	RESPIRATORY THERAPY	2, 177, 757	49, 877	172, 289	2, 399, 923	355, 162	65. 00
66. 00		PHYSI CAL THERAPY	6, 555, 973				1, 072, 783	66. 00
67. 00		OCCUPATI ONAL THERAPY	0	0	O	0	0	67.00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0 684, 207	0 224, 854	62, 770	971, 831	0 143, 820	68. 00 69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	084, 207	224, 654	02,770	971,031	143, 620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9, 491, 902	0	C	9, 491, 902	1, 404, 697	
73.00		DRUGS CHARGED TO PATIENTS	0	l	1	0	0	73.00
		RENAL DIALYSIS OTHER ANCILLARY	353, 551 0	31, 478 0			56, 980 0	
76. 01		CARDI AC REHAB	1, 009, 667	372, 690		-	216, 844	
76. 02	03070	WOMEN'S CENTER	568, 166				137, 654	76. 02
76. 03		ENDOSCOPY	0	0			0	76. 03
77. 00		ALLOGENEIC STEM CELL ACQUISITION TIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
90.00		CLINIC	528, 932	81, 694	39, 276	649, 902	96, 178	90.00
90. 01		OUTPATI ENT	1, 143, 571	118, 967			196, 188	90. 01
90. 02	1	NEUROPSYCHOLOGY	265, 256				53, 911	90.02
91. 00 91. 01		EMERGENCY SHORT STAY	17, 321, 262 0	718, 409 0	1		2, 809, 261 0	91. 00 91. 01
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	9			0		92.00
		REIMBURSABLE COST CENTERS						
		AMBULANCE SERVICES OPIOID TREATMENT PROGRAM	75, 720 0	l ·	1		13, 219	95. 00 102. 00
102.00		AL PURPOSE COST CENTERS	0	0		0	U	102.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194, 154, 460	19, 430, 925	6, 793, 621	189, 430, 979	23, 474, 249	118. 00
100.00		IMBURSABLE COST CENTERS	050,000	202 000	10.044	4/0 444	(0.000	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	252, 088 32, 377, 333				69, 320 5, 370, 251	
		FOUNDATION	32, 377, 333 216, 118				34, 952	
192. 02	19202	CLINICS	1, 175, 100	l	101, 303	1, 276, 403	188, 894	192. 02
		HOME HEALTH PARTNERSHIP	1, 617	0	124 143	.,		192.03
		WESTFIELD SCHOOLS PRACTICE MANAGEMENT	1, 360, 862 1, 084, 057	l .	124, 143 42, 810		219, 764 166, 764	
	1	MOB - NOBLESVILLE SQUARE	59, 166	l				192. 05 192. 06
							-,	· · · · · ·

					5/25/2023 3:5	2 pm
	No. 1. E	CAPITAL RELATED COSTS	EMDI OVEE	6 1 1 1 1	ADMINI CEDATIV	
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost		BENEFI TS		E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1. 00	4.00	4A	5. 00	
192.07 19208 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 07
192.08 19205 RIVERVIEW MEDICAL ARTS	151, 554	0	0	151, 554	22, 428	192. 08
192. 09 19209 BEHAVI OR CARE	686, 821	0	52, 476	739, 297	109, 408	192. 09
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	267	0	0	267	40	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	52, 555	0	4, 960	57, 515	8, 512	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	602, 102	0	54, 222	656, 324	97, 129	193. 03
193.04 19304 OB/GYN SPEC GATHERS	139, 900	0	12, 234	152, 134	22, 514	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	871, 332	0	79, 983	951, 315	140, 784	193. 05
193. 06 19306 OUTPATIENT PHARMACY	4, 842, 957	0	60, 042	4, 902, 999	725, 590	193. 06
194. 00 07950 WORKMED	553, 775	0	28, 262	582, 037	86, 135	194.00
194.01 07951 MEALS ON WHEELS	414, 016	0	16, 196	430, 212	63, 667	194.01
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	238, 996, 080	21, 255, 918	9, 692, 109	238, 996, 080	30, 809, 396	202. 00

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm

				12/31/2022	5/25/2023 3:5	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	_ p
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11.00	
GENERAL SERVICE COST CENTERS			<u> </u>			
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT	19, 383, 882					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	77, 253	1, 871, 468				8.00
9. 00 00900 HOUSEKEEPI NG	62, 493	0	-,,	0 400 000		9.00
10. 00 01000 DI ETARY	675, 420	0	309, 852	2, 422, 332		10.00
11. 00 01100 CAFETERI A	0	0	0	0	1, 750, 249	11.00
13.00 O1300 NURSING ADMINISTRATION	이	0	0	이	16, 707	•
14.00 01400 CENTRAL SERVICES & SUPPLY	369, 806	15, 167	136, 398	0	39, 686	14.00
15. 00 01500 PHARMACY	461, 182	0	88, 754	0	82, 150	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	122, 702	0	0	0	41, 491	16.00
17. 00 01700 SOCIAL SERVICE	87, 235	0	17, 683	0	24, 366	17.00
23.00 02300 PARAMED ED PRGM PHARMACY	8, 230	0	0	ol	3, 487	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				- 1		
30. 00 03000 ADULTS & PEDIATRICS	4, 976, 158	632, 473	1, 797, 728	1, 694, 203	290, 505	30.00
31. 00 03100 I NTENSI VE CARE UNI T	750, 337	147, 446		191, 751	75, 930	31.00
41. 00 04100 SUBPROVI DER - I RF	793, 291	157, 649		536, 378	47, 657	1
43. 00 04300 NURSERY	773, 271	137, 047		330, 370	47,037	43.00
	o	0	0	ol ol	0	•
	υĮ	0	l 0	υ	0	44.00
ANCILLARY SERVICE COST CENTERS	0 (70 00=	105.011	(0.750	اء	100 (10	E0 00
50. 00 05000 OPERATING ROOM	2, 679, 805	195, 841	63, 750	0	180, 649	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	0	이	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	705, 525	118, 161	110, 605	0	76, 752	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	381, 009	16, 325		0	18, 645	
57. 00 05700 CT SCAN	0	0	110, 605	0	15, 839	57.00
57. 01 03630 ULTRA SOUND	0	0	0	0	12, 648	57. 01
58. 00 05800 MRI	ol	0	110, 605	ol	10, 878	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	125, 304	52, 063	l o	ol	25, 751	59.00
60. 00 06000 LABORATORY	769, 876	0	136, 398	0	145, 166	•
60. 01 06001 BLOOD LABORATORY	0	0	0	ő	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	131, 144	0		0	0	63.00
64. 00 06400 NTRAVENOUS THERAPY	131, 144	0		ol Ol	0	64.00
	70 154	0		ol ol		•
65. 00 06500 RESPI RATORY THERAPY	78, 156	17.014	42 014	U O	56, 473	1
66. 00 06600 PHYSI CAL THERAPY	249, 440	17, 014	43, 814	O	202, 992	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	O	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	이	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	352, 338	17, 317	0	0	22, 590	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	0	73.00
74. 00 07400 RENAL DI ALYSI S	49, 325	0	O	ol	0	74.00
76. 00 03020 OTHER ANCI LLARY	0	0	0	o	0	76.00
76. 01 03140 CARDI AC REHAB	583, 991	1, 489	ا	ol	33, 037	76. 01
76. 02 03070 WOMEN' S CENTER	489, 376	10, 065		Ö	23, 663	76.02
76. 03 03330 ENDOSCOPY	407, 370	0,009		0	25, 005	76.02
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	
	υĮ	0	l 0	υ	0	17.00
OUTPATIENT SERVICE COST CENTERS	400.040	0.700		ام	47.405	00.00
90. 00 09000 CLI NI C	128, 012	2, 730		O	17, 485	1
90. 01 09001 OUTPATI ENT	186, 416	54, 820		0	21, 613	1
90. 02 09002 NEUROPSYCHOLOGY	90, 155	0	0	0	13, 836	
91. 00 09100 EMERGENCY	1, 125, 718	272, 363	0	O	224, 544	
91. 01 09101 SHORT STAY	o	0	0	o	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	14, 495	0	0	ol	2, 049	95.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		ol		102.00
SPECIAL PURPOSE COST CENTERS	٧		<u>۷</u>	<u> ۲</u>		102.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 524, 192	1, 710, 923	2, 926, 192	2, 422, 332	1, 726, 589	110 00
	10, 524, 172	1, /10, 723	2, 720, 172	2, 422, 332	1, 720, 307	1110.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	210 (24	^	2 007	<u></u>	/ 500	100.00
	319, 631	450 1::	2, 027	٥		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 540, 059	159, 166		0		192.00
192. 01 19201 FOUNDATI ON	0	0	0	0		192. 01
192. 02 19202 CLI NI CS	0	717	0	0		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192. 03
192. 04 19207 WESTFI ELD SCHOOLS	ol	0	0	ol	0	192. 04
192. 05 19203 PRACTI CE MANAGEMENT	ol	662	0	ol	0	192. 05
192.06 19204 MOB - NOBLESVILLE SQUARE	ol	0	0	ol		192.06
192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES	n	n	ا	n		192.07
192. 08 19205 RI VERVI EW MEDI CAL ARTS	n o	n	ا م	n n		192. 08
192. 09 19209 BEHAVI OR CARE	o	0	0	٥		192.09
193. 00 19300 NONPALD WORKERS	0	0	0	Š		192.09
193. 00 19300 NONPALD WORKERS 193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	0		Ö		193.00
170. OT TOUTH THE OF AIR SERVICES-LIUNS	·	0	ı U	·	0	1 7 J. U I

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0059 | Period: | Worksheet B | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | To 1

					5/25/2023 3:5	2 pm
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. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	0	0	0	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI	0	0	0	0	0	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	0	0	0	0	193. 04
193. 05 19305 OB 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	10, 465	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)	19, 383, 882	1, 871, 468	2, 928, 219	2, 422, 332	1, 750, 249	202. 00

Provider CCN: 15-0059

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

			10	12/31/2022	Date/lime Pre 5/25/2023 3:5	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N 13. 00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS	10.00		101.00	10.00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSING ADMINISTRATION	818, 862					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	10, 922, 332				14. 00
15. 00 01500 PHARMACY	0	0	26, 071, 939			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	1, 876, 783		16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	1, 374, 132	17. 00
23. 00 O2300 PARAMED ED PRGM PHARMACY	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	272 400	ما	0	1 011 512	1 107 704	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T	372, 489 97, 357	0	0	1, 011, 513	1, 187, 784 84, 757	30. 00 31. 00
41. 00 04100 SUBPROVI DER - I RF	61, 105	0	0	0	101, 591	41.00
43. 00 04300 NURSERY	01, 109	Ö	0	0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	Ö	o	Ö	Ö	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND	U O	0	0	0	0	57. 00 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	Ö	o	Ö	Ö	0	60.00
60. 01 06001 BLOOD LABORATORY	O	0	0	O	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	O	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	U O	0	0	0	0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 922, 332	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	10, 722, 332	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	ő	26, 071, 939	o	0	73. 00
74. 00 07400 RENAL DI ALYSI S	Ö	Ö	0	Ö	0	74. 00
76. 00 03020 OTHER ANCI LLARY	0	О	0	О	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
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	O	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	٥	ام	0	٥١	0	90.00
90. 01 09001 OUTPATI ENT	0	0	0	0	0	90.00
90. 02 09002 NEUROPSYCHOLOGY	0	Ö	0	0	0	90. 02
91. 00 09100 EMERGENCY	287, 911	o	Ö	865, 270	0	91.00
91. 01 09101 SHORT STAY	0	О	0	0	0	91. 01
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	818, 862	10, 922, 332	26, 071, 939	1, 876, 783	1, 374, 132	110 00
NONREI MBURSABLE COST CENTERS	010, 002	10, 922, 332	20, 071, 939	1, 0/0, /03	1, 3/4, 132	116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	O	0	ol	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o	Ö	0	0		192. 00
192. 01 19201 FOUNDATI ON	O	0	0	O		192. 01
192. 02 19202 CLI NI CS	0	0	0	0	0	192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	o	o	0	o		192. 03
192. 04 19207 WESTFI ELD SCHOOLS	o	O	0	o		192. 04
192. 05 19203 PRACTI CE MANAGEMENT	O	0	0	0		192. 05
192. 06 19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192.06
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES	O	ol	0	0		192.07
192.08 19205 RIVERVIEW MEDICAL ARTS 192.09 19209 BEHAVIOR CARE	0		0	0		192. 08 192. 09
193. 00 19300 NONPALD WORKERS	O O		0	٥		192. 09 193. 00
	<u> </u>	<u> </u>	٥١	<u> </u>		1.70.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 RI VERVI EW HOSPI TAL Provider CCN: 15-0059

					5/25/2023 3:5	2 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15. 00	16.00	17. 00	
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0	C	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	0	0	C	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	0	0	0	C	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	0	0	0	C	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	0	0	0	C	193. 05
193. 06 19306 OUTPATIENT PHARMACY	0	0	0	0	C	193. 06
194. 00 07950 WORKMED	0	0	0	0	C	194.00
194.01 07951 MEALS ON WHEELS	0	0	0	0	C	194. 01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	818, 862	10, 922, 332	26, 071, 939	1, 876, 783	1, 374, 132	202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | Part | | Pa Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0059

				To	12/31/2022	Date/Time Prepared 5/25/2023 3:52 pm	ł:
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	37 237 2023 3. 32 pm	
		PRGM PHARMACY		Residents			
				Cost & Post Stepdown			
				Adjustments			
		23. 00	24. 00	25. 00	26. 00		
1 00	GENERAL SERVICE COST CENTERS	T					20
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT					1.0 4.0	
5. 00	00500 ADMINISTRATIVE & GENERAL					5.0	
7. 00	00700 OPERATION OF PLANT					7.0	
8. 00	00800 LAUNDRY & LINEN SERVICE					8.0	
9.00	00900 HOUSEKEEPI NG					9.0	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10.0 11.0	
13. 00	01300 NURSI NG ADMI NI STRATI ON					13. 0	
14.00	01400 CENTRAL SERVICES & SUPPLY					14. 0	
15.00	01500 PHARMACY					15.0	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					16. 0 17. 0	
23. 00	02300 PARAMED ED PRGM PHARMACY	391, 375				23.0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0717070				2010	, ,
	03000 ADULTS & PEDIATRICS	0	32, 412, 257		32, 412, 257	30.0	
31.00		0	7, 163, 643		7, 163, 643		
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	5, 320, 066 0	1	5, 320, 066 0	l	
44. 00	04400 SKILLED NURSING FACILITY		0		0		
	ANCILLARY SERVICE COST CENTERS			-	-		
50.00	05000 OPERATING ROOM	0	14, 968, 112		14, 968, 112	· ·	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0		
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C		5, 215, 158 2, 022, 290		5, 215, 158 2, 022, 290		
57. 00	05700 CT SCAN		845, 762		845, 762	57.0	
57. 01	03630 ULTRA SOUND	O	632, 243		632, 243	57.0	01
58. 00	05800 MRI	0	591, 100		591, 100	· ·	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	1, 611, 689 13, 641, 984		1, 611, 689 13, 641, 984	· ·	
60. 01	06001 BL00D LABORATORY	0	13, 041, 704	1	13, 041, 704	l	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	839, 462	0	839, 462	63.0	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	١	0	64.0	
65.00	06500 RESPIRATORY THERAPY	0	2, 889, 714		2, 889, 714	65.0	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		8, 835, 115 0	1	8, 835, 115 0	66. 0 67. 0	
68. 00	06800 SPEECH PATHOLOGY		0	Ö	o	68.0	
69. 00	06900 ELECTROCARDI OLOGY	0	1, 507, 896		1, 507, 896		
71. 00		0	10, 922, 332		10, 922, 332		
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 391, 375	10, 896, 599		10, 896, 599	72. 0 73. 0	
74.00	07400 RENAL DI ALYSI S	391, 3/3	26, 463, 314 491, 334		26, 463, 314 491, 334	73.0	
76. 00	03020 OTHER ANCI LLARY	Ö	0		0	l	
	03140 CARDI AC REHAB	0	2, 300, 629		2, 300, 629	76.0	
	03070 WOMEN' S CENTER	0	1, 590, 923		1, 590, 923		
	03330 ENDOSCOPY 07700 ALLOGENEIC STEM CELL ACQUISITION		0		0		
	OUTPATIENT SERVICE COST CENTERS	. 9		. 9	<u> </u>	77.0	. •
	09000 CLI NI C	0	894, 307	0	894, 307		
90. 01	09001 OUTPATI ENT	0	1, 784, 730		1, 784, 730		
90.02	09002 NEUROPSYCHOLOGY 09100 EMERGENCY	0	522, 194 24, 567, 971		522, 194 24, 567, 971	90. 0 91. 0	
	09101 SHORT STAY		24, 307, 771		24, 307, 971		
	09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92.0	
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM	0	119, 086 0		119, 086 0		
102.00	SPECIAL PURPOSE COST CENTERS	U U	U	0	U	102.0	JU
118.00		391, 375	179, 049, 910	0	179, 049, 910	118. 0	00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	865, 914		865, 914		
	19200 PHYSICIANS' PRIVATE OFFICES 19201 FOUNDATION		44, 357, 271 277, 805		44, 357, 271 277, 805	192. 0 192. 0	
	19202 CLINICS		1, 466, 014		1, 466, 014		
192. 03	19206 HOME HEALTH PARTNERSHIP	0	1, 856		1, 856	192. 0	03
	19207 WESTFI ELD SCHOOLS	0	1, 704, 769		1, 704, 769		
	5 19203 PRACTICE MANAGEMENT 5 19204 MOB - NOBLESVILLE SQUARE	0	1, 294, 293 67, 922		1, 294, 293 67, 922		
	7 19208 PHYSICIANS' PRIVATE OFFICES		67, 922 0		07, 922	l	
	19205 RI VERVI EW MEDI CAL ARTS		173, 982	-	173, 982		
				·			_

Health Financial Systems	RI VERVIEW HOSPITAL		In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN:	15-0059 Peri od:	Worksheet B

				From 01/01/2022 Fo 12/31/2022	Part Date/Time Prepared: 5/25/2023 3:52 pm
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM PHARMACY		Residents		
			Cost & Post		
			Stepdown		
	00.00	0.4.00	Adjustments	24.22	
	23. 00	24. 00	25. 00	26.00	
192. 09 19209 BEHAVI OR CARE	0	848, 705	(848, 705	192. 09
193. 00 19300 NONPALD WORKERS	0	0	(0	193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	307	(307	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	66, 027	(66, 027	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	753, 453	(753, 453	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	174, 648	(174, 648	193. 04
193.05 19305 OB SPECIALISTS DAVENPORT	0	1, 092, 099	(1, 092, 099	193. 05
193.06 19306 OUTPATIENT PHARMACY	0	5, 628, 589	(5, 628, 589	193. 06
194. 00 07950 WORKMED	0	668, 172	(668, 172	194. 00
194.01 07951 MEALS ON WHEELS	0	504, 344	(504, 344	194. 01
200.00 Cross Foot Adjustments	0	0	(0	200. 00
201.00 Negative Cost Centers	0	o	(o o	201.00
202.00 TOTAL (sum lines 118 through 201)	391, 375	238, 996, 080	(238, 996, 080	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0059

					Ť	0 12/31/2022	Date/Time Pre 5/25/2023 3:5	
				CAPI TAL			37 237 2023 3. 3	2 (2)
		Cost Contor Description	Dimontly	RELATED COSTS	Subtotal	EMDL OVEE	ADMINICTDATIV	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	Subtotai	EMPLOYEE BENEFITS	ADMINISTRATIV E & GENERAL	
			Capi tal			DEPARTMENT	E a SEIVEIVIE	
			Related Costs	1.00	24	4.00	F 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2A	4. 00	5. 00	
1.00	1	CAP REL COSTS-BLDG & FIXT						1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	78, 204			1 (10 224	4.00
5. 00 7. 00	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	0	1, 613, 184 7, 194, 155			1, 619, 324 131, 332	5. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	0	49, 301		69	12, 156	8. 00
9.00		HOUSEKEEPI NG	0	39, 881		992	19, 416	9.00
10. 00 11. 00		DI ETARY CAFETERI A	0	431, 039 0			9, 737 11, 859	10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	Ö	Ö		464	5, 435	13.00
14. 00		CENTRAL SERVICES & SUPPLY	0	236, 002			70, 201	14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	294, 317 78, 306			172, 363 11, 603	15. 00 16. 00
17. 00		SOCIAL SERVICE	0	55, 671			8, 434	
23. 00	02300	PARAMED ED PRGM PHARMACY	0	5, 252			2, 572	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	2 175 470	2 175 (70	9, 050	138, 551	30. 00
31.00	1	INTENSIVE CARE UNIT	0	3, 175, 678 478, 849			39, 406	
41.00	04100	SUBPROVI DER - I RF	0	506, 261		1, 284	24, 543	41.00
43.00	1	NURSERY	0	0	•		0	43.00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	<u> </u>	0	0	0	44. 00
50.00	05000	OPERATING ROOM	0	1, 710, 194	1, 710, 194		80, 275	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	450 251		1 045	0	52.00
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	0	450, 251 243, 152		1, 865 428	28, 484 10, 883	54. 00 55. 00
57. 00		CT SCAN	0	0			4, 874	
57. 01		ULTRA SOUND	0	0		377	4, 198	
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	0	0 79, 966	· -	279 779	3, 182 9, 544	58. 00 59. 00
60.00		LABORATORY	o o	491, 318			85, 305	60.00
60. 01		BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	83, 694	83, 694	0	4, 799 0	63. 00 64. 00
65. 00	1	RESPIRATORY THERAPY	0	49, 877	49, 877	1, 390	18, 667	65.00
66.00		PHYSI CAL THERAPY	0	159, 187	159, 187	4, 307	56, 383	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	0	224, 854	1	_	7, 559	
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	73, 828	
73. 00 74. 00	1	RENAL DIALYSIS	0	31, 478	31, 478	0	0 2, 995	73.00 74.00
	03020	OTHER ANCI LLARY	0	0	0	0	0	l <u>-</u>
76. 01		CARDIAC REHAB WOMEN'S CENTER	0	372, 690			11, 397	
76. 02 76. 03		ENDOSCOPY	0	312, 309 0	1		7, 235 0	76. 02 76. 03
77. 00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
90. 00		TIENT SERVICE COST CENTERS	0	81, 694	81, 694	317	5, 055	90.00
90.00	1	OUTPATIENT	0	118, 967			10, 311	
90. 02	09002	NEUROPSYCHOLOGY	0	57, 535	57, 535	335	2, 833	90. 02
91. 00 91. 01		EMERGENCY SHORT STAY	0	718, 409 0			147, 649 0	91. 00 91. 01
91.01	1	OBSERVATION BEDS (NON-DISTINCT PART	0	0		-	U	91.01
	OTHER	REIMBURSABLE COST CENTERS						
		AMBULANCE SERVICES OPIOID TREATMENT PROGRAM	0					95. 00 102. 00
102.00		AL PURPOSE COST CENTERS	0	0	0	<u> </u>	U	102.00
118.00)	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	19, 430, 925	19, 430, 925	54, 804	1, 233, 759	118. 00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
		PHYSICIANS' PRIVATE OFFICES FOUNDATION	0	1, 621, 011	1, 621, 011	18, 488	282, 295 1 837	192. 00 192. 01
		CLINICS	0	0	0	162 817		192.01
192. 03	19206	HOME HEALTH PARTNERSHIP	0	o	0	0	13	192. 03
		WESTFIELD SCHOOLS	0	0	0	1, 001	11, 550	
		PRACTICE MANAGEMENT MOB - NOBLESVILLE SQUARE	0	0	0	345		192. 05 192. 06
		PHYSICIANS' PRIVATE OFFICES	0	Ö		-		192.07
-								

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 3:52 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RI VERVI EW HOSPI TAL Provider CCN: 15-0059

						5/25/2023 3:5	2 pm
			CAPI TAL				
	Cost Center Description	Di rectly	RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE	ADMINISTRATIV	
	300 COMEST 2000 F F COM	Assigned New	5250 a 1170	oub to tu.	BENEFITS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs					
		0	1. 00	2A	4. 00	5. 00	
192. 08 19205	RIVERVIEW MEDICAL ARTS	0	0	(0	1, 179	192. 08
192. 09 19209	BEHAVI OR CARE	0	0	(423	5, 750	192. 09
193. 00 19300	NONPALD WORKERS	0	0	(0		193. 00
193. 01 19301	PHYSICIAN SERVICES-LYONS	0	0	(0	2	193. 01
193. 02 19302	UNI VERSI TY HS ATHLETI CS	0	0	(40	447	193. 02
193. 03 19303	OB/GYN SPEC NEMUNALTI	0	0	(437	5, 105	193. 03
1 1	OB/GYN SPEC GATHERS	0	0	(99		193. 04
	OB SPECIALISTS DAVENPORT	0	0	(645		193. 05
	OUTPATIENT PHARMACY	0	0	(484		193. 06
194. 00 07950		0	0	(228		194. 00
	MEALS ON WHEELS	0	0	(131	3, 346	194. 01
	Cross Foot Adjustments			(200. 00
	Negative Cost Centers		0	(0	l e	201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	21, 255, 918	21, 255, 918	78, 204	1, 619, 324	202. 00

Provider CCN: 15-0059

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 3:52 pm

September Construction Constru		ODERATION OF	1 ALINDRY 6	Luquasussana	DI 574 DV	5/25/2023 3: 5	
DEMPARE SERVICE SERVICES (ENTIRES 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
1.00 GIDOCORP RET. CESTS R. RIDE A. F. LYT				9. 00	10.00	11. 00	
1.00 00000 DUNOU							
5.00 DODOLO AMMINISTRATIVE & CEMERAL 7, 327 407 8							
7.00 000000 000000 00000 000000 000000							
0.00 0.000 LAURDRY A, LINEN SERVICE 29, 208 90, 729 0.0000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000		7, 327, 467					
0.000 0.000 DETARY 255, 321			90, 729				
11.00 01100 OFFITHIA 0 0 0 0 12,536 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13		23, 623	0	83, 912			9. 00
13.00 01300 MIRSH MA ZOMM IN STRATION 0 0 0 0 170 13.00		1	0		705, 260		
14-00 01400 (EMTRAL SERVICES & SUPPLY 139, 793 735 3, 009 0 294 14-00 15-00 1500 01400 MEDICAL ECORDOS & LIBRARY 46, 384 0 0 0 0 0 0 297 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-00 10-		1	0	-	0		
15.00 OTSO] PHARBACY		1	735	j	0		
0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 17.00 17.00 0.00 0.00 0.00 17.00 0.00 0.00 0.00 17.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			, , , ,		0		
23.00 0.3000 PARAMED ED PROM PHARAMOY 3, 1111 0 0 0 25 25.00			0		0		
INPATI ENT ROUTINE SERVICE COST CENTERS 1,881,084 30,664 51,514 493,266 2,079 30 00 31 00 00 00 00 UTS & PEDIATRIC S 1,881,084 7,148 10 0 55,828 544 31 00 41 00 01 00 10 0 0 0 0 0 0 0 0 0 0 0 0		32, 976	0	507	0		17. 00
30.00		3, 111	0	0	0	25	23. 00
31.00		1 001 004	20 444	E1 E14	402 244	2.070	20.00
14.00						· ·	
43.00 04300 SILLED NURSING FACILITY 0 0 0 0 0 0 0 44.00							
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192. 00 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 1920		120 827	0	58	Ο	47	190 00
192. 01 19201 FOUNDATION 0 0 0 0 48 192. 01 192. 02 19202 CLINICS 0 35 0 0 0 192. 02 192. 03 19206 HOME HEALTH PARTNERSHIP 0 0 0 0 0 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 0 0 0 0 0 192. 04 192. 05 19203 PRACTICE MANAGEMENT 0 32 0 0 0 192. 05 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 0 192. 05 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 06 192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 0 192. 08 192. 09 19209 BEHAVI OR CARE 0 0 0 0 0 0 192. 09 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00		1	7. 716		o		
192. 03 19206 HOME HEALTH PARTNERSHIP 0 0 0 0 0 192. 03 1920 WESTFI ELD SCHOOLS 0 0 0 0 192. 04 19207 WESTFI ELD SCHOOLS 0 0 0 0 0 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 0 32 0 0 0 192. 05 192. 06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 0 192. 06 192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 07 192. 08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 192. 08 192. 09 19209 BEHAVI OR CARE 0 0 0 0 0 0 192. 09 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00		1	0	-	0		
192. 04 19207 WESTFI ELD SCHOOLS 0 0 0 0 192. 04 192. 05 19203 PRACTI CE MANAGEMENT 0 32 0 0 0 192. 05 192. 06 19204 MOB - NOBLESVI LLE SQUARE 0 0 0 0 0 192. 06 192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 07 192. 08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 192. 07 192. 09 19209 BEHAVI OR CARE 0 0 0 0 0 0 192. 09 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00		0	35	0	0		
192. 05 19203 PRACTI CE MANAGEMENT		0		0	0		
192. 06 19204 MOB - NOBLESVILLE SQUARE 0 0 0 0 192. 06 192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 07 192. 08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 0 192. 08 192. 09 19209 BEHAVI OR CARE 0 0 0 0 0 0 192. 09 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00		0	· ·	0	0		
192. 07 19208 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 07 192. 08 19205 RI VERVI EW MEDI CAL ARTS 0 0 0 0 0 192. 08 192. 09 19209 BEHAVI OR CARE 0 0 0 0 0 0 192. 09 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00		0	32	0	0		
192. 08 19205 RI VERVI EW MEDI CAL ARTS		0	0	0	n		
192. 09 19209 BEHAVI OR CARE 0 0 0 0 192. 09 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00		0	Ö	o	ől		
		0	0	0	o	0	192. 09
193. 01 19301 PHYSI CI AN SERVI CES-LYONS 0 0 0 0 193. 01		-	0	0	О		
	193. 01 19301 PHYSLCLAN SERVICES-LYONS	1 0	0	0	0	0	193. 01

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0059
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

				7 12/31/2022	5/25/2023 3:5	
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. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	0	0	0	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI	0	0	0	0	0	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	0	0	0	0	193. 04
193. 05 19305 OB 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	75	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, 327, 467	90, 729	83, 912	705, 260	12, 536	202. 00

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm

					5/25/2023 3:5	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	
	ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
	13. 00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS			'	1		
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7. 00 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 01300 NURSING ADMINISTRATION	6, 019					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	451, 577				14.00
15. 00 01500 PHARMACY	0	0	646, 178			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	137, 259		16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	98, 363	17. 00
23. 00 O2300 PARAMED ED PRGM PHARMACY	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	2 720	ما		72 077	05.024	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	2, 738 716	0	0	73, 977	85, 024 6, 067	30. 00 31. 00
41. 00 04100 SUBPROVI DER - I RF	449	0	0	0	7, 272	41.00
43. 00 04300 NURSERY	0	0	0	0	7,272	43. 00
44.00 04400 SKILLED NURSING FACILITY	o	Ö	Ö	o	0	44. 00
ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	- 1	- "	-1		
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 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	U O	0	0	0	58. 00 59. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	o	Ö	Ö	o	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	451, 577	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	646, 178	0	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 OTHER ANCI LLARY	0	0	0	0	0	74. 00 76. 00
76. 00 03020 OTHER ANCI LEART 76. 01 03140 CARDI AC REHAB	0	0	0	0	0	76. 00 76. 01
76. 02 03070 WOMEN' S CENTER	0	0	0	0	0	76. 02
76. 03 03330 ENDOSCOPY	o	Ö	Ö	o	0	76. 03
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	,	1		,		
90. 00 09000 CLINIC	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	2, 116	0	0	63, 282	0	91.00
91. 01 09101 SHORT STAY	U	U	U	O	0	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	O	٥	0	ol	0	95. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	5	<u> </u>		.02.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 019	451, 577	646, 178	137, 259	98, 363	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192. 01 19201 FOUNDATI ON	0	0	0	0		192. 01
192. 02 19202 CLINICS	0	0	0	0		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192.03
192. 04 19207 WESTFI ELD SCHOOLS	0	0	0	0		192.04
192. 05 19203 PRACTI CE MANAGEMENT 192. 06 19204 MOB - NOBLESVI LLE SQUARE		0	0	0		192. 05 192. 06
192. 06 19204 MOB - NOBLESVILLE SQUARE 192. 07 19208 PHYSICIANS' PRIVATE OFFICES		0	0	0		192. 06 192. 07
192. 07 19208 PHTSICIANS PRIVATE OFFICES 192. 08 19205 RI VERVI EW MEDI CAL ARTS		0	0	0		192. 07
192. 09 19209 BEHAVI OR CARE	l o	o	o o	o o		192. 09
193. 00 19300 NONPAI D WORKERS	o	o	o	ol		193. 00
<u> </u>			- 1			

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0059 | Period: | Worksheet B | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | Propagation | Propagation

					5/25/2023 3:5	52 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15. 00	16.00	17. 00	
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0	C	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	0	0	C	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	0	0	0	C	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	0	0	0	C	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	0	0	0	C	193. 05
193. 06 19306 OUTPATIENT PHARMACY	0	0	0	0	C	193. 06
194. 00 07950 WORKMED	0	0	0	0	C	194.00
194.01 07951 MEALS ON WHEELS	0	0	0	0	C	194. 01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 019	451, 577	646, 178	137, 259	98, 363	202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | Part | Part | Prepared: | Part | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0059

				To	12/31/2022	Date/Time Prepared: 5/25/2023 3:52 pm
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	37 237 2023 3. 32 piii
	·	PRGM PHARMACY		Resi dents		
				Cost & Post		
				Stepdown Adjustments		
		23. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
4. 00 5. 00	OO400					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT					7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15. 00
	01600 MEDICAL RECORDS & LIBRARY					16.00
17.00	01700 SOCIAL SERVICE					17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY	11, 196				23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		5 040 /05		5 040 (05	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT		5, 943, 625 874, 699	0	5, 943, 625 874, 699	30. 00 31. 00
41. 00	04100 SUBPROVI DER – I RF		1, 003, 838	0	1, 003, 838	41.00
43. 00	04300 NURSERY		0	Ö	0	43. 00
	04400 SKILLED NURSING FACILITY		0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		2, 820, 224	0	2, 820, 224	50.00
52. 00 54. 00	O5200 DELI VERY ROOM & LABOR ROOM O5400 RADI OLOGY-DI AGNOSTI C		0 756, 749	0	756 740	52. 00 54. 00
	1 1		399, 416	0	756, 749 399, 416	55.00
	05700 CT SCAN		8, 552	Ö	8, 552	57. 00
57. 01	03630 ULTRA SOUND		4, 666	0	4, 666	57. 01
58. 00	05800 MRI		6, 709	0	6, 709	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		140, 364	0	140, 364	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY		875, 448 0	0	875, 448 0	60. 00 60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		138, 068	0	138, 068	63. 00
64. 00	06400 I NTRAVENOUS THERAPY		0	Ö	0	64.00
65.00	06500 RESPI RATORY THERAPY		99, 883	0	99, 883	65.00
66.00	06600 PHYSI CAL THERAPY		317, 705	0	317, 705	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		367, 111	0	367, 111	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		451, 577	0	451, 577	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		73, 828	0	73, 828	72.00
	07300 DRUGS CHARGED TO PATIENTS		646, 178	0	646, 178	73. 00
74.00	07400 RENAL DIALYSIS		53, 119	0	53, 119	74.00
76. 00 76. 01	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB		0 605, 824	0	0 605, 824	76. 00 76. 01
	03070 WOMEN' S CENTER		505, 595	0	505, 595	76. 01
	03330 ENDOSCOPY		0	Ö	0	76. 03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	O	77. 00
	OUTPATIENT SERVICE COST CENTERS		405 744		405 744	
	09000 CLI NI C 09001 OUTPATI ENT		135, 714 203, 069	0	135, 714 203, 069	90. 00 90. 01
	09002 NEUROPSYCHOLOGY		94, 882	0	94, 882	90.01
	09100 EMERGENCY		1, 379, 419	Ö	1, 379, 419	91.00
	09101 SHORT STAY		0	0	o	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
05 00	OTHER REIMBURSABLE COST CENTERS		15 474		15 474	95.00
	09500 AMBULANCE SERVICES 10200 OPIOID TREATMENT PROGRAM		15, 474 0		15, 474 0	
102.00	SPECIAL PURPOSE COST CENTERS			o _l	·,	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	17, 921, 736	0	17, 921, 736	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		328, 657	0	328, 657	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		2, 889, 700	0	2, 889, 700	192. 00
	19201 FOUNDATI ON		2, 047	0	2, 047	192. 01
	19202 CLINICS		10, 780		10, 780	192. 02
	19206 HOME HEALTH PARTNERSHIP		13	0	13	192.03
	19207 WESTFI ELD SCHOOLS 19203 PRACTI CE MANAGEMENT		12, 551 9, 142		12, 551 9, 142	192. 04 192. 05
	19204 MOB - NOBLESVILLE SQUARE		460	0	460	192.06
192. 07	19208 PHYSICIANS' PRIVATE OFFICES		0	0	o	192. 07
192. 08	19205 RIVERVIEW MEDICAL ARTS		1, 179	0	1, 179	192. 08
						

Health Financial Systems	RIVERVIEW HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0059	Period: Worksheet B

				Γο 12/31/2022	
Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23. 00	24. 00	25. 00	26.00	
192. 09 19209 BEHAVI OR CARE		6, 173	(6, 173	192. 09
193. 00 19300 NONPALD WORKERS		0	(0	193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS		2	(2	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS		487	(487	193. 02
193.03 19303 OB/GYN SPEC NEMUNALTI		5, 542	(5, 542	193. 03
193.04 19304 OB/GYN SPEC GATHERS		1, 282	(1, 282	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT		8, 044	(8, 044	193. 05
193. 06 19306 OUTPATIENT PHARMACY		38, 620	(38, 620	193. 06
194. 00 07950 WORKMED		4, 755	(4, 755	194. 00
194.01 07951 MEALS ON WHEELS		3, 552	(3, 552	194. 01
200.00 Cross Foot Adjustments	11, 196	11, 196	(11, 196	200. 00
201.00 Negative Cost Centers	0	0	(0	201. 00
202.00 TOTAL (sum lines 118 through 201)	11, 196	21, 255, 918	(21, 255, 918	202.00

	Financial Systems	RIVERVIEW		ON 45 0050 B		u or Form CMS-2	
COSTA	LLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet B-1 Date/Time Pre 5/25/2023 3:5	pared:
	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	<u> </u>
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS				1		
1. 00	00100 CAP REL COSTS-BLDG & FIXT	627, 314					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 308	93, 081, 098	1	200 104 404		4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	47, 609 212, 317	7, 309, 672 2, 357, 346				5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 455	2, 357, 340 82, 569	1		l '	
9. 00	00900 HOUSEKEEPI NG	1, 177	1, 181, 088		2, 496, 301	1, 177	9. 00
10.00	01000 DI ETARY	12, 721	338, 088		1, 251, 806		
11. 00	01100 CAFETERI A	0	805, 780	l .	.,,	l e	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	552, 063	l .	698, 748		
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	6, 965	777, 394	l .	.,,	1	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	8, 686 2, 311	2, 418, 630 796, 689	l .	,,	1	
17. 00	01700 SOCI AL SERVI CE	1, 643	714, 588			1	1
23. 00	02300 PARAMED ED PRGM PHARMACY	155	281, 411	l .			1
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	93, 722	10, 774, 051	1			
31.00	03100 I NTENSI VE CARE UNI T	14, 132	2, 975, 944	1		1	1
41. 00 43. 00	04100 SUBPROVI DER - I RF	14, 941	1, 528, 814	0	-,,	l	1
44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0 0	0			1	
44.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>		1 44.00
50.00	05000 OPERATING ROOM	50, 472	4, 909, 865	0	10, 320, 715	50, 472	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 288	2, 219, 802	1		l	
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 176	508, 954	1	1, 399, 239	1	
57. 00 57. 01	05700 CT SCAN 03630 ULTRA SOUND	0	469, 787 448, 660	1	626, 590 539, 722		
58. 00	05800 MRI		332, 689	1			1
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 360	927, 536	l .	·	ł	
60.00	06000 LABORATORY	14, 500	3, 392, 101	0	10, 967, 478	14, 500	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 470	0	0			1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 472	1, 654, 638		_	0 1, 472	
66. 00	06600 PHYSI CAL THERAPY	4, 698	5, 127, 607	l .		1	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	o o		l	1
68.00	06800 SPEECH PATHOLOGY	0	0	o	0	0	
69. 00	06900 ELECTROCARDI OLOGY	6, 636	602, 834	l .	971, 831	1	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	-		l e	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	0		0	
74.00	07400 RENAL DI ALYSI S	929	0				
	03020 OTHER ANCI LLARY	0	0	l o	0	0	
76. 01	03140 CARDI AC REHAB	10, 999	796, 262	C	1, 465, 268	10, 999	
76. 02	03070 WOMEN' S CENTER	9, 217	477, 213	O	930, 165	9, 217	
76. 03	03330 ENDOSCOPY	0	0		-	l e	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77.00
90.00	09000 CLINIC	2, 411	377, 203	0	649, 902	2, 411	90.00
	09001 OUTPATI ENT	3, 511	606, 534		1, 325, 693		
90. 02	09002 NEUROPSYCHOLOGY	1, 698	398, 572	o c		l	
91.00	09100 EMERGENCY	21, 202	9, 058, 665	O	18, 982, 904		
	09101 SHORT STAY	0	0	C	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES	273	41, 802	C	89, 323	273	95.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	l .			102.00
	SPECIAL PURPOSE COST CENTERS						
118.00		573, 454	65, 244, 851	-30, 809, 396	158, 621, 583	311, 220	118.00
100.00	NONREI MBURSABLE COST CENTERS	/ 000	110 547	_	440 444	/ 000	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	6, 020 47, 840	118, 547 21, 987, 162	l .	·		190. 00 192. 00
	19201 FOUNDATION	47, 040 N	192, 673	l .	236, 180		192.00
	19202 CLI NI CS		972, 896		1, 276, 403	l	192. 02
192. 03	19206 HOME HEALTH PARTNERSHIP	0	0	O	1, 617	0	192. 03
	19207 WESTFI ELD SCHOOLS	0	1, 192, 253	1	1, 485, 005		192.04
	19203 PRACTI CE MANAGEMENT	0	411, 136	1	.,,		192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	0	0	59, 166	0	192. 06

In Lieu of Form CMS-2552-10 Health Financial Systems RI VERVI EW HOSPI TAL COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0059 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm CAPI TAL RELATED COSTS **EMPLOYEE** Reconciliatio ADMINISTRATIV OPERATION OF Cost Center Description BLDG & FIXT (SQUARE FEET) BENEFITS E & GENERAL PI ANT n (SQUARE FEET) DEPARTMENT (ACCUM. COST) (GROSS SALARIES) 1. 00 5. 00 4.00 5A 7. 00 192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES 00 0 0 192.07 192.08 19205 RI VERVI EW MEDICAL ARTS 0 192.08 151, 554 192. 09 19209 BEHAVI OR CARE 503, 969 0 739, 297 0 192.09 0000000 193.00 19300 NONPALD WORKERS 0 0 193.00 193. 01 19301 PHYSI CI AN SERVI CES-LYONS 0 0 193. 01 267 0 193. 02 19302 UNI VERSI TY HS ATHLETI CS 47,634 57, 515 0 193.02 193. 03 19303 OB/GYN SPEC NEMUNALTI 520, 739 656, 324 0 193. 03 0 152, 134 0 193. 04 193. 04 19304 OB/GYN SPEC GATHERS 117, 491 193.05 19305 OB SPECIALISTS DAVENPORT 0 0 193.05 768, 142 951, 315 193. 06 19306 OUTPATIENT PHARMACY 576, 634 4, 902, 999 0 193.06 194. 00 07950 WORKMED 0 0 582, 037 0 194.00 271, 423 194. 01 07951 MEALS ON WHEELS 430, 212 0 194. 01 155, 548 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 21, 255, 918 9, 692, 109 30, 809, 396 19, 383, 882 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 33. 884017 0.104125 0. 147989 53. 094889 203. 00 204.00 Cost to be allocated (per Wkst. B, 78, 204 1, 619, 324 7, 327, 467 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000840 0.007778 20. 070853 205. 00 Π 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0059
Period:
From 01/01/2022
To 12/31/2022
Date/Time Prepared:
5/25/2023 3: 52 pm

Cost Center Description
LAUNDRY & HOUSEKEEPING DIETARY CAFETERIA NURSING

Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIO N (DIRECT NRSING HR)	
OFFICE ASSESSMENT OF ASSESSMEN	8. 00	9. 00	10.00	11. 00	13. 00	
GENERAL SERVICE COST CENTERS 1.00	67, 867 0 0 0 0 550 0 0 0	25, 998 2, 751 0 0 1, 211 788 0 157	69, 164 0 0 0 0 0 0	1, 225, 113 11, 694 27, 779 57, 502 29, 042 17, 055 2, 441	447, 024 0 0 0	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
30. 00 03000 ADULTS & PEDIATRICS	22, 936		48, 374	203, 345		30. 00
31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	5, 347 5, 717 0	0	5, 475 15, 315 0 0	53, 148 33, 358 0 0	33, 358 0	31.00 41.00 43.00 44.00
ANCILLARY SERVICE COST CENTERS			9			
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 57. 01 03630 ULTRA SOUND	7, 102 0 4, 285 592 0	0 982 0 982 0	0 0 0 0 0	126, 448 0 53, 724 13, 051 11, 087 8, 853	0 0 0 0 0	50. 00 52. 00 54. 00 55. 00 57. 00 57. 01
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TR	0 1, 888 0 0 0 ANS. 0	982 0 1, 211 0 0	0 0 0 0	7, 614 18, 025 101, 611 0 0	0 0 0 0	58. 00 59. 00 60. 00 60. 01 63. 00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 617 0 0 628	0	0 0 0 0	0 39, 529 142, 087 0 0 15, 812	0 0 0 0	64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATEURS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS 76.00 03020 OTHER ANCILLARY 76.01 03140 CARDIAC REHAB 76.02 03070 WOMEN'S CENTER	l l	0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 23, 125 16, 563	0 0 0 0 0	71. 00 72. 00 73. 00 74. 00 76. 00 76. 01 76. 02
76.03 03330 ENDOSCOPY 77.00 07700 ALLOGENEIC STEM CELL ACQUISITI	O O NC		0 0	0		76. 03 77. 00
90. 00 09000 CLI NI C 090. 01 09000 OUTPATI ENT SERVI CE COST CENTERS 90. 01 09000 OUTPATI ENT 90. 02 09002 NEUROPSYCHOLOGY 91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	99 1, 988 0 9, 877 0 PART		0 0 0 0	12, 239 15, 128 9, 685 157, 173 0	0 0 157, 173	90. 00 90. 01 90. 02 91. 00 91. 01 92. 00
95.00 09500 AMBULANCE SERVICES 102.00 10200 OPIOLD TREATMENT PROGRAM	0		0	1, 434		95. 00 102. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 thro		-	69, 164	1, 208, 552		
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CA 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 FOUNDATION 192. 02 19202 CLI NI CS	NTEEN 0 5, 772 0 26	0	0 0	4, 565 0 4, 671 0	0 0	190. 00 192. 00 192. 01 192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP 192. 04 19207 WESTFIELD SCHOOLS 192. 05 19203 PRACTICE MANAGEMENT 192. 06 19204 MOB - NOBLESVILLE SQUARE	0 0 24 0	0 0 0	0 0	0 0 0	0 0 0	192. 02 192. 03 192. 04 192. 05 192. 06
192.07 19208 PHYSICIANS' PRIVATE OFFICES 192.08 19205 RIVERVIEW MEDICAL ARTS	0	0	0 0	0		192. 07 192. 08

Provi der CCN: 15-0059

				10	5 12/31/2022		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/25/2023 3: 5 NURSI NG	2 piii
	cost center bescriptron	LI NEN SERVI CE	(HOURS OF	(MEALS	(MAN HOURS)	ADMI NI STRATI O	
		(POUNDS OF	SERVIC)	SERVED)	(MAIN HOURS)	N	
		LAUNDR)	SERVIC)	SERVED)		(DI RECT	
		LAUNDK)				NRSI NG HR)	
		8. 00	9. 00	10.00	11. 00	13.00	
192 09 19200	BEHAVI OR CARE	0.00	7. 00 N	10.00	11.00		192. 09
	NONPALD WORKERS	0	n	0	0		193.00
	PHYSI CI AN SERVI CES-LYONS	0	n	0	0		193. 01
	UNI VERSI TY HS ATHLETI CS	0	0	0	0		193. 01
	OB/GYN SPEC NEMUNALTI	0	0	0	0	_	193. 02
	OB/GYN SPEC GATHERS	0	0	0	0		193. 03
	OB SPECIALISTS DAVENPORT	0	0	0	0		193.04
	OUTPATIENT PHARMACY	0	0	0	0		193. 05
194. 00 07950		0	0	0	0		194. 00
	MEALS ON WHEELS	0	0	0	7, 325		194. 00
200. 00	Cross Foot Adjustments	U	U	U	7, 323		200.00
							200.00
201. 00 202. 00	Negative Cost Centers	1 071 440	2 020 210	2 422 222	1 750 040		
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 871, 468	2, 928, 219	2, 422, 332	1, 750, 249	818,802	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	27. 575523	112. 632472	35. 023018	1. 428643	1. 831808	203.00
204. 00	Cost to be allocated (per Wkst. B,	90, 729	83, 912	705, 260	12, 536	6, 019	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	1. 336865	3. 227633	10. 196923	0. 010233	0. 013465	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)						

	Financiai Systems	RIVERVIEW F				u or form CMS-2	
COST A	NLLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2022 o 12/31/2022		
						5/25/2023 3:5	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	PARAMED ED	
		SERVICES &	(COSTED	RECORDS &	SERVI CE	PRGM PHARMACY	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
		(COSTED		(TIME SPENT)		TIME)	
		REQUIS.)					
	CENEDAL CEDALCE COCT CENTEDO	14. 00	15. 00	16. 00	17. 00	23. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT			I		I	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	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500 PHARMACY	o	100				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	308			16.00
17. 00	01700 SOCIAL SERVICE	0	0	C	4, 653		17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY	0	0	0	0	100	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	0	166		0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	287	0	31.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	344		41.00
43.00	04300 NURSERY	0	0		0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	0	0	0	0	E0 00
50.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1		•	50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0	1		0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0		0	0	55.00
57. 00	05700 CT SCAN		0		0	0	57.00
57. 01	03630 ULTRA SOUND	l ol	0	o o	0	0	57. 01
58. 00	05800 MRI	o	0	d	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	o c	0	0	59.00
60.00	06000 LABORATORY	o	0	o c	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	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	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 69. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY	0	0		0	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	100	0		0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	l ő	100	1	0		1
	07400 RENAL DI ALYSI S		0		0	0	1
	03020 OTHER ANCI LLARY	o	0	d	0	0	76.00
76. 01	03140 CARDI AC REHAB	o	0	o c	0	0	76. 01
76. 02	03070 WOMEN' S CENTER	o	0	O.	0	0	76. 02
	03330 ENDOSCOPY	0	0	C	0	0	76. 03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			1	1		
90.00	09000 CLI NI C 09001 OUTPATI ENT	0	0		_		90.00
90. 01 90. 02	09001 DUTPATTENT	0	0	0	0	0	90. 01 90. 02
	09100 EMERGENCY	0	0	142	0	0	91.00
91. 00	09101 SHORT STAY		0	142	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	٩	0	1		0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS			l			72.00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
	10200 OPIOID TREATMENT PROGRAM	o	0	d	0		102.00
	SPECIAL PURPOSE COST CENTERS			•		•	1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100	308	4, 653	100	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19201 FOUNDATI ON	0	0	0	0		192.01
	19202 CLINICS	0	0	9	0		192. 02
	19206 HOME HEALTH PARTNERSHIP	0	0] 0	0		192. 03
	19207 WESTFI ELD SCHOOLS	0	0		0		192.04
	19203 PRACTI CE MANAGEMENT	0	0		0		192.05
	19204 MOB - NOBLESVILLE SQUARE 19208 PHYSICIANS' PRIVATE OFFICES		0				192. 06 192. 07
	19208 PHYSICIANS PRIVATE OFFICES		0		0		192.07
. , 2. 00		<u>, </u>		1		. 0	1,,,2,00

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0059 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm Cost Center Description CENTRAL PHARMACY MEDI CAL SOCI AL PARAMED ED SERVICES & (COSTED RECORDS & SERVI CE PRGM PHARMACY SUPPLY LI BRARY (ASSI GNED REQUIS.) (TIME SPENT) (COSTED (TIME SPENT) TIME) REQUIS.) 23.00 14.00 15.00 16.00 17.00 192. 09 19209 BEHAVI OR CARE 0 192.09 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 0 0 0 0 0 0 193. 01 19301 PHYSI CI AN SERVI CES-LYONS 0 193.01 0 193. 02 19302 UNI VERSI TY HS ATHLETI CS 0 193.02 193. 03 19303 OB/GYN SPEC NEMUNALTI 0 0 0 193. 03 0 0 193. 04 19304 OB/GYN SPEC GATHERS 0 0 193. 04 0 193.05 19305 OB SPECIALISTS DAVENPORT 0 0 193. 05 0 193. 06 19306 OUTPATIENT PHARMACY 0 0 0 193.06 194. 00 07950 WORKMED 0 o 0 194.00 194. 01 07951 MEALS ON WHEELS 0 194. 01 0 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 391, 375 202. 00 202.00 Cost to be allocated (per Wkst. B, 10, 922, 332 26, 071, 939 1, 876, 783 1, 374, 132 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 109, 223. 32000 260, 719. 39000 6, 093. 451299 295. 321728 3, 913. 750000 203. 00 451, 577 11, 196 204. 00 204.00 Cost to be allocated (per Wkst. B, 646, 178 137, 259 98, 363 Part II) Unit cost multiplier (Wkst. B, Part 111. 960000 205. 00 205.00 4, 515. 770000 6, 461. 780000 445.646104 21. 139695 II) 206.00 NAHE adjustment amount to be allocated 0 206.00

0.000000 207.00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

						5/25/2023 3:5	2 pm
			Title	· XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescriptron			lotal costs		Total costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	32, 412, 257		22 412 25	7 0	22 412 257	30.00
				32, 412, 25			
31. 00	03100 I NTENSI VE CARE UNI T	7, 163, 643		7, 163, 64		,	31.00
41.00	04100 SUBPROVI DER - I RF	5, 320, 066		5, 320, 06	6 0	5, 320, 066	41.00
43.00	04300 NURSERY	0			0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0			0	0	
	ANCILLARY SERVICE COST CENTERS				<u> </u>		1 00
50. 00	05000 OPERATING ROOM	14 060 110		14 040 11		14 060 110	FO 00
		14, 968, 112		14, 968, 11			
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	l	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 215, 158		5, 215, 15			
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 022, 290		2, 022, 29	0	2, 022, 290	55.00
57.00	05700 CT SCAN	845, 762		845, 76	2 0	845, 762	57.00
57. 01	03630 ULTRA SOUND	632, 243		632, 24		632, 243	
58. 00	05800 MRI	591, 100		591, 10			
				•			
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 611, 689		1, 611, 68		., ,	
60.00	06000 LABORATORY	13, 641, 984		13, 641, 98	4 0	13, 641, 984	60.00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	839, 462		839, 46	2 0	839, 462	63.00
64.00	06400 I NTRAVENOUS THERAPY	. 0			0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	2, 889, 714	0	2, 889, 71	-	1	65.00
66. 00	06600 PHYSI CAL THERAPY	1 ' '					1
		8, 835, 115	0	8, 835, 11		8, 835, 115	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 507, 896		1, 507, 89	6 0	1, 507, 896	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 922, 332		10, 922, 33	2 0	10, 922, 332	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 896, 599		10, 896, 59			
73. 00	07300 DRUGS CHARGED TO PATIENTS	26, 463, 314		26, 463, 31			
74.00	07400 RENAL DIALYSIS						
		491, 334		491, 33		491, 334	74.00
76.00	03020 OTHER ANCI LLARY	0		1	0		76. 00
76. 01	03140 CARDI AC REHAB	2, 300, 629		2, 300, 62		, ,	
76. 02	03070 WOMEN' S CENTER	1, 590, 923		1, 590, 92	3 0	1, 590, 923	76. 02
76. 03	03330 ENDOSCOPY	0			0	0	76. 03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	77.00
77.00	OUTPATIENT SERVICE COST CENTERS				<u>J</u>		77.00
00 00		004 207	ĺ	004.20	7	004 207	00.00
90.00	09000 CLI NI C	894, 307		894, 30			
90. 01	09001 OUTPATI ENT	1, 784, 730		1, 784, 73		,	
90. 02	09002 NEUROPSYCHOLOGY	522, 194		522, 19	4 0	522, 194	90.02
91.00	09100 EMERGENCY	24, 567, 971		24, 567, 97	1 0	24, 567, 971	91.00
91. 01	09101 SHORT STAY	0			0	0	91.01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 671, 575		5, 671, 57	9	5, 671, 575	
72.00		5,071,373		3,071,37	ار	5,071,373	72.00
05 -	OTHER REIMBURSABLE COST CENTERS				.		
95. 00		119, 086		119, 08			
	10200 OPIOID TREATMENT PROGRAM	0			O		102.00
200.00	Subtotal (see instructions)	184, 721, 485	0	184, 721, 48	5 0	184, 721, 485	200.00
201.00		5, 671, 575		5, 671, 57		5, 671, 575	
202.00		179, 049, 910					
202.00	1.023. (300 111311 4011 5113)	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	1 177,017,71	9	177,017,710	1-32.00

Health Financial Systems

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

				XVIII	ноѕрі таі	L PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	•	+ col. 7)	Rati o	I npati ent	
				,		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
INI	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	40, 786, 691		40, 786, 691			30.00
	100 I NTENSI VE CARE UNI T	10, 991, 986		10, 991, 986			31.00
	100 SUBPROVI DER - I RF	6, 394, 836		6, 394, 836			41.00
	300 NURSERY	0, 374, 030		0, 374, 030			43.00
	400 SKILLED NURSING FACILITY			0			44.00
	CILLARY SERVICE COST CENTERS	<u> </u>					44.00
	OOO OPERATING ROOM	15, 532, 730	93, 006, 663	108, 539, 393	0. 137905	0. 000000	50.00
		13, 332, 730	93,000,003				1
	200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC	1 005 011			0.000000	0.000000	
		1, 995, 011	13, 348, 805		0. 339887	0.000000	1
	500 RADI OLOGY-THERAPEUTI C	188, 175	9, 896, 428		0. 200532	0.000000	
	700 CT SCAN	4, 863, 154	20, 578, 173		0. 033244	0. 000000	
	630 ULTRA SOUND	1, 300, 588	9, 602, 240		0. 057989	0. 000000	
	800 MRI	712, 797	6, 808, 791		0. 078587	0. 000000	
	900 CARDI AC CATHETERI ZATI ON	8, 513, 583	16, 423, 552	24, 937, 135	0. 064630	0. 000000	
	000 LABORATORY	18, 588, 952	51, 636, 133	70, 225, 085	0. 194261	0. 000000	60.00
	001 BLOOD LABORATORY	0	0		0. 000000	0.000000	1
	300 BLOOD STORING, PROCESSING & TRANS.	1, 247, 413	601, 884	1, 849, 297	0. 453936	0. 000000	1
	400 INTRAVENOUS THERAPY	0	0	0	0. 000000	0. 000000	64.00
65.00 06	500 RESPI RATORY THERAPY	6, 014, 699	2, 283, 465	8, 298, 164	0. 348235	0.000000	65.00
	600 PHYSI CAL THERAPY	7, 659, 601	24, 384, 725	32, 044, 326	0. 275715	0.000000	66.00
67.00 06	700 OCCUPATI ONAL THERAPY	0	0	0	0. 000000	0.000000	67.00
68.00 06	800 SPEECH PATHOLOGY	0	0	0	0. 000000	0.000000	68.00
69. 00 06	900 ELECTROCARDI OLOGY	2, 949, 401	8, 339, 830	11, 289, 231	0. 133569	0.000000	69.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 939, 052	33, 238, 781	50, 177, 833	0. 217672	0.000000	71.00
72. 00 07:	200 IMPL. DEV. CHARGED TO PATIENTS	5, 656, 559	23, 342, 251		0. 375760	0.000000	72.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	13, 118, 416	50, 541, 873	63, 660, 289	0. 415696	0. 000000	73.00
	400 RENAL DIALYSIS	918, 202	5, 637			0.000000	1
	020 OTHER ANCI LLARY	0	0		0. 000000	0. 000000	1
	140 CARDI AC REHAB	578, 003	15, 258, 698	15, 836, 701	0. 145272	0. 000000	
	070 WOMEN'S CENTER	96, 443	8, 601, 340		0. 182911	0. 000000	1
	330 ENDOSCOPY	70, 110	0, 001, 010	1	0. 000000	0. 000000	76.02
	700 ALLOGENEIC STEM CELL ACQUISITION		0		0. 000000	0. 000000	1
	TPATIENT SERVICE COST CENTERS	<u> </u>		0	0.000000	0.000000	17.00
	000 CLINIC	13, 848	6, 048, 322	6, 062, 170	0. 147523	0. 000000	90.00
	001 OUTPATI ENT	283, 146	7, 618, 276		0. 147323	0. 000000	
	002 NEUROPSYCHOLOGY	203, 140	2, 715, 354		0. 223873	0.000000	
		(247 7/4					•
	100 EMERGENCY	6, 247, 764	66, 442, 689			0.000000	
	101 SHORT STAY	4 400 000	0		0.000000	0.000000	1
	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 120, 839	6, 643, 878	7, 764, 717	0. 730429	0. 000000	92.00
	HER REIMBURSABLE COST CENTERS	_1		_	0.005	0.000	
	500 AMBULANCE SERVICES	0	0	0	0. 000000	0. 000000	
	200 OPI OI D TREATMENT PROGRAM	0	0	0			102.00
200. 00	Subtotal (see instructions)	172, 711, 889	477, 367, 788	650, 079, 677			200.00
201. 00	Less Observation Beds						201.00
202. 00	Total (see instructions)	172, 711, 889	477, 367, 788	650, 079, 677			202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0059
Period: From 01/01/2022 To 12/31/2022 To 12/31/2022 Part I

Date/Time Prepared:

5/25/2023 3:52 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 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.137905 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.339887 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 200532 55.00 57. 00 05700 CT SCAN 0.033244 57.00 57.01 03630 ULTRA SOUND 0.057989 57.01 05800 MRI 0.078587 58.00 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.064630 59.00 60.00 06000 LABORATORY 0. 194261 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0. 453936 63.00 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64 00 65.00 06500 RESPIRATORY THERAPY 0. 348235 65.00 06600 PHYSI CAL THERAPY 0. 275715 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 133569 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.217672 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.375760 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 415696 73.00 74.00 07400 RENAL DIALYSIS 0. 531839 74.00 76.00 03020 OTHER ANCI LLARY 0.000000 76.00 03140 CARDI AC REHAB 76.01 0. 145272 76.01 76.02 03070 WOMEN'S CENTER 0.182911 76.02 76.03 03330 ENDOSCOPY 0.000000 76.03 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 0. 147523 90.00 09000 CLI NI C 09001 OUTPATIENT 90.01 0. 225875 90.01 09002 NEUROPSYCHOLOGY 90.02 90.02 0. 192312 91.00 09100 EMERGENCY 0.337981 91.00 0.000000 91. 01 09101 SHORT STAY 91.01 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.730429 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.000000 95.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

In Lieu of Form CMS-2552-10
Worksheet C
01/2022 Part I
31/2022 Date/Time Prepared:
5/25/2023 3:52 pm
tal Cost Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-0059 Peri od: From 01/01/2022 To 12/31/2022 Title XIX Hospi tal

			1111	e vi v	1105pi tai	COST	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	32, 412, 257		32, 412, 257	O	32, 412, 257	30.00
	3100 INTENSIVE CARE UNIT	7, 163, 643	l e	7, 163, 643	l	7, 163, 643	
	4100 SUBPROVI DER - I RF	5, 320, 066		5, 320, 066	0	5, 320, 066	
	14300 NURSERY	0		0	0	0	
	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
Al	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	14, 968, 112		14, 968, 112	0	14, 968, 112	50.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0		0	ol	0	52.00
	5400 RADI OLOGY-DI AGNOSTI C	5, 215, 158		5, 215, 158	ol	5, 215, 158	ł
	5500 RADI OLOGY-THERAPEUTI C	2, 022, 290		2, 022, 290		2, 022, 290	
	15700 CT SCAN	845, 762		845, 762	l .	845, 762	1
	3630 ULTRA SOUND	632, 243		632, 243		632, 243	
	5800 MRI	591, 100		591, 100		591, 100	
	5900 CARDI AC CATHETERI ZATI ON	1, 611, 689	l e	1, 611, 689		1, 611, 689	
	6000 LABORATORY	13, 641, 984		13, 641, 984	0	13, 641, 984	60.00
60. 01 0	6001 BLOOD LABORATORY	0		0	0	0	60. 01
63.00 0	6300 BLOOD STORING, PROCESSING & TRANS.	839, 462		839, 462	o	839, 462	63.00
	06400 INTRAVENOUS THERAPY	0		0	ol	0	64.00
	6500 RESPIRATORY THERAPY	2, 889, 714	0	2, 889, 714	ام	2, 889, 714	
	6600 PHYSI CAL THERAPY	8, 835, 115	1		ام	8, 835, 115	•
	16700 OCCUPATI ONAL THERAPY	0,033,113			٥	0, 655, 115	1
			1		U	_	
	6800 SPEECH PATHOLOGY	0	0		0	0	
	6900 ELECTROCARDI OLOGY	1, 507, 896		1, 507, 896		1, 507, 896	
71. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 922, 332		10, 922, 332	0	10, 922, 332	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	10, 896, 599		10, 896, 599	0	10, 896, 599	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	26, 463, 314		26, 463, 314	0	26, 463, 314	73.00
	7400 RENAL DIALYSIS	491, 334		491, 334	ol	491, 334	74.00
76.00 0	3020 OTHER ANCI LLARY	0		1 0	ol	0	76.00
	3140 CARDI AC REHAB	2, 300, 629		2, 300, 629	ol	2, 300, 629	1
	3070 WOMEN' S CENTER	1, 590, 923		1, 590, 923	ام	1, 590, 923	
	3330 ENDOSCOPY	1, 370, 723		1, 370, 723	٥	1, 370, 723	76. 02
	17700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	•
		0			U	U	17.00
	UTPATIENT SERVICE COST CENTERS		l		_1		
	9000 CLI NI C	894, 307		894, 307	0	894, 307	1
	99001 OUTPATI ENT	1, 784, 730		1, 784, 730	0	1, 784, 730	1
90. 02 0	99002 NEUROPSYCHOLOGY	522, 194		522, 194	0	522, 194	90. 02
91.00 0	9100 EMERGENCY	24, 567, 971		24, 567, 971	0	24, 567, 971	91.00
91. 01 0	9101 SHORT STAY	0		0	ol	0	91.01
	9200 OBSERVATION BEDS (NON-DISTINCT PART	5, 671, 575		5, 671, 575		5, 671, 575	92.00
	THER REIMBURSABLE COST CENTERS	.,, 3, 0		., ., ., ,, ,, ,	· · · · · · · · · · · · · · · · · · ·	.,, ., .	1
	9500 AMBULANCE SERVI CES	119, 086		119, 086	O	119, 086	95.00
	0200 OPIOID TREATMENT PROGRAM	0 117,000	l e	117,000	l		102.00
200.00	Subtotal (see instructions)	184, 721, 485	l	ľ			
201.00	Less Observation Beds	5, 671, 575		5, 671, 575		5, 671, 575	
202. 00	Total (see instructions)	179, 049, 910	0	179, 049, 910	0	179, 049, 910	J202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059

					5/25/2023 3: 5	2 pm	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		,		+ col . 7)	Ratio	Inpatient	
				' ' ' ' ' ' '	nati o	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
20.00		10.707 (04)		10.707.70	. [00.00
30.00	03000 ADULTS & PEDIATRICS	40, 786, 691		40, 786, 69			30.00
31.00	03100 INTENSIVE CARE UNIT	10, 991, 986		10, 991, 98			31.00
41.00	04100 SUBPROVI DER - I RF	6, 394, 836		6, 394, 83			41.00
43.00	04300 NURSERY	0					43.00
44.00	04400 SKILLED NURSING FACILITY	0					44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	15, 532, 730	93, 006, 663	108, 539, 39	0. 137905	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 995, 011	13, 348, 805			0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	188, 175	9, 896, 428			0. 000000	
57. 00	05700 CT SCAN	4, 863, 154	20, 578, 173			0. 000000	
57. 01	03630 ULTRA SOUND	1, 300, 588	9, 602, 240			0. 000000	
58.00	05800 MRI	712, 797	6, 808, 791			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	8, 513, 583	16, 423, 552	24, 937, 13	0. 064630	0.000000	59.00
60.00	06000 LABORATORY	18, 588, 952	51, 636, 133	70, 225, 08	0. 194261	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	o	0		0. 000000	0. 000000	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 247, 413	601, 884	1, 849, 29 ⁻		0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	1,217,110	00.700.	1,017,27		0. 000000	
65. 00	06500 RESPI RATORY THERAPY	6, 014, 699	2, 283, 465			0. 000000	
	I I	1					
66.00	06600 PHYSI CAL THERAPY	7, 659, 601	24, 384, 725			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0. 000000	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 949, 401	8, 339, 830			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 939, 052	33, 238, 781	50, 177, 83	0. 217672	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 656, 559	23, 342, 251	28, 998, 810	0. 375760	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	13, 118, 416	50, 541, 873	63, 660, 289	0. 415696	0.000000	73.00
74.00	07400 RENAL DI ALYSI S	918, 202	5, 637	923, 839	0. 531839	0. 000000	74.00
76.00	03020 OTHER ANCI LLARY	0	0			0. 000000	
76. 01	03140 CARDI AC REHAB	578, 003	15, 258, 698			0. 000000	
76. 01	03070 WOMEN' S CENTER	96, 443	8, 601, 340			0. 000000	
76. 02	03330 ENDOSCOPY	70, 443				0. 000000	
		1 -1	0				
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	'	0.000000	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	13, 848	6, 048, 322			0. 000000	
90. 01	09001 OUTPATI ENT	283, 146	7, 618, 276	7, 901, 42	0. 225875	0. 000000	
90.02	09002 NEUROPSYCHOLOGY	0	2, 715, 354	2, 715, 35	0. 192312	0.000000	90.02
91.00	09100 EMERGENCY	6, 247, 764	66, 442, 689	72, 690, 45	0. 337981	0. 000000	91.00
91. 01	09101 SHORT STAY	0	0		0. 000000	0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 120, 839	6, 643, 878			0. 000000	
/2.00	OTHER REIMBURSABLE COST CENTERS	1, 120, 037	0, 043, 070	1, 104, 11	0.730427	0.00000	1 /2.00
05 00	09500 AMBULANCE SERVICES				0.00000	0. 000000	05.00
		0	0	•	0. 000000	0.000000	
	10200 OPI OI D TREATMENT PROGRAM	0	0	1			102.00
200.00		172, 711, 889	477, 367, 788	650, 079, 67	<u>'</u>		200.00
201.00							201.00
202.00	Total (see instructions)	172, 711, 889	477, 367, 788	650, 079, 67	7		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: From 01/01/2022 To 12/31/2022 Date/Time Prepared: From 01/01/2022 Part I Date/Time Part I Date/Time Prepared: From 01/01/2022 Part I Date/

					5/25/2023 3:52 pm
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.0
31.00	03100 INTENSIVE CARE UNIT				31.0
41.00	04100 SUBPROVI DER - I RF				41.0
43.00	04300 NURSERY				43.0
44.00	04400 SKILLED NURSING FACILITY				44.0
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.0
57.00	05700 CT SCAN	0. 000000			57.0
57.01	03630 ULTRA SOUND	0. 000000			57.0
58.00	05800 MRI	0. 000000			58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0
60.00	06000 LABORATORY	0. 000000			60.0
60. 01	06001 BLOOD LABORATORY	0. 000000			60.0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
64.00	06400 I NTRAVENOUS THERAPY	0. 000000			64. 0
65. 00	06500 RESPI RATORY THERAPY	0. 000000			65. 0
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66. 0
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 0
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.0
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
	07400 RENAL DI ALYSI S	0. 000000			74.0
76. 00	03020 OTHER ANCI LLARY	0. 000000			76.0
76. 01	03140 CARDI AC REHAB	0. 000000			76.0
76. 02	03070 WOMEN' S CENTER	0. 000000			76.0
76. 03	03330 ENDOSCOPY	0. 000000			76.0
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 0
50	OUTPATIENT SERVICE COST CENTERS				77.0
90.00	09000 CLINIC	0. 000000			90.0
90. 01	09001 OUTPATI ENT	0. 000000			90.0
90. 02	09002 NEUROPSYCHOLOGY	0. 000000			90.0
91. 00	09100 EMERGENCY	0. 000000			91.0
91. 01	09101 SHORT STAY	0. 000000			91.0
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.0
,	OTHER REIMBURSABLE COST CENTERS	0. 000000			72.0
95. 00	09500 AMBULANCE SERVICES	0. 000000			95.0
	10200 OPI OI D TREATMENT PROGRAM	5. 000000			102.0
200.00					200. 0
201.00	,				201. 0
202.00					202. 0
00	, , , , , , , , , , , , , , , , , , , ,	i I			1232.0

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der Co	F	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col . 26)		col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5, 943, 625		-,		385. 62	1
31.00 INTENSIVE CARE UNIT	874, 699		874, 699	3, 181	274. 98	31.00
41. 00 SUBPROVI DER - I RF	1, 003, 838	0	1, 003, 838	3, 987	251. 78	41.00
43. 00 NURSERY	0			1, 518	0.00	43.00
44.00 SKILLED NURSING FACILITY	0		(0	0.00	44.00
200.00 Total (lines 30 through 199)	7, 822, 162		7, 822, 162	24, 099		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 873					30.00
31.00 INTENSIVE CARE UNIT	878		•			31.00
41. 00 SUBPROVI DER - I RF	2, 096	527, 731				41.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	6, 847	2, 262, 669				200. 00

Heal th	n Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der Co	CN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/25/2023 3:5	pared: 2 pm
-			Title	: XVIII	Hospi tal PPS		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	, , , , , , , , , , , , , , , , , , ,	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)	3		
		col . 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			2. 2.		2.22	
50.00	05000 OPERATING ROOM	2, 820, 224	108, 539, 393	0. 02598	3, 965, 413	103, 033	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0. 00000		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	756, 749	15, 343, 816	•		39, 076	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	399, 416			· ·	4, 263	ı
57. 00	05700 CT SCAN	8, 552				508	
57. 01	03630 ULTRA SOUND	4, 666					
58. 00	05800 MRI	6, 709			· ·	168	
59. 00	05900 CARDI AC CATHETERI ZATI ON	140, 364			· ·	12, 565	
60.00	06000 LABORATORY	875, 448					
60. 01	06001 BLOOD LABORATORY	075,440		0.00000		04, 313	60.01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	138, 068	_			10, 068	
64. 00	06400 I NTRAVENOUS THERAPY	130,000	1,047,277	0.00000		10,008	64.00
65. 00	06500 RESPI RATORY THERAPY	99, 883	8, 298, 164			23, 854	
66. 00	06600 PHYSI CAL THERAPY	317, 705				10, 590	ı
67. 00	06700 OCCUPATIONAL THERAPY	317, 703		0.00000		10, 590	67.00
	06800 SPEECH PATHOLOGY		_	1		0	68.00
68.00	1	-	_			-	•
69.00	06900 ELECTROCARDI OLOGY	367, 111					•
71.00		451, 577					
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	73, 828			,		•
73. 00		646, 178				34, 772	
74. 00	07400 RENAL DIALYSIS	53, 119				12, 813	
76. 00	03020 OTHER ANCI LLARY	0	_	0.00000		0	
76. 01	03140 CARDI AC REHAB	605, 824					
76. 02	1	505, 595				4, 510	
76. 03	03330 ENDOSCOPY	0	_	0. 00000		0	
77. 00		0	0	0.00000	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS		1				
90. 00		135, 714				193	
90. 01	09001 OUTPATI ENT	203, 069	, , , , , ,		· ·	1, 800	
90. 02	09002 NEUROPSYCHOLOGY	94, 882				0	90.02
91. 00		1, 379, 419	72, 690, 453			38, 502	
91. 01	09101 SHORT STAY	0	0	0. 00000		0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 040, 031	7, 764, 717	0. 13394	3 292, 512	39, 180	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200. 0	Total (lines 50 through 199)	11, 124, 131	591, 906, 164		30, 237, 676	475, 875	200. 00

Health Financial Systems	RI VERVI EW			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 3:5	epared: 52 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		n Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	1	0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0	1	0	0	31.00
41. 00 04100 SUBPROVI DER - RF	0	0	1	0	0	
43. 00 04300 NURSERY	0	0	1	0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0	1	0		44.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
LABATI ENT. DOUTLAGE OFFICE OF COST. OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					0.070	
30. 00 03000 ADULTS & PEDIATRICS	0	0			3, 873	
31. 00 03100 I NTENSI VE CARE UNI T		0	3, 18			
41. 00 04100 SUBPROVI DER - I RF	0	0	3, 98			
43. 00 04300 NURSERY		0	1, 51		0	
44.00 04400 SKILLED NURSING FACILITY		0	1	0.00	0	
200.00 Total (lines 30 through 199)	1	0	24, 09	19	6, 847	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through Cost (col. 7					
	x col. 8) 9.00	•				
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSIVE CARE UNIT						31.00
41. 00 04100 SUBPROVI DER - I RF						41.00
43. 00 04300 NURSERY						43.00
44. 00 04400 SKI LLED NURSI NG FACILITY						44.00
200.00 Total (lines 30 through 199)	0					200.00
200.00 (10tal (11163 30 till bugil 177)	1	I				₁ 200.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0059	Period: Worksheet D		

From 01/01/2022 Part IV To 12/31/2022 Part IV Date/Time Prepared: 5/25/2023 3:52 pm THROUGH COSTS

						5/25/2023 3:5	2 pm
			Ti tl	e 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	1	Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0		0	0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		ol	0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		ol	0 0	0	55.00
57.00	05700 CT SCAN	0		ol	0	0	57.00
57. 01	03630 ULTRA SOUND	0			0	Ō	57. 01
58. 00	05800 MRI	0			0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		n n		o o	59.00
60.00	06000 LABORATORY	0				ő	60.00
60. 01	06001 BLOOD LABORATORY					0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0				_	64.00
65. 00	06500 RESPIRATORY THERAPY	0				0	65.00
		0			0	0	
66. 00	06600 PHYSI CAL THERAPY	0		0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0		0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0 0	391, 375	73.00
74.00	07400 RENAL DIALYSIS	0		o	0 0	0	74.00
76.00	03020 OTHER ANCI LLARY	0		ol	0 0	0	76. 00
76. 01	03140 CARDI AC REHAB	0		ol	0 0	0	76. 01
76. 02	03070 WOMEN' S CENTER	0		ol	0 0	0	76. 02
76. 03	03330 ENDOSCOPY	0		ol	0 0	0	76. 03
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	77. 00
,,,,,,	OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		77.00
90.00	09000 CLI NI C	0			0 0	0	90.00
90. 01	09001 OUTPATI ENT	0			0 0	Ö	90. 01
90. 02	09002 NEUROPSYCHOLOGY			n n		o o	90. 02
91. 00	09100 EMERGENCY	0				0	91.00
91. 00	09101 SHORT STAY					_	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			9	0	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				O _I	0	1 72.00
95 00	09500 AMBULANCE SERVICES						95.00
200.00	I I	0		o	0 0	391, 375	
200.00	Total (Thies so through 177)	1	I	۲۱	٥,	371,373	1200.00

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | Part IV | Par THROUGH COSTS

					0 12/31/2022	5/25/2023 3:5	pared: 2 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)	,	(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	108, 539, 393	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	15, 343, 816	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	10, 084, 603	0.000000	55.00
57.00	05700 CT SCAN	0	0	0	25, 441, 327	0.000000	57.00
57. 01	03630 ULTRA SOUND	0	0	0	10, 902, 828	0.000000	57. 01
58.00	05800 MRI	0	0	0	7, 521, 588	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	24, 937, 135	0.000000	59.00
60.00	06000 LABORATORY	0	0	0		0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0.000000	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	1, 849, 297	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	8, 298, 164	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	32, 044, 326	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	l c	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	l c	11, 289, 231	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	l c	50, 177, 833	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l c		0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	391, 375	391, 375	63, 660, 289	0. 006148	73.00
74.00	07400 RENAL DIALYSIS	0	0		923, 839	0.000000	74.00
76.00	03020 OTHER ANCI LLARY	0	0	l c	. 0	0. 000000	1
76. 01	03140 CARDI AC REHAB	0	0		15, 836, 701	0.000000	1
76. 02	03070 WOMEN' S CENTER	0	0		8, 697, 783	0.000000	
76. 03	03330 ENDOSCOPY	0	0			0.000000	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	0	0	C	6, 062, 170	0.000000	90.00
90. 01	09001 OUTPATI ENT	0	0		7, 901, 422	0. 000000	90. 01
90. 02	09002 NEUROPSYCHOLOGY	0	0			0. 000000	90. 02
91.00	09100 EMERGENCY	o	0	Ö		0. 000000	
91. 01	09101 SHORT STAY	0	0			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0			0. 000000	1
	OTHER REIMBURSABLE COST CENTERS				,		1
95.00	09500 AMBULANCE SERVICES						95.00
200.00	1 1	0	391, 375	391, 375	591, 906, 164		200.00
		'				•	

Health Financial Systems	RIVERVIEW HOS	SPI TAL		In Lieu of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0059	Peri od:	Worksheet D	

Part IV From 01/01/2022 THROUGH COSTS 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 10) x col. 12) 13.00 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50 00 05000 OPERATING ROOM 3, 965, 413 16, 478, 086 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 792, 312 0 54.00 3, 154, 258 0 54.00 05500 RADI OLOGY-THERAPEUTI C 107, 625 0.000000 0 55.00 3, 221, 037 55.00 0 05700 CT SCAN 57.00 0.000000 1, 512, 935 5, 184, 636 0 57.00 57.01 03630 ULTRA SOUND 0.000000 346, 738 1, 422, 298 0 57.01 58.00 05800 MRI 0.000000 188, 561 1, 509, 290 0 58.00 5, 382, 084 05900 CARDIAC CATHETERIZATION 2, 232, 233 0 59 00 0.000000 0 59 00 0 60.00 06000 LABORATORY 0.000000 5, 159, 198 4, 383, 992 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 134, 857 53, 950 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 1, 981, 694 651, 309 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 1,068,032 202, 111 0 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 0 67.00 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 886, 148 0 1, 609, 801 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 4, 111, 650 6, 707, 019 71.00 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 356, 277 72.00 0.000000 1, 468, 240 0 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.006148 3, 425, 835 21,062 19, 217, 559 118, 150 73.00 07400 RENAL DIALYSIS 74.00 0.000000 222, 841 0 74.00 76 00 03020 OTHER ANCILLARY 0.000000 0 76.00 C 0 0 03140 CARDI AC REHAB 155, 729 0 5, 038, 793 76.01 0.000000 0 76.01 76.02 03070 WOMEN'S CENTER 0.000000 77, 586 976, 763 0 76.02 03330 ENDOSCOPY 0 76.03 0.000000 0 0 76.03 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 2, 893, 807 0 90.00 8,606 90.01 09001 OUTPATI ENT 0.000000 70,038 0 2, 606, 882 0 90.01 09002 NEUROPSYCHOLOGY 0 979, 344 90.02 90.02 0.000000 0 91.00 09100 EMERGENCY 0.000000 2,028,893 0 6, 477, 986 0 91.00 09101 SHORT STAY 0.000000 0 91.01 91.01 0 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 0.000000 292, 512 0 29, 205 0 92.00

30, 237, 676

21, 062

94, 536, 487

95.00

118, 150 200. 00

95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		VACCINE COST	Provi der C	CN: 15-0059	Peri od:	Worksheet D	
					From 01/01/2022	Part V	
					To 12/31/2022	Date/Time Pre 5/25/2023 3:5	
			Ti tl o	xVIII	Hospi tal	PPS	z piii
			11110	Charges	1103pi tai	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	cost center bescription	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Servi ces (see	Servi ces	Servi ces Not	(366 11131.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	11.00	2.00	0.00	00	0.00	
50.00	05000 OPERATI NG ROOM	0. 137905	16, 478, 086		0 0	2, 272, 410	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0		ı
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 339887	3, 154, 258		0	1, 072, 091	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 200532	3, 221, 037		0	645, 921	
57. 00	05700 CT SCAN	0. 033244	5, 184, 636		0	172, 358	1
57. 01	03630 ULTRA SOUND	0. 053244	1, 422, 298			82, 478	
58. 00	05800 MRI	0. 037 787	1, 509, 290		0	118, 611	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 064630			0	347, 844	
60.00	06000 LABORATORY	0. 194261	5, 382, 084		-		
	l l		4, 383, 992			851, 639	
60. 01	06001 BLOOD LABORATORY	0.000000	J		0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 453936	53, 950	•	-	24, 490	
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	(54 000	1	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 348235	651, 309	1	0		
66.00	06600 PHYSI CAL THERAPY	0. 275715	202, 111		0	55, 725	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	1	0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 133569	1, 609, 801		0	215, 020	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217672	6, 707, 019			1, 459, 930	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 375760	6, 356, 277		0	2, 388, 435	
	07300 DRUGS CHARGED TO PATIENTS	0. 415696	19, 217, 559		21, 741	7, 988, 662	
74.00	07400 RENAL DI ALYSI S	0. 531839	0		0	0	
76. 00	03020 OTHER ANCI LLARY	0. 000000	0		0	0	
	03140 CARDI AC REHAB	0. 145272	5, 038, 793		0	731, 996	
76. 02	03070 WOMEN'S CENTER	0. 182911	976, 763		0	178, 661	
	03330 ENDOSCOPY	0. 000000	0		0	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 147523	2, 893, 807		0	426, 903	
90. 01	09001 OUTPATI ENT	0. 225875	2, 606, 882		0	588, 829	
90. 02	09002 NEUROPSYCHOLOGY	0. 192312	979, 344		0	188, 340	
91. 00	09100 EMERGENCY	0. 337981	6, 477, 986		0	2, 189, 436	91.00
91. 01	09101 SHORT STAY	0. 000000	0		0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 730429	29, 205	(0	21, 332	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0. 000000			O		95.00
200.00	Subtotal (see instructions)]	94, 536, 487	45	8 21, 741	22, 247, 920	200.00
201.00					0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		94, 536, 487	45	21, 741	22, 247, 920	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 Provi der CCN: 15-0059 Peri od: Worksheet D From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/25/2023 3:52 pm 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 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 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 03630 ULTRA SOUND 57.01 0 57.01 58.00 05800 MRI 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 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 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 06500 RESPIRATORY THERAPY 0 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 9,038 73.00 74.00 07400 RENAL DIALYSIS 74 00 0 76.00 |03020 OTHER ANCILLARY 0 76.00 76.01 03140 CARDI AC REHAB 0 76.01 03070 WOMEN'S CENTER 76.02 0 76.02 03330 ENDOSCOPY 76.03 0 76.03 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0 0 0 90.01 09001 OUTPATI ENT 0 90.01 09002 NEUROPSYCHOLOGY 90.02 90.02 0 0 91.00 09100 EMERGENCY 0 91.00 91.01 91.01 09101 SHORT STAY 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

91

91

9, 038

9.038

95.00

200.00

201.00

202.00

OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

95.00

200.00

201.00

202.00

Health Financial Contant	DI VEDVI EW	LIOCOL TAL		la lia		2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	RI VERVI EW	Provi der C	CN: 15 0050	Peri od:	u of Form CMS-2 Worksheet D	2552-10
APPORTIONWENT OF INPATTENT ANCILLARY SERVICE CAPITA	AL 00313	Provider C	CN. 13-0039	From 01/01/2022	Part II	
		Component	CCN: 15-T059	To 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared: 2 pm
		Title	· XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Capi tal	Total Charges	Patio of Cos		Capital Costs	
cost center bescription	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)	onal ges	COT GIIIIT 1)	
	col . 26)	001. 0)	001. 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS					0.00	
50. 00 05000 OPERATING ROOM	2, 820, 224	108, 539, 393	0. 02598	155, 401	4, 038	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	756, 749	15, 343, 816	0. 04931	9 38, 881	1, 918	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	399, 416			1	516	1
57. 00 05700 CT SCAN	8, 552				22	1
57. 01 03630 ULTRA SOUND	4, 666		l .		7	57. 01
58. 00 05800 MRI	6, 709				13	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	140, 364		l .		44	59.00
60. 00 06000 LABORATORY	875, 448	70, 225, 085	0. 01246	696, 217	8, 679	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	138, 068	1, 849, 297	0. 07466	19, 621	1, 465	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	99, 883	8, 298, 164	0. 01203	186, 792	2, 248	65.00
66. 00 06600 PHYSI CAL THERAPY	317, 705	32, 044, 326	0. 00991	5 2, 544, 825	25, 232	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	00	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000	00	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	367, 111	11, 289, 231	0. 03251	9 24, 824	807	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	451, 577	50, 177, 833	0.00900	587, 895	5, 291	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	73, 828	28, 998, 810	0. 00254		123	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	646, 178	63, 660, 289	0. 01015	527, 263	5, 352	73.00
74. 00 07400 RENAL DI ALYSI S	53, 119	923, 839	0.05749	136, 992	7, 877	74.00
76. 00 03020 OTHER ANCI LLARY	0	0	0. 00000	00	0	76.00
76. 01 03140 CARDI AC REHAB	605, 824	15, 836, 701	0. 03825	5, 131	196	76. 01
76. 02 03070 WOMEN' S CENTER	505, 595	8, 697, 783	0. 05812	4, 203	244	76. 02
76. 03 03330 ENDOSCOPY	0	0	0.00000	00	0	76. 03
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 00000	00	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	135, 714				4	
90. 01 09001 OUTPATI ENT	203, 069		l .	1	542	1
90. 02 09002 NEUROPSYCHOLOGY	94, 882				0	
91. 00 09100 EMERGENCY	1, 379, 419		l .	1	815	1
91. 01 09101 SHORT STAY	0	_	1 0.0000		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7, 764, 717	0. 00000	00 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		1	1			
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	10, 084, 100	591, 906, 164		5, 156, 743	65, 433	200. 00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAI			In lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS		S Provider C	CN: 15-0059 CCN: 15-T059		ri od: om 01/01/2022 12/31/2022	Worksheet D Part IV Date/Time Pre 5/25/2023 3:5	pared:
			Title	xVIII	Su	ubprovi der – I RF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments		Р	ost-Stepdown Adjustments	Allied Health	
		1. 00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_		1				
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52. 00 54. 00
	05400 RADI OLOGY THERAPEUT C	0	0		0	0	0	
55. 00 57. 00	O5500 RADI OLOGY-THERAPEUTI C O5700 CT SCAN	0	0		0	0	0	55. 00 57. 00
57. 00	03630 ULTRA SOUND	0	0		0	0	0	57.00
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	1	Ö	o	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		Ö	o	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö		Ö	o	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0	O	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	391, 375	73.00
74.00	07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76.00	03020 OTHER ANCI LLARY	0	0		0	0	0	76. 00
76. 01	03140 CARDI AC REHAB	0	0		0	0	0	76. 01
76. 02	03070 WOMEN' S CENTER	0	0		0	0	0	76. 02
76. 03	03330 ENDOSCOPY	0	0	1	0	0	0	76. 03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77. 00
	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

0

0

0

0 92.00 95.00

391, 375 200. 00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES
200. 00 Total (lines 50 through 199)

Health Financial Systems	RI VERVI EW			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY STHROUGH COSTS	SERVICE OTHER PAS		CN: 15-0059 CCN: 15-T059	Peri od: From 01/01/2022 To 12/31/2022		epared:
		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, and 4)	Total Charges (from Wkst.	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	391, 37	0 108, 539, 393 0 15, 343, 816 10, 084, 603 0 25, 441, 327 0 10, 902, 828 0 7, 521, 588 0 24, 937, 135 70, 225, 085 0 0 1, 849, 297 0 8, 298, 164 32, 044, 326 0 0 0 11, 289, 231 50, 177, 833 0 28, 998, 810 75 63, 660, 289 0 0 0 15, 836, 701 8, 697, 783 0 8, 697, 783	0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	52. 00 54. 00 55. 00 57. 01 58. 00 59. 00 60. 01 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 76. 01 76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0. 000000	77. 00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 90. 01 09001 OUTPATI ENT 90. 02 09002 NEUROPSYCHOLOGY	0 0	0 0		0 6, 062, 170 0 7, 901, 422 0 2, 715, 354	0. 000000 0. 000000 0. 000000	90. 01
91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART DEL MILIPO API E COST CENTERS	0 0	0 0 0		0 72, 690, 453 0 0 0 7, 764, 717	0. 000000 0. 000000 0. 000000	91. 01
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)	0	391, 375	391, 37	75 591, 906, 164		95. 00 200. 00

Health Financial Systems	RI VERVI EW HO				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2022	Worksheet D Part IV	
I I I I I I I I I I I I I I I I I I I		Component		To 12/31/2022	Date/Time Pre 5/25/2023 3:5	
			XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)	40.00	x col. 10)	10.00	x col . 12)	
ANCILL ARV CERVICE COCT CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0. 000000	155, 401		0 0	0	50.00
52. 00 05000 DELIVERY ROOM & LABOR ROOM	0. 000000	155, 401		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	38. 881		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	13, 018		0 0	0	55.00
57. 00 05700 CT SCAN	0. 000000	65, 548			0	57.00
57. 00 03700 CT 3CAN 57. 01 03630 ULTRA SOUND	0. 000000	15, 540			0	57.00
58. 00 05800 MRI	0.000000	14, 145		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	7, 851		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	696, 217		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	070, 217		0 0	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	19, 621		0 0	0	63.00
64. 00 06400 NTRAVENOUS THERAPY	0. 000000	0		o o	Ö	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	186, 792		o o	Ö	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 544, 825		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		o o	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		o o	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	24, 824		o o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	587, 895		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	48, 411		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 006148	527, 263	3, 24	2 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	136, 992		0 0	0	74.00
76.00 03020 OTHER ANCILLARY	0. 000000	0		0	0	76.00
76. 01 03140 CARDI AC REHAB	0. 000000	5, 131		0 118	0	76. 01
76. 02 03070 WOMEN' S CENTER	0. 000000	4, 203		0	0	76. 02
76. 03 03330 ENDOSCOPY	0. 000000	0		0	0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	163		0	0	90.00
90. 01 09001 0UTPATI ENT	0. 000000	21, 089		0	0	90. 01
90. 02 09002 NEUROPSYCHOLOGY	0. 000000	0		0	0	90.02
91. 00 09100 EMERGENCY	0. 000000	42, 933		0	0	91.00
91. 01 09101 SHORT STAY	0. 000000	0		0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES						95.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)		5, 156, 743	3, 24	2 118	0	200.00
200.00 Total (Tries 30 through 177)		5, 150, 743	3, 24	۲۱۵	0	₁ 200.00

		ooportorre		12,01,2022	5/25/2023 3: 5	2 pm
		Title	: XVIII	Subprovi der -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 137905	0	(0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 339887	0	(0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 200532	0	(0	0	55.00
57. 00 05700 CT SCAN	0. 033244	0	(0	0	57.00
57. 01 03630 ULTRA SOUND	0. 057989	0		o	0	57. 01
58. 00 05800 MRI	0. 078587	0		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 064630	0		0	0	59.00
60. 00 06000 LABORATORY	0. 194261	0		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 453936	0			0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	Ö			0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 348235	0			o o	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 275715	Ö			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0			o o	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0			o o	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 133569	Ö			0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217672	0	•		0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 375760	0		1	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 415696	0			0	1
74. 00 07400 RENAL DI ALYSI S	0. 531839	Ö			· -	
76. 00 03020 OTHER ANCI LLARY	0. 000000	0			0	1
76. 01 03140 CARDI AC REHAB	0. 145272	118		-	17	76.00
76. 02 03070 WOMEN' S CENTER	0. 143272	0			0	76.01
76. 03 03330 ENDOSCOPY	0. 000000	0			0	1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0			0	1
OUTPATIENT SERVICE COST CENTERS	0.00000			<u>, </u>		17.00
90. 00 O9000 CLINIC	0. 147523	0		0	0	90.00
90. 01 09001 0UTPATI ENT	0. 147323	0			0	
	1	0		-	ľ	
90. 02 09002 NEUROPSYCHOLOGY	0. 192312	_			0	1
91. 00 09100 EMERGENCY	0. 337981	0			0	1
91. 01 09101 SHORT STAY	0.000000	0			0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 730429	0	(0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			.1		
95. 00 09500 AMBULANCE SERVI CES	0. 000000		(95.00
200.00 Subtotal (see instructions)		118	•		17	200.00
201.00 Less PBP Clinic Lab. Services-Program			(0		201.00
Only Charges (Line 200 Line 201)		440			4-7	202 00
202.00 Net Charges (line 200 - line 201)	1	118	(233	1 17	202. 00

Health Financial Systems	RI VERVI EW	HOSDI TAI		In Lie	u of Form CMS-2	0552_1(
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVIC		Provi der C	CN: 15-0059 CCN: 15-T059	Peri od: From 01/01/2022	Worksheet D	pared:
		Title	XVIII	Subprovi der - I RF	PPS	
	Со	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(coo inct)	(see inst)				

		00.	313		
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
			Services Not		
		Servi ces			
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6. 00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00		1	0		50.00
			_		
52. 00		0	0		52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	J Comment of the comm	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0)	55.00
57.00	05700 CT SCAN	0	0		57.00
57. 01	03630 ULTRA SOUND	1	0	1	57. 01
58. 00					58.00
					1
59. 00		0			59. 00
60.00		0	0	J Company of the Comp	60.00
60. 01	06001 BLOOD LABORATORY	0	0)	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00		1	0	1	64.00
	06500 RESPIRATORY THERAPY				65.00
	1 1				
66. 00		0			66.00
	06700 OCCUPATI ONAL THERAPY	0	0	J Company of the Comp	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0)	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		69. 00
71 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1	0	1	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l o		72.00
	07300 DRUGS CHARGED TO PATIENTS		97	1	73.00
		0	l .		1
	07400 RENAL DIALYSIS	0	0	,	74.00
76. 00	03020 OTHER ANCI LLARY	0	0	J	76. 00
76. 01	03140 CARDI AC REHAB	0	0		76. 01
76. 02	03070 WOMEN' S CENTER	0	0)	76. 02
76. 03		0			76. 03
	07700 ALLOGENEIC STEM CELL ACQUISITION		l o		77. 00
77.00			1		177.00
00.00	OUTPATIENT SERVICE COST CENTERS				00.00
	09000 CLI NI C	0		1	90.00
90. 01		0	0)	90. 01
90.02	09002 NEUROPSYCHOLOGY	0	0)	90. 02
91.00	09100 EMERGENCY	0	0)	91.00
91. 01	1 1	1	l o		91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART			1	92.00
92.00			<u>'</u>	1	72.00
0=	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	0	1		95.00
200.0	O Subtotal (see instructions)	0	97	1	200.00
201.0	Less PBP Clinic Lab. Services-Program	0			201.00
	Only Charges				1
202. 0		0	97	,	202.00
202.0	o ₁ 110 200 1116 201)	1	1 77	İ	1202.00

Hoal th	Financial Systems RIVERVIEW HO	SDI TAI	In Lio	u of Form CMS-:	0552 10
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Peri od:	Worksheet D-1	
001111 01	THE OF THE MEETING GOOT	11001461 0010. 10 0007	From 01/01/2022		
			To 12/31/2022		pared:
		Title XVIII	Hospi tal	5/25/2023 3: 5 PPS	2 pm
	Cost Center Description	Title XVIII	nospi tai	113	
	oust deliter bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		15, 413	1.00
2.00	Inpatient days (including private room days, excluding swing			15, 413	2.00
3.00	Private room days (excluding swing-bed and observation bed days	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation between the semi-private room days)			12, 716	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	7. 00
0.00	reporting period		04 . 6 . 11		0.00
8. 00	Total swing-bed NF type inpatient days (including private room	om days) after December	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	to the December (const		2 072	9. 00
9.00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	g swing-bed and	3, 873	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room davs) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e			_	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
	through December 31 of the cost reporting period	3 .	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendary				
14.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
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
47.00	SWING BED ADJUSTMENT		. 6. 11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	or the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	oos after December 21 of	the cost	0.00	18. 00
16.00	reporting period	Les ai tei December 31 01	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19. 00
17.00	reporting period	es till odgir beceiliber 31 o	i the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
20.00	reporting period	33 41 (31 2333		0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction	ns)		32, 412, 257	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	,	ting period (line		22.00
	5 x line 17)	·	`		
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line d	0	23. 00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. 00

1. 00	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS	15, 413	1
2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	15, 413	•
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	15, 415	3.
3.00	do not complete this line.	U	ا ع
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	12, 716	4.
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	12, 710	5.
3.00	reporting period	O] 5.
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.
0.00	reporting period (if calendar year, enter 0 on this line)	J	0.
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.
,, 00	report in a peri od	· ·	''
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)	_	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 873	9.
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.
15. 00	Total nursery days (title V or XIX only)	0	15.
16. 00	3 1 1	0	16.
	SWING BED ADJUSTMENT		
7. 00		0. 00	17.
_	reporting period		
8. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.
	reporting period	0.00	
9. 00		0. 00	19.
20.00	reporting period	0.00	20
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.
21. 00	reporting period	32, 412, 257	21
21.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		21. 22.
22.00	5 x line 17)	0	22.
23. 00	, and the second	0	23.
.5.00	Swing-bed cost appropriate to swintype services after become sinor the cost reporting period (fine to skin type services after become sinor the cost reporting period (fine to skin type services after become sinor the cost reporting period (fine to skin type services after become sinor the cost reporting period (fine to skin type services after become sinor the cost reporting period (fine to skin type services after become sinor the cost reporting period (fine to skin type services after become sinor the cost reporting period (fine to skin type services after become sinor the cost reporting period (fine to skin type services after become services).	O	25.
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.
. 1. 00	7 x line 19)	J	
25. 00	, and the second	0	25.
	x line 20)	· ·	
26. 00	Total swing-bed cost (see instructions)	0	26.
27. 00	, , , , , , , , , , , , , , , , , , ,	32, 412, 257	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00		0	28.
		0	29.
9. 00		0	30.
	Semi - pri vate room charges (excluding swing-bed charges)	U	J 30.
0.00		0. 000000	
0. 00 1. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31.
0. 00 1. 00 2. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000	31. 32.
0. 00 1. 00 2. 00 3. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 0. 00	31. 32. 33.
0. 00 1. 00 2. 00 3. 00 4. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 000000 0. 00 0. 00	31. 32. 33. 34.
30.00 31.00 32.00 33.00 34.00 35.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 000000 0. 00 0. 00 0. 00	31. 32. 33. 34.
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 32. 33. 34. 35.
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 32. 33. 34. 35. 36.
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 32. 33. 34. 35. 36.
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 32. 33. 34. 35. 36.
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 32. 33. 34. 35. 36. 37.
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	0. 000000 0. 00 0. 00 0. 00 0. 00 0 32, 412, 257	31. 32. 33. 34. 35. 36. 37.
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	0. 000000 0. 00 0. 00 0. 00 0. 00 0 32, 412, 257	31. 32. 33. 34. 35. 36. 37.

COMPLIA	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW 1		CN: 15-0059	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMPU I	ATION OF INPATIENT OPERATING COST				From 01/01/2022 To 12/31/2022		pared:
	Cost Contor Dosorintion	Total	Ti tl e	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	Cost Center Description	Inpatient	Inpatient	Di em (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NUDCEDY (+: +1 - V 0 VIV1)	1.00	2.00	3.00	4.00	5. 00	42.0
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	0	C	0.0	00 0	0	42.0
43. 00	INTENSIVE CARE UNIT	7, 163, 643	3, 181	2, 252. 0	1 878	1, 977, 265	43.0
44.00	CORONARY CARE UNIT		-,	,			44.0
45. 00	BURN INTENSIVE CARE UNIT						45.0
46.00	SURGICAL INTENSIVE CARE UNIT						46.0
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	oost center bescriptron					1. 00	
48. 00	Program inpatient ancillary service cost (W					7, 176, 204	
48. 01	Program inpatient cellular therapy acquisit				, column 1)	0	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instru	ctions)		17, 298, 078	49.0
50. 00	Pass through costs applicable to Program in	natient routine	services (fro	m Wkst D su	m of Parts I and	1, 734, 938	50.0
30. 00	III)	patrent routine	301 11 003 (11 0	ii wkst. b, sui	iii or rarts r and	1, 754, 750	30.0
51. 00	Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D,	sum of Parts II	496, 937	51.0
E2 00	and IV)	EO and E1)				2 224 075	E2 ^
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated non-nh	veician anget	hatist and	2, 231, 875 15, 066, 203	
33.00	medical education costs (line 49 minus line		rated, non-pii	ysi ci aii aliesti	netrst, and	13, 000, 203	33.0
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
55.00	Target amount per discharge					0.00	
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	r use only)				0. 00 0. 00	1
56. 00	Target amount (line 54 x sum of lines 55, 5					0.00	1
57. 00	Difference between adjusted inpatient opera			line 56 minus	line 53)	Ō	1
58. 00	Bonus payment (see instructions)					0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost rep	orting period	endi ng 1996,	0.00	59.0
60. 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54		m nrior vear	cost report	undated by the	0.00	60.0
00. 00	market basket)	, or time 55 tro	iii piroi yeai	cost report,	apaarea by the	0.00	00.0
61. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)	sser of 50% of t	he amount by	which operati	ng costs (line	0	61.0
62. 00	Relief payment (see instructions)					0	62.0
63.00	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	63.0
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	ete through Doco	mbor 21 of th	a cost report	ing paried (Saa	0	64.0
04.00	instructions)(title XVIII only)	ists through bece	iliber 31 of th	e cost report	ing period (see	l	04.0
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65.0
	instructions)(title XVIII only)			(=) (\n.)			
66. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line	64 plus line	65)(title XVI	II only); for	0	66.0
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	eportina period	0	67.0
	(line 12 x line 19)				3 1		
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost rep	orting period	0	68. 0
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 ± lin	e 68)		0	69.0
07.00	PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY	, AND ICF/IID	ONLY			1 07.0
70. 00	Skilled nursing facility/other nursing faci	lity/ICF/IID rou	tine service	cost (line 37)		70.0
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.0
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli	,	(lino 14 v l	ino 25)			72.0
74. 00	Total Program general inpatient routine ser		,				74.0
75. 00	Capital-related cost allocated to inpatient	,		•	Part II, column		75.0
	26, line 45)	>					l
76. 00 77. 00	Per diem capital related costs (line 75 ÷ l						76.0
78.00	Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min						77.0
79. 00	Aggregate charges to beneficiaries for exce		rovi der recor	ds)			79.0
80.00	Total Program routine service costs for com	parison to the c			nus line 79)		80.0
81.00	Inpatient routine service cost per diem lim		`				81.0
82.00	Inpatient routine service cost limitation (•				82. 0 83. 0
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i		3)				84.0
85. 00	Utilization review - physician compensation		ns)				85.0
05.00	Total Program inpatient operating costs (su					1	86.0
86. 00	Total Trogram Impatrent operating costs (sa	III OI IIIIOS OO tii	· cug cc/				1
	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction	SS THROUGH COST	. cug.: cc/			2, 697	87. 0

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 01/01/2022 To 12/31/2022		pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			5, 671, 575	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	5, 943, 625	32, 412, 257	0. 18337	6 5, 671, 575	1, 040, 031	90.00
91.00 Nursing Program cost	0	32, 412, 257	0.00000	0 5, 671, 575	0	91.00
92.00 Allied health cost	o	32, 412, 257	0.00000	0 5, 671, 575	0	92.00
93.00 All other Medical Education	o	32, 412, 257	0. 00000	0 5, 671, 575	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od:	Worksheet D-1
		From 01/01/2022	
	Component CCN: 15-T059	To 12/31/2022	
			5/25/2023 3:52 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

PART ALL REQUIPER COMPONENTS 1.00				I RF		
MARTILL IMPS		Cost Center Description			1 00	
Inpatt ent days (Including private room days and swing-bed days, excluding newborn) 3,987 1,00		PART I - ALL PROVIDER COMPONENTS			1.00	
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29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room 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, 320, 066) 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) 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 30.00 30.00 30.00 30.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 3	28 00		d and observation hed ch	arnes)	0	28 00
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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, 320, 066) 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, 334. 35 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35. 00 36. 00 37. 00 37. 00 38. 00 40. 00			nus line 33)(see instruc	tions)		
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, 320, 066 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) 79.00 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) 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.0		, , ,		5115)		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 27.796, 798 39.00 40.00		,	•			
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) 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	37. 00	,	and private room cost di	fferential (line	5, 320, 066	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,334.35 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,796,798 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,334.35 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,796,798 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,796,798 39.00 40.00	38. 00			T	1, 334. 35	38. 00
		'	•			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,796,798 41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 796, 798	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW			Peri od:	worksheet D-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:
			Title	e XVIII	Subprovi der -	5/25/2023 3: 5 PPS	52 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost	I npati ent Days	Diem (col. 1 ÷ col. 2)	0	(col. 3 x col. 4)	
42.00	MUDCEDV (+; +Lo V 0 VLV only)	1.00	2.00	3.00	4.00	5. 00	12.0
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units) (0.0	00 0	0	42.0
	INTENSIVE CARE UNIT	0		0.0	00 0	0	43.0
4	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
4	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 0
47.00	Cost Center Description						47.0
40.00	D		2 11 200			1.00	40.0
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti	St. D-3, COL.	3, line 200)	: III lino 10	column 1)	1, 415, 131	1
	Total Program inpatient costs (sum of lines				, corumir r)	4, 211, 929	
	PASS THROUGH COST ADJUSTMENTS	· · · · · · · · · · · · · · · · · · ·	01) (000 11.01.0	01.01.0)		1,211,727	1
	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	m of Parts I and	527, 731	50.00
	<pre>III) Pass through costs applicable to Program inp</pre>	ationt ancilla	ry convices (f	From Wkst D	cum of Dorte II	68, 675	51.0
	rass through costs appricable to Frogram inp and IV) Total Program excludable cost (sum of lines		iry services (i	TOII WKSt. D, :	Sum Of Farts II	596, 406	
	Total Program inpatient operating cost exclu		elated, non-ph	ysician anest	hetist, and	3, 615, 523	
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor	use only)				0.00	
	Target amount (line 54 x sum of lines 55, 55					0	
	Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	line 53)	0	1
	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line EE fro	m the cost ron	orting ported	anding 1004	0.00	
	updated and compounded by the market basket)	or title 55 fro	ill the cost rep	or tring period	enuring 1990,	0.00	39.0
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fr	om prior year	cost report, i	updated by the	0.00	60.0
	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of	the amount by	which operation	ng costs (line	0	61.0
	enter zero. (see instructions) Relief payment (see instructions)					0	62.0
63.00	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	63.0
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost report	ing period (See	0	64.0
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decem	her 31 of the	cost reportin	a neriod (See	0	65.0
	instructions)(title XVIII only)	ts arter becein	ibei 31 01 the	cost reporting	g perrou (see		05.0
	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	e 64 plus line	65)(title XVI	II only); for	0	66.0
	Title V or XIX swing-bed NF inpatient routin (line 12×1 line 19)	e costs throug	h December 31	of the cost re	eporting period	0	67.0
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after	December 31 of	the cost rep	orting period	0	68. 0
69.00	Total title V or XÍX swing-bed NF inpatient PART III – SKILLED NURSING FACILITY, OTHER N					0	69.0
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID ro	utine service	cost (line 37))		70.0
	Adjusted general inpatient routine service of		ııne 70 ÷ line	2)			71.0
	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	m (line 14 x l	ine 35)			72.0
	Total Program general inpatient routine serv						74.0
	Capital-related cost allocated to inpatient 26, line 45)	routine servic	e costs (from	Worksheet B, I	Part II, column		75.0
	Per diem capital-related costs (line 75 ÷ li	,					76.0
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. C
	Aggregate charges to beneficiaries for exces		provi den recon	·ds)			79.0
	Total Program routine service costs for comp				nus line 79)		80.0
1	Inpatient routine service cost per diem limi			•	,		81.0
31. 00 T	Inpatient routine service cost limitation (I						82.0
82. 00	Reasonable inpatient routine service costs (see instructio	ns)				83.0
82. 00 83. 00	·	a+mua+! · `					
82. 00 83. 00 84. 00	Program inpatient ancillary services (see in		ons)				1
82. 00 83. 00 84. 00 85. 00	·	(see instructi					84. 0 85. 0 86. 0

Health Financial Systems RIVERVIEW HOSPITAL In Lieu						2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059 Peri od:				Worksheet D-1	
		Component (From 01/01/2022 To 12/31/2022		pared: 2 pm
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	: line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	ee instructions))			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		,		(from line	(col. 3 x	
				89)	col. 4) (see	
				,	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 003, 838	5, 320, 066	0. 18868	39 0	0	90.00
91.00 Nursing Program cost	o	5, 320, 066	0.00000	00	0	91.00
92.00 Allied health cost	o	5, 320, 066	0. 00000	00 0	0	92.00
93.00 All other Medical Education	0	5, 320, 066		00	0	93.00
•	'			1	'	

111 4-	DIVEDUE W HO	CDI TAI	la lia	6 F CMC (NEE 2 4 0
	Financial Systems RIVERVIEW HOS ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INFAITENT OFERATING COST	FIOVIDE CCN. 15-0039	From 01/01/2022	WOLKSHEET D-1	
			To 12/31/2022	5/25/2023 3: 5	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	vs excluding newborn)		15, 413	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			15, 413	2.00
3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days	0	3.00
3.00	do not complete this line.	rys). Tr you have only p	Trvate room days,	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed davs)		12, 716	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	3 /			
7. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	466	9. 00
40.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		soom dovo) often	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, e		days) arter	ا	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12. 00
12.00	through December 31 of the cost reporting period	X only (Therdaring priva	te room days)	١	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y			-	
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)		,	1, 518	15.00
16. 00	Nursery days (title V or XIX only)			141	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0. 00	17.00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.00
00.00	reporting period	Class Davids and a C		0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	tne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	nc)		32, 412, 257	21. 00
	Swing-bed cost applicable to SNF type services through Decemb		ting ported (line		
22.00	Swing-bed cost appricable to SNF type services through beceinib 5 x line 17)	ber 31 of the cost repor	ting period (ITH	U	22.00
23 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	na neriod (line A	0	23. 00
20.00	x line 18)	c. c. the cost reportin	.9 251104 (11110 0	١	20.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)	,	- , , ,		

	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15, 413	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	15, 413 0	2. 00 3. 00
3.00	do not complete this line.	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	12, 716	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	466	9. 00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	1, 518	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	141	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
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	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21. 00	reporting period Total general impatient routine corvice cost (coe instructions)	32, 412, 257	21. 00
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		21.00
22.00	5 x line 17)		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
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
27, 00	x line 20)	0	27.00
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 32, 412, 257	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	02/112/20/	27.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	29.00
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
	Average private room per diem charge (line 29 ÷ line 3)	0.00000	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	-	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	2 102 22	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 102. 92	38.00
	Program general inpatient routine service cost (line 9 x line 38) Medically processary private room cost applicable to the Program (line 14 x line 35)	979, 961	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 979, 961	40. 00 41. 00
41.00	Total Trogram general Tripatrent routine Service Cost (Title 39 + Title 40)	7/7, 701	41.00

OMPUTATION OF INPATIENT OPERATING COST		RI VERVI EW H	Provi der CC		Period: From 01/01/2022 To 12/31/2022		epar
	Cost Center Description	Total Inpatient Cost	Titl Total Inpatient Days	e XIX Average Per Diem (col. 1 ÷ col. 2)	Hospi tal Program Days	Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only)	0	1, 518	0.0	0 141		42
	Intensive Care Type Inpatient Hospital Units				-1	_	١
. 00	INTENSIVE CARE UNIT	7, 163, 643	3, 181	2, 252. 0	0	0	
. 00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46
. 00	Cost Center Description						47
	cost center beserretron					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			394, 326	48
. 01	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	0	48
00	Total Program inpatient costs (sum of lines				,	1, 374, 287	
	PASS THROUGH COST ADJUSTMENTS		, ,	,			
00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, su	n of Parts I and	0	50
	[111]						
00	Pass through costs applicable to Program inp	atient ancillary	y services (fr	om Wkst. D,	sum of Parts II	0	51
	and IV)						
. 00	Total Program excludable cost (sum of lines					0	
. 00	Total Program inpatient operating cost exclu		ated, non-phy	ısıcıan anest	netist, and	0	53
	medical education costs (line 49 minus line	52)					-
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54
. 00						0.00	
. 00	Target amount per discharge Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor	uso only)				0.00	
. 00	Target amount (line 54 x sum of lines 55, 55					0.00	1
. 00	Difference between adjusted inpatient operat		raet amount (1	ine 56 minus	line 53)	0	1
. 00	Bonus payment (see instructions)	ring cost and tai	get amount (i	THE 30 III HUS	11110 33)	ĺ	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost reno	orting period	endi ng 1996	0.00	
. 00	updated and compounded by the market basket)		11.0 0001 . opc	. tring portou	onaring 1770,		
. 00	Expected costs (lesser of line 53 ÷ line 54,		m prior vear o	ost report.	updated by the	0.00	60
. 00	market basket) Continuous improvement bonus payment (if lir					0	61
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)						
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instrud	ctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	its through Decer	mber 31 of the	cost report	ng period (See	0	64
00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	to after Decembe	or 21 of the c	act reportin	a pariod (Saa		65
. 00	instructions)(title XVIII only)	is after beceilibe	er 31 or the c	ost reportini	j period (see	l	' 0:
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line /	64 nlus line A	5)(title XVI	II only). for	0	66
. 00	CAH, see instructions	ne costs (True t	of prus triic c	13) (ti ti c XVI	1 0111 y), 101	l	7 00
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eportina period	0	6
	(line 12 x line 19)		•		. 5 1 - 1 - 2 - 3	1	-
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)						
. 00	Total title V or XIX swing-bed NF inpatient					0	69
00	PART III - SKILLED NURSING FACILITY, OTHER N						١
. 00	Skilled nursing facility/other nursing facil	•		•	,		70
. 00	Adjusted general inpatient routine service of		ne /u ÷ line	۷)			7
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 1/ v li	ne 35)			73
00	Total Program general inpatient routine serv	9	•	•			7
00	Capital -related cost allocated to inpatient	•			Part II column		7!
55	26, line 45)				,		^`
00	Per diem capital-related costs (line 75 ÷ li	ne 2)					70
00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu					1	78
00	Aggregate charges to beneficiaries for exces		rovi der record	ls)			79
00	Total Program routine service costs for comp	arison to the co	ost limitation	ı (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem limi						8
00	Inpatient routine service cost limitation (I	ine 9 x line 81))				82
00	Reasonable inpatient routine service costs (s)				83
. 00	Program inpatient ancillary services (see in						84
	Utilization review - physician compensation	•					85
. 00	Training Branch and the state of the state o					(86
	Total Program inpatient operating costs (sum		rough 85)				1 ~
00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions	S THROUGH COST	rough 85)			2, 697	

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:			Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				5, 671, 575	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	5, 943, 625	32, 412, 257	0. 18337	6 5, 671, 575	1, 040, 031	90.00
91.00 Nursing Program cost	0	32, 412, 257	0.00000	0 5, 671, 575	0	91.00
92.00 Allied health cost	o	32, 412, 257	0.00000	0 5, 671, 575	0	92.00
93.00 All other Medical Education	o	32, 412, 257	0. 00000	0 5, 671, 575	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od:	Worksheet D-1
		From 01/01/2022	
	Component CCN: 15-T059	To 12/31/2022	
			5/25/2023 3:52 pm
	Title XIX	Subprovi der -	Cost
		IRF	

			I RF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS			0.007	
1. 00 2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 987 3, 987	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed da		vate room days.	3, 767	3.00
	do not complete this line.	,-,· · · · , · · · · · · · · · · · · ·	,		
4.00	Semi-private room days (excluding swing-bed and observation b			3, 987	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	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 roo	m days) through December	31 of the cost	0	7.00
7.00	reporting period	m days) tim dagn bedember	or or the cost	Ü	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3°	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	10	9. 00
	newborn days) (see instructions)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e		s seem devel	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed to	lays)		15.00
16. 00	Nursery days (title V or XIX only)			141	ı
17.00	SWING BED ADJUSTMENT			0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0 00	19.00
	reporting period	Ü			
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of th	ne cost	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instruction			5, 320, 066	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23.00
	x line 18)		, , , ,		
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reportir	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 320, 066	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had cha	arnes)	0	28. 00
	Private room charges (excluding swing-bed charges)	a and observation bed cha	ii ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruct	ti ons)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)	ļ	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 dif	ferential (line	5, 320, 066	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		Ţ	1, 334. 35	38 00
39. 00	Program general inpatient routine service cost per drem (see	•		13, 344	1
	Medically necessary private room cost applicable to the Progr			0	1
	Total Program general inpatient routine service cost (line 39	,		13, 344	

	ancial Systems DN OF INPATIENT OPERATING COST	RI VERVI EW		CCN: 15-0059	Peri od:	wof Form CMS-2 Worksheet D-1	
			Component	CCN: 15-T059	From 01/01/2022 To 12/31/2022		enare
			'			5/25/2023 3:5	
			liti	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpati ent	Inpatient	Diem (col.	1	(col. 3 x	
		Cost 1.00	2. 00	÷ col. 2)	4. 00	col . 4) 5.00	
	SERY (title V & XIX only)	0					42.
	ensive Care Type Inpatient Hospital Units		I a		00 0	1 0	4.2
	ENSIVE CARE UNIT	0	(0.4	00 0	0	43.
	N INTENSIVE CARE UNIT						45.
	GICAL INTENSIVE CARE UNIT						46
7. 00 OTH	ER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3.00 Pro	gram inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)	-		36, 192	48
	gram inpatient cellular therapy acquisiti), column 1)	0	
	al Program inpatient costs (sum of lines - S THROUGH COST ADJUSTMENTS	41 through 48.	01)(see instru	ctions)		49, 536	49
	s through costs applicable to Program inp	atient routine	services (fro	m Wkst D si	um of Parts I and	0	50
111		211 0111 1 0411 110	33. 1. 333 (01 . 41 . 63 . 41		
	s through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	0	51
	IIV) al Program excludable cost (sum of lines !	50 and 51)				0	52
	al Program inpatient operating cost exclu		elated, non-ph	vsician anes	thetist, and	0	1
med	ical education costs (line 49 minus line	9 1					
	GET AMOUNT AND LIMIT COMPUTATION					1	١.,
	gram discharges get amount per discharge					0.00	
	manent adjustment amount per discharge					0.00	
. 02 Adj	ustment amount per discharge (contractor					0.00	
	get amount (line 54 x sum of lines 55, 55			11 F/		0	
	Ference between adjusted inpatient operatuus payment (see instructions)	ing cost and t	arget amount (line 56 minus	s line 53)	0	
	ended costs (lesser of line 53 ÷ line 54, o	or line 55 fro	m the cost rep	ortina period	d endi na 1996.	0.00	
upd	ated and compounded by the market basket)		·	0 .			
	ected costs (lesser of line 53 ÷ line 54,	or line 55 fr	om prior year	cost report,	updated by the	0.00	60
1	ket basket) tinuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than	the lowest of	flines 55 plus	0	61
55.	01, or line 59, or line 60, enter the less	ser of 50% of	the amount by	which operati	ng costs (line		
	are less than expected costs (lines 54 x	60), or 1 % o	f the target a	mount (line 5	56), otherwise		
1	er zero. (see instructions) ief payment (see instructions)					0	62
	owable Inpatient cost plus incentive payment	ent (see instr	uctions)			Ö	1
	GRAM INPATIENT ROUTINE SWING BED COST						
	licare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost report	ting period (See	0	64
5. 00 Med	tructions)(title XVIII only) licare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reportir	na period (See	0	65
	tructions)(title XVIII only)				5 1		
	al Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66
	, see instructions le V or XIX swing-bed NF inpatient routin	e costs through	h December 31	of the cost i	reporting period	0	67
	ne 12 x line 19)	_ 500 to till oug	3000	2. 2 0031 1	composition		"
	le V or XIX swing-bed NF inpatient routing	e costs after	December 31 of	the cost rep	oorting period	0	68
1	ne 13 x line 20) al title V or XIX swing-bed NF inpatient :	routine costs	(line 67 ± lin	ie 68)		0	69
	T III - SKILLED NURSING FACILITY, OTHER NU		•				"
). 00 Ski	lled nursing facility/other nursing facil	ity/ICF/IID ro	utine service	cost (line 37	7)		70
1 -	usted general inpatient routine service co		line 70 ÷ line	2)			71
1	gram routine service cost (line 9 x line i lically necessary private room cost applic		m (line 14 x L	ine 35)			72
4	al Program general inpatient routine serv						74
	ital-related cost allocated to inpatient	routine servic	e costs (from	Worksheet B,	Part II, column		75
	-line 45) diem capital-related costs (line 75 ÷ li	ne 2)					76
1	gram capital-related costs (line 9 x line						77
. 00 I np	atient routine service cost (line 74 minu	s line 77)					78
	regate charges to beneficiaries for exces						79
	al Program routine service costs for compartions routine service cost per diam limit		cost limitatio	n (line 78 mi	nus line 79)		80
	atient routine service cost per diem limi atient routine service cost limitation (l		1)				81
	sonable inpatient routine service costs (83
.00 Pro	gram inpatient ancillary services (see in	structions)	,				84
5.00 Uti	lization review - physician compensation	(see instructi					85
5.00 <u>Tot</u>	<u>al Program inpatient operating costs (sum</u> T IV - COMPUTATION OF OBSERVATION BED PAS:		nrough 85)				86
PΔP.							

Health Financial Systems RIVERVIEW HOSPITAL In Lieu					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0059 Peri od:				
		'	CCN: 15-T059	From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 003, 838	5, 320, 066	0. 18868	39 0	0	90.00
91.00 Nursing Program cost	0	5, 320, 066	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	5, 320, 066	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 320, 066	0. 00000	0 0	0	93.00

Heal th	Financial Systems	RI VERVI EW HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0059	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-3	
					5/25/2023 3:5	2 pm
		Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS			8, 360, 541		30.00
	03100 INTENSIVE CARE UNIT			3, 137, 922		31.00
41. 00	04100 SUBPROVI DER - I RF			652, 603		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 13790		546, 850	
	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 33988		269, 297	
	05500 RADI OLOGY-THERAPEUTI C		0. 20053		21, 582	
	05700 CT SCAN		0. 03324		50, 296	
	03630 ULTRA SOUND		0. 05798		20, 107	
	05800 MRI		0. 07858		14, 818	
	05900 CARDI AC CATHETERI ZATI ON		0.06463		144, 269	
60. 00	06000 LABORATORY		0. 19426		1, 002, 231	
	06001 BLOOD LABORATORY		0.00000		0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 45393		61, 216	
	06400 I NTRAVENOUS THERAPY		0. 00000		0	64.00
	06500 RESPI RATORY THERAPY		0. 34823	1, 981, 694	690, 095	
	06600 PHYSI CAL THERAPY		0. 27571	5 1, 068, 032	294, 472	66.00
	06700 OCCUPATI ONAL THERAPY		0.00000		0	67.00
68.00	06800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00

0.133569

0.217672

0.375760

0.415696

0.531839

0.000000

0.145272

0. 182911

0.000000

0.000000

0.147523

0. 225875

0.192312

0.337981

0.000000

0. 730429

886, 148

4, 111, 650

1, 468, 240

3, 425, 835

222, 841

155, 729

77, 586

8,606

70, 038

2, 028, 893

292, 512

30, 237, 676

30, 237, 676

118, 362

894, 991

551, 706

118, 516

22, 623

14, 191

1, 270

15, 820

685, 727

213, 659

0

Ω

0 77.00

0 91.01

7, 176, 204 200. 00

1, 424, 106

71.00

72.00

73.00

74.00

76.00

76.01

76.02

76.03

90.00

90. 01

90.02

91.00

92.00

95.00

201.00

202.00

06900 ELECTROCARDI OLOGY

73. 00 07300 DRUGS CHARGED TO PATIENTS

07400 RENAL DIALYSIS

03140 CARDI AC REHAB

03330 ENDOSCOPY

09001 OUTPATI ENT

09100 EMERGENCY

09101 SHORT STAY

09000 CLI NI C

03070 WOMEN'S CENTER

09002 NEUROPSYCHOLOGY

09500 AMBULANCE SERVICES

03020 OTHER ANCI LLARY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

07200 IMPL. DEV. CHARGED TO PATIENTS

07700 ALLOGENEIC STEM CELL ACQUISITION

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61)

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

71.00

72.00

74.00

76.00

76.01

76.02

76 03

77.00

90.00

90. 01

90.02

91.00

91.01

92.00

95.00

200.00

201.00

202.00

Health Financial Systems RIVERVIEW H INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-3	
			From 01/01/2022		
	Component	CCN: 15-T059	To 12/31/2022	Date/Time Pre 5/25/2023 3:5	
	Title	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 INTENSIVE CARE UNIT					31.00
41. 00 04100 SUBPROVI DER - I RF			3, 403, 427		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 13790	•	21, 431	
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 33988		13, 215	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 20053		2, 611	
57. 00 05700 CT SCAN		0. 03324			1
57. 01 03630 ULTRA SOUND		0. 05798			
58. 00 05800 MRI		0. 07858		1, 112	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.06463		507	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 19426		135, 248 0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 45393		8. 907	
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000		0, 707	
65. 00 06500 RESPIRATORY THERAPY		0. 34823		1	1
66. 00 06600 PHYSI CAL THERAPY		0. 27571		701, 646	
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	1
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	1
69. 00 06900 ELECTROCARDI OLOGY		0. 13356	9 24, 824	3, 316	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21767	72 587, 895	127, 968	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 37576	48, 411	18, 191	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 41569		219, 181	
74. 00 07400 RENAL DI ALYSI S		0. 53183		72, 858	
76. 00 03020 OTHER ANCI LLARY		0.00000		0	
76. 01 03140 CARDI AC REHAB		0. 14527		745	1
76. 02 03070 WOMEN' S CENTER		0. 18291		769	
76. 03 03330 ENDOSCOPY		0.00000			
77. 00 O7700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	00 0	0	77. 00
90. 00 O9000 CLINIC		0.1475	23 163	24	90.00
90. 00 09000 CETNI C 90. 01 09001 OUTPATI ENT		0. 14752 0. 22587			
90. 02 09002 NEUROPSYCHOLOGY		0. 19231		4,763	1
91. 00 09100 EMERGENCY		0. 33798			1
91. 01 09101 SHORT STAY		0.00000		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 73042			
OTHER REIMBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVICES					95.00
200 00 Total (sum of lines 50 through 94 and 96 through 98)			5 156 743	1 415 131	200 00

1, 415, 131 200. 00 201. 00 202. 00

5, 156, 743

5, 156, 743

200.00

201. 00 202. 00 Total (sum of lines 50 through 94 and 96 through 98)

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

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 01/01/2022	Worksheet D-3	
			To 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared: 2 pm
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 383, 350		30.00
31.00 03100 INTENSIVE CARE UNIT			259, 536		31.00

		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	
30. 00	03000 ADULTS & PEDI ATRI CS		1, 383, 350		30.00
31. 00	03100 NTENSI VE CARE UNIT		259, 536		31.00
41. 00	04100 SUBPROVI DER - I RF		0		41.00
43. 00	04300 NURSERY		0		43.00
	ANCI LLARY SERVI CE COST CENTERS	l.	-		
50.00	05000 OPERATI NG ROOM	0. 137905	479, 738	66, 158	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 339887	27, 136	9, 223	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 200532	0	0	55.00
57.00	05700 CT SCAN	0. 033244	80, 035	2, 661	57.00
57. 01	03630 ULTRA SOUND	0. 057989	20, 588	1, 194	57. 01
58.00	05800 MRI	0. 078587	7, 902	621	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.064630	117, 693	7, 606	59. 00
60.00	06000 LABORATORY	0. 194261	374, 426	72, 736	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 453936	37, 552	17, 046	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 348235	110, 628	38, 525	65.00
66.00	06600 PHYSI CAL THERAPY	0. 275715	27, 504	7, 583	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 133569	46, 456	6, 205	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217672	943	205	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 375760	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 415696	271, 296	112, 777	73.00
74.00	07400 RENAL DI ALYSI S	0. 531839	0	0	74.00
76.00	03020 OTHER ANCI LLARY	0. 000000	0	0	76.00
76. 01	O3140 CARDI AC REHAB	0. 145272	8, 219	1, 194	76. 01
	03070 WOMEN' S CENTER	0. 182911	0	0	76. 02
	03330 ENDOSCOPY	0. 000000	0	0	76. 03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS				
90. 00	09000 CLI NI C	0. 147523	0	0	90.00
90. 01	09001 OUTPATI ENT	0. 225875	15, 644	3, 534	90. 01
90. 02	09002 NEUROPSYCHOLOGY	0. 192312	0	0	90. 02
91. 00	09100 EMERGENCY	0. 337981	139, 233	47, 058	
91. 01	09101 SHORT STAY	0. 000000	0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 730429	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	ı			
95.00	09500 AMBULANCE SERVI CES				95.00
200.00			1, 764, 993	394, 326	
201.00			0		201.00
202.00	Net charges (line 200 minus line 201)	I I	1, 764, 993		202. 00

Health Financial Systems RIVERVIEW I INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-3	
		CCN: 15-T059	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 3:5	
	Ti tl	e XIX	Subprovi der - I RF	Cost	, <u>z</u> p
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	<u>col. 2)</u> 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 NTENSI VE CARE UNIT					31.00
41. 00 04100 SUBPROVI DER - I RF			906, 395		41.00
43. 00 04300 NURSERY			,		43.00
ANCILLARY SERVICE COST CENTERS					1
50. 00 05000 OPERATING ROOM		0. 13790	05 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. 33988	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 20053	32 0	0	55.00
57. 00 05700 CT SCAN		0. 03324	14 0	0	57.0
57. 01 03630 ULTRA SOUND		0. 05798		0	1
58. 00 05800 MRI		0. 07858		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 06463		0	
60. 00 06000 LABORATORY		0. 19426		1, 321	
60. 01 06001 BLOOD LABORATORY		0.00000		0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 45393		0	
64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPIRATORY THERAPY		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 34823 0. 27571		0 19, 374	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 00000		17, 374	
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	1
69. 00 06900 ELECTROCARDI OLOGY		0. 13356		1, 744	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21767	· ·	13, 753	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 37576	· ·	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 41569	0	0	73.00
74. 00 07400 RENAL DI ALYSI S		0. 53183	0	0	74.00
76. 00 03020 OTHER ANCI LLARY		0.00000	00	0	76.00
76. 01 03140 CARDI AC REHAB		0. 14527	72 0	0	76. 0°
76. 02 03070 WOMEN' S CENTER		0. 18291		0	1
76. 03 03330 ENDOSCOPY		0.00000		0	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	00 0	0	77.00
OUTPATIENT SERVICE COST CENTERS		1 0 4 4 7 5 6			
90. 00 09000 CLI NI C		0. 14752		0	
90. 01 09001 0UTPATI ENT 90. 02 09002 NEUROPSYCHOLOGY		0. 22587 0. 19231		0	
90. 02 09002 NEUROPSYCHOLOGY 91. 00 09100 EMERGENCY		0. 19231		0	
91. 00 09100 EMERGENCY 91. 01 09101 SHORT STAY		0.00000		0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 73042		0	
OTHER REI MBURSABLE COST CENTERS		0.73042	- / 0		1 /2.00
95. 00 09500 AMBULANCE SERVI CES					95.00
200 00 Total (sum of lines 50 through 94 and 96 through 98)			153 307	36 192	

36, 192 200. 00 201. 00 202. 00

153, 307

153, 307

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)

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 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 3:52 pm

		10 12/31/2022	5/25/2023 3: 5	
	Title XVIII	Hospi tal	PPS	
			1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October	6, 653, 487	1.01	
4 00	instructions)		0.740.547	4.00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after Oct	tober 1 (see	2, 762, 567	1.02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occur	ring prior to October	. 0	1.03
1.03	1 (see instructions)	Tring piror to october	O	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occur	ring on or after	0	1.04
	October 1 (see instructions)	-		
2. 00	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 instructions)		0	2.02
2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)	20)	256, 604	2.03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instruction Managed Care Simulated Payments	15)	13, 200 0	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see i	netructions)	113. 42	4.00
4.00	Indirect Medical Education Adjustment	ristructi oris)	113. 42	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost repor	rting period ending or	0.00	5.00
	or before 12/31/1996. (see instructions)	and partial and an		
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instr	ructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an	add-on to the cap for	0.00	6.00
	new programs in accordance with 42 CFR 413.79(e)			
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window	closed under §127 of	0. 00	6. 26
	the CAA 2021 (see instructions)			
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.1		0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)	(1)(IV)(B)(2) If the	0. 00	7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limi	tation(s) for rural	0.00	7. 02
7.02	track programs with a rural track for Medicare GME affiliated programs in accord		0.00	7.02
	and 87 FR 49075 (August 10, 2022) (see instructions)	dance with 413.73(b)		
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathi	c programs for	0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FF			
	1998), and 67 FR 50069 (August 1, 2002).	, ,		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of	f the ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.			
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed to	teaching hospital	0. 00	8. 02
0.01	under § 5506 of ACA. (see instructions)		0.00	0.04
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of tinstructions)	the CAA 2021 (See	0. 00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines	7 and 7 01 plus or	0.00	9.00
7. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instruction		0.00	7.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your		0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.		0.00	
12.00	Current year allowable FTE (see instructions)			12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after	er September 30, 1997,	0.00	14.00
	otherwise enter zero.			
15. 00				15. 00
	Adjustment for residents in initial years of the program (see instructions)			16.00
17.00	Adjustment for residents displaced by program or hospital closure			17.00
18.00	Adjusted rolling average FTE count		0.00	
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)		0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0. 000000 0. 000000	
22. 00	IME payment adjustment (see instructions)		0.000000	22.00
22. 00	IME payment adjustment - Managed Care (see instructions)		0	22.00
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA			22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under	- 42 CFR 412, 105	0.00	23. 00
	(f)(1)(iv)(C).			
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or	rline 24 (see	0.00	25. 00
	instructions)			
26. 00	Resident to bed ratio (divide line 25 by line 4)		0. 000000	26.00
27. 00	IME payments adjustment factor. (see instructions)		0. 000000	1
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) Disprepartionate Share Adjustment		0	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see in	nstructions)	1. 92	30.00
31. 00	Percentage of SSI recipient patient days to medical e Part A patient days (see in Percentage of Medicaid patient days (see instructions)	isti uoti olisj		31.00
32. 00	Sum of lines 30 and 31			32.00
	Allowable disproportionate share percentage (see instructions)			33.00
	The state of the s	'	2.00	

	n Financial Systems RIVERVIEW			u of Form CMS-2	2552-10				
CALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022		epared:				
		Ti II . Mali I		5/25/2023 3:5					
		Title XVIII	Hospi tal	PPS					
				1. 00					
34. 00	Disproportionate share adjustment (see instructions)		Dui 10 /1	154, 894	34.00				
			Pri or to 10/1 1.00	2. 00					
	Uncompensated Care Payment Adjustment								
35.00	Total uncompensated care amount (see instructions)		0	0					
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is ze	ero enter zero on this lir	0. 000000000 ne) 1, 478, 064	0. 000000000 1, 468, 768					
33. 02	(see instructions)	ero, errer zero on tili 3 i i	1, 470, 004	1, 400, 700	33.02				
35. 03	1	,	1, 105, 511	370, 210					
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.0)		1, 475, 721		36.00				
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	y discharges (Titles 40 thic	0		40.00				
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00				
41. 01	Total ESRD Medicare covered and paid discharges (see inst		0		41.01				
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not que Total Medicare ESRD inpatient days (see instructions)	ualify for adjustment)	0.00		42. 00 43. 00				
44. 00		ded by line 41 divided by 7	0.00000		44.00				
	days)	,	0.00000						
45. 00	, ,	*	0.00		45.00				
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	e 41.01)	11, 316, 473		46. 00 47. 00				
48. 00	Hospital specific payments (to be completed by SCH and MDI	H, small rural hospitals	0		48. 00				
	only. (see instructions)	· '							
				Amount					
49. 00	Total payment for inpatient operating costs (see instruct	i ons)		1. 00 11, 316, 473	49.00				
50.00	842, 648								
51.00				0					
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4. Nursing and Allied Health Managed Care payment	, line 49 see instructions)	•	0 44, 597					
54.00				86, 994					
54. 01	Islet isolation add-on payment			0	1				
55. 00		ne 69)		0					
55. 01 56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see	intructions)		0					
57.00	Routine service other pass through costs (from Wkst. D, P		through 35).	0	1				
58.00			<i>y</i>	21, 062					
59.00	, ,			12, 311, 774	1				
60. 00 61. 00		inus line 60)		4, 403 12, 307, 371					
62.00		Thus Time 60)		1, 130, 348					
63.00	1 9			5, 446					
	Allowable bad debts (see instructions)				64.00				
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see	instructions)		22, 110 0	1				
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			11, 193, 687					
68. 00				0	1				
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	96).(For SCH see instruction	ons)	0					
70. 50	Rural Community Hospital Demonstration Project (§410A Dem	onstration) adjustment (see	e instructions)	0	1				
70. 75				0	1				
70.87	Demonstration payment adjustment amount before sequestration			0	1				
70. 88 70. 89	,			0	70. 88 70. 89				
70. 89	1 3 3			0	1				
	HSP bonus payment HRR adjustment amount (see instructions)			0	1				
70. 91	Bundled Model 1 discount amount (see instructions)			0	70. 92				
70. 92				0	70. 93				
70. 92 70. 93	HVBP payment adjustment amount (see instructions)		0.93 HVBP payment adjustment amount (see instructions) 0.94 HRR adjustment amount (see instructions)						

ealth Financial Syste	ns RI VI	ERVIEW HOSPITAL			In Lie	u of Form CMS-	2552-
ALCULATION OF REIMBUR	SEMENT SETTLEMENT	Provi	der C	CN: 15-0059	Peri od: From 01/01/2022 To 12/31/2022		
			Title	XVIII	Hospi tal	PPS	<u> </u>
,		<u> </u>			(уууу)	Amount	
					0	1.00	
	tment for federal fiscal year (yyyy)		mn O		0	C	70.
	ng federal year for the period prior		mn 0		0	,	70
	stment for federal fiscal year (yyyy) ng federal year for the period ending				0	C	70.
). 98 Low Volume Paym		g on or arter to	/ 1)			C	70.
,	mount (see instructions)					88, 106	
	der (line 67 minus lines 68 plus/mir	nus lines 69 & 7	0)			11, 059, 765	71.
.01 Sequestration a	ljustment (see instructions)					139, 353	71.
	yment adjustment amount after seques					C	71.
1 .	ljustment-PARHM or CHART pass-through	ns					71.
.00 Interim payment						10, 353, 661	
1.01 Interim payment						_	72.
	ement (for contractor use only)					C	
	ement-PARHM or CHART (for contractor vider/program (line 71 minus lines 71		and			566, 751	73. 74.
73)	rider/program (Title /Timillus Titles /T	1.01, 71.02, 72,	anu			300, 731	/4.
	rider/program-PARHM or CHART (see ins	structions)					74.
	s (nonallowable cost report items) i	,	th			151, 523	
	chapter 1, §115.2	n dooor dance in				1017020	1
	BY CONTRACTOR (lines 90 through 96)						
.00 Operating outli	er amount from Wkst. E, Pt. A, line 2	2, or sum of 2.0	3			C	90.
pl us 2.04 (see							
	from Wkst. L, Pt. I, line 2					C	
	er reconciliation adjustment amount (C	
	reconciliation adjustment amount (se					0. 00	
	o calculate the time value of money (oney for operating expenses (see inst	•	5)			0.00	1
1	oney for capital related expenses (see						96.
. 00 Trille varue or ill	mey for capital ferated expenses (se	ce mistractrons)			Prior to 10/1		
					1.00	2.00	
HSP Bonus Paymer	t Amount						
0.00 HSP bonus amoun	(see instructions)				0	C	100.
	for HSP Bonus Payment						
	factor (see instructions)				0. 0000000000		
	amount for HSP bonus payment (see in	nstructions)			0		102.
	or HSP Bonus Payment				0.0000	0.000	1400
	actor (see instructions) Imount for HSP bonus payment (see ins	-t			0.0000		
	Hospital Demonstration Project (§410) \\di_	ictmont	0		104.
	st year of the current 5-year demonst						200.
	tt? Enter "Y" for yes or "N" for no.	tratron period d	nacı	1110 2131			200.
Cost Reimburseme							
	ent service costs (from Wkst. D-1, Pt	t. II, line 49)					201.
2.00 Medicare discha	ges (see instructions)						202.
	nent factor (see instructions)						203.
•	emonstration Target Amount Limitatio	on (N/A in first	year	of the curre	ent 5-year demons	strati on	
peri od)							4
4.00 Medicare target		22.1					204.
1	ed target amount (line 203 times line						205.
	ent routine cost cap (line 202 times						206.
	dicare Part A Inpatient Reimbursemen sement under the §410A Demonstration		ne)				207.
7. OULTIOUTAILLE LIIDUL			113/		i i		1207
	inpatient service costs (from Wkst.	E. Pt. A line	59)				208

208.00

209.00

210.00

211. 00

212.00

213. 00 218. 00

210.00 Reserved for future use

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

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2022 Part A Exhibit 4 To 12/31/2022 Date/Time Prepared: 5/25/2023 3: 52 pm Provider CCN: 15-0059

					10	72/31/2022	5/25/2023 3:5	
		lw (0 5 5			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		Title	E, Part A)	EIILI LI ellleiil	10 10/01	10/01	tili ougii 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
4 04	payments	1 01	4 450 407		((50 407		/ /50 407	4 04
1. 01	DRG amounts other than outlier payments for discharges	1. 01	6, 653, 487	0	6, 653, 487		6, 653, 487	1. 01
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	2, 762, 567	0		2, 762, 567	2, 762, 567	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	О		0	1.03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.01	operating payment for Model 4	1.01	Ĭ	J		J	· ·	1.01
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00						2.00
2.00	discharges (see instructions)	2.00						2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
0.00	discharges for Model 4 BPCI	0.00	05/ /04		05/ /04		057 704	0.00
2. 02	Outlier payments for discharges occurring prior to	2. 03	256, 604	0	256, 604		256, 604	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	13, 200	0		13, 200	13, 200	2. 03
	discharges occurring on or after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	0	0	0	0	3.00
	reconciliation							
4. 00	Managed care simulated payments	3. 00	0	O	0	O	0	4. 00
	Indirect Medical Education Adj	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
0.00	instructions)	22.00		O	J	O	0	0.00
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adj	l ustment for th	Add-on for Se	ection 422 of t	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
	(see instructions)							
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on	28. 01	0	0	О	0	0	8. 01
	for managed care (see							
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9.00	lines 6 and 8)	29.00	U	U	U	U	0	9.00
9. 01	Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and							
	8.01) Disproportionate Share Adjustm	l ent						
10.00	Allowable disproportionate	33. 00	0. 0658	0. 0658	0. 0658	0. 0658		10.00
	share percentage (see							
11. 00	instructions) Disproportionate share	34.00	154, 894	0	109, 450	45, 444	154, 894	11 00
11.00	adjustment (see instructions)	34.00	134, 074	0	107, 430	45, 444	134, 074	11.00
11. 01	Uncompensated care payments	36. 00	1, 475, 721	0	1, 105, 511	370, 210	1, 475, 721	11. 01
10.00	Additional payment for high pe		RD beneficiary				^	12.00
12. 00	Total ESRD additional payment (see instructions)	46. 00		0	0	0	0	12.00
13. 00	Subtotal (see instructions)	47. 00	11, 316, 473	0	8, 125, 052	3, 191, 421	11, 316, 473	13.00
14.00	Hospital specific payments	48. 00	0	0	0	0	0	14. 00
	(completed by SCH and MDH,							
	small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient	49. 00	11, 316, 473	0	8, 125, 052	3, 191, 421	11, 316, 473	15.00
	operating costs (see							
	instructions)	I						I

LOW VC	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2022 To 12/31/2022	5/25/2023 3:5	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	842, 648	O	624, 24	218, 404	842, 648	16.00
17. 00	Special add-on payments for new technologies	54. 00	86, 994	0	70, 72	0 16, 274	86, 994	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
19.00	SUBTOTAL			0	8, 820, 01	6 3, 426, 099	12, 246, 115	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	705, 274 0	0	,	1 204, 903 0 0	705, 274 0	20. 00 20. 01
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	106, 695 0	0	102, 10	7 4, 588 0 0	106, 695 0	21. 00 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	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0435	0. 0435	0. 043	5 0. 0435		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	30, 679	0	21, 76	6 8, 913	30, 679	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	842, 648	0	624, 24	4 218, 404	842, 648	26. 00
		W/S E, Part A	(Amounts to					
		line 0	E, Part A)	2.00	2.00	4.00	F 00	
27. 00	Low volume adjustment factor	U	1. 00	2.00	3. 00 0. 00000	4. 00 0 0. 000000	5. 00	27. 00
28. 00	Low volume adjustment ractor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.0000	0.000000	0	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer I ow volume adjustments to Wkst. E, Pt. A.		Y					100.00

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5
Provider CCN: 15-0059
Feriod:
From 01/01/2022
To 12/31/2022
Date/Time Prepared:
5/25/2023 3:52 pm

Wkst. E, Pt. Amt. from Period to A, line Wkst. E, Pt. 10/01
Period on after 10/01 2 and 3)

						5/25/2023 3: 5	2 pm
		W		XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		A, TITIE	A)	10/01	ai tei 10/01	2 anu 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00			0.00		1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	6, 653, 487	6, 653, 487		6, 653, 487	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 762, 567		2, 762, 567	2, 762, 567	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharges (see	2. 00					2. 00
2. 01	instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	256, 604	256, 604		256, 604	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	13, 200		13, 200	13, 200	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	3.00
4.00	Managed care simulated payments	3. 00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
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 Adjustment for the	Add on for S	oction 122 of	the MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
,, 00	instructions)	27.00	0.00000	0.00000	0.00000		7.00
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	9. 01
40.00	Disproportionate Share Adjustment			0.0450	0.0450		40.00
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0658	0. 0658	0. 0658		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	154, 894	109, 450	45, 444	154, 894	11.00
11. 01	Uncompensated care payments	36. 00	1, 475, 721	1, 105, 511	370, 210	1, 475, 721	11. 01
	Additional payment for high percentage of ESI			,		, , , , , ,	
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47. 00	11, 316, 473	8, 125, 052		11, 316, 473	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	11, 316, 473	8, 125, 052	3, 191, 421	11, 316, 473	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	842, 648	624, 244	218, 404	842, 648	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	86, 994	70, 720	16, 274	86, 994	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			8, 820, 016	3, 426, 099	12, 246, 115	19. 00

Health Financial Systems	RI VERVI EW HOS	SPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION	(HAC) REDUCTION CALCULATION EXHIBIT 5	Provi der CCN: 15-0059		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2023 3:52 pm
		Title XVIII	Hospi tal	PPS
	Wkst. L, line	(Amt. from		

				Т	0 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	705, 274	500, 371	204, 903	705, 274	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	106, 695	102, 107	4, 588	106, 695	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. 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. 0435	0. 0435	0. 0435		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	30, 679	21, 766	8, 913	30, 679	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	842, 648	624, 244	218, 404	842, 648	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
27.00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	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	0	0	0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-45, 816	-9, 413	-36, 403	-45, 816	
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst. E, Pt.	
						A)	
		0	1. 00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		88, 106	0	88, 106	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Υ				100. 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 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 3:52 pm

		5/25/2023 3:5	
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9, 129	1
2.00	Medical and other services reimbursed under OPPS (see instructions)	22, 129, 770	
3.00	OPPS payments	18, 087, 530	
4. 00	Outlier payment (see instructions)	232, 775	
4. 01	Outlier reconciliation amount (see instructions)	0 000	
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	1
7. 00	Line 2 times line 5	0.00	
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	118, 150	
10.00	Organ acquisitions	118, 130	10.00
	Total cost (sum of lines 1 and 10) (see instructions)	9, 129	1
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	7,127	11.00
	Reasonable charges		1
12. 00	Ancillary service charges	22, 199	12 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	1
	Total reasonable charges (sum of lines 12 and 13)	22, 199	
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	s 0	15.00
	Amounts that would have been realized from patients liable for payment for services on a chargebas		16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
	Total customary charges (see instructions)	22, 199	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	13, 070	19. 00
	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
	instructions)		
	Lesser of cost or charges (see instructions)	9, 129	1
	Interns and residents (see instructions)	0	
	Cost of physicians' services in a teaching hospital (see instructions)	0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	18, 438, 455	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		05.00
	Deductibles and coinsurance amounts (for CAH, see instructions)	61	1
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3, 233, 714	1
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	15, 213, 809	27. 00
20 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	1
	Subtotal (sum of lines 27 through 29)	15, 213, 809	1
	Primary payer payments	5, 258	1
	Subtotal (line 30 minus line 31)	15, 208, 551	1
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	10, 200, 001	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	32, 005	
	Adjusted reimbursable bad debts (see instructions)	20, 803	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	1
37.00	Subtotal (see instructions)	15, 229, 354	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-92	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
	Demonstration payment adjustment amount before sequestration	0	
	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40.00	Subtotal (see instructions)	15, 229, 446	
	Sequestration adjustment (see instructions)	191, 891	
	Demonstration payment adjustment amount after sequestration	0	
	Sequestration adjustment-PARHM or CHART pass-throughs		40. 03
	Interim payments	15, 021, 232	1
	Interim payments-PARHM or CHART		41.01
	Tentative settlement (for contractors use only)	0	
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)	1, 2	42. 01
	Balance due provider/program (see instructions)	16, 323	1
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
	§115. 2 TO BE COMPLETED BY CONTRACTOR		1
90 00	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)	0.00	
	Total (sum of lines 91 and 93)		94.00
		•	•

Health Financial Systems	RI VERVI EW HOSPI TAL	L	In Lieu	of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi			Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/lime Pre	pared:
				5/25/2023 3:5	2 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Peri od: From 01/01/2022 To 12/31/2022	
	'		5/25/2023 3:52 pm
	Title XVIII	Subprovi der -	PPS

	litle XVIII Subprovider	- PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1. 00	
1.00	Medical and other services (see instructions)	97	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17	2.00
3.00	OPPS payments	40	3.00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
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 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10. 00	Organ acquisitions		1
	Total cost (sum of lines 1 and 10) (see instructions)	97	
	COMPUTATION OF LESSER OF COST OR CHARGES		
10.00	Reasonable charges	200	10.00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	233	12. 00 13. 00
	Total reasonable charges (sum of lines 12 and 13)	233	1
00	Customary charges		00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasi	s 0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
	Total customary charges (see instructions)	233	1
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	136	1
00.00	instructions)		00.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21. 00	Lesser of cost or charges (see instructions)	97	21.00
	Interns and residents (see instructions)	0	22.00
	Cost of physicians' services in a teaching hospital (see instructions)	0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	40	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)		25.00
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	137	27. 00
	instructions)		
	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27 through 29)	137	1
	Primary payer payments	0	1
32.00	Subtotal (line 30 minus line 31)	137	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)	0	
	Adjusted reimbursable bad debts (see instructions)		1
	Allowable bad debts for dual eligible beneficiariés (see instructions)	0	1
	Subtotal (see instructions)	137	
	MSP-LCC reconciliation amount from PS&R	0	38.00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	١	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	1
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	0 137	39. 99 40. 00
40. 00	Sequestration adjustment (see instructions)	137	40.00
	Demonstration payment adjustment amount after sequestration	Ö	1
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs		40. 03
	Interim payments	108	1
	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)	o	41. 01 42. 00
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)		42.00
	Balance due provider/program (see instructions)	28	
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
	§115.2 TO BE COMPLETED BY CONTRACTOR		1
90. 00	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	O	
	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)	0	
94.00	Total (sum of lines 91 and 93)		94.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Peri od:	Worksheet E	
		From 01/01/2022		
	Component CCN: 15-T059	To 12/31/2022		
			5/25/2023 3:5	52 pm
	Title XVIII	Subprovi der -	PPS	
		IRF		
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200.00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0059

Title XVIII Hospital PPS					10 12/31/2022	5/25/2023 3:5	
1.00			Title	e XVIII	Hospi tal		
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00			Inpatier	nt Part A	Par	rt B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00							
1.00 Total interim payments paid to provider 10,278,083 14,886,111 1.00 2.00 1.00 1.00 2.00 1.4,86,111 1.00 2.00 2.00 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.0							
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "Note" or enter a zero to the interim rate for the cost reporting period. Also show date of each payment. If none, write "Note" or enter a zero (1)	1 00	Total interim nayments paid to provider	1.00				1 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00				10, 276, 00			
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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 12/21/2022 75,578 12/21/2022 135,121 3.01 3.02 3.03 3.04 0 0 0 3.03 3.04 0 0 0 3.03 3.04 0 0 0 3.04 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3	2.00						2.00
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
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 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROVIDER 3.50 Brovider to Program 3.51 3.52 Buttotal (sum of lines 3.01-3.49 minus sum of lines appropriate) 5.00 Citransfer to Wkst. E or Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E or Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E or Wkst. E-3, line and column as appropriate) 5.00 Frovider to Program 5.00 Citransfer to Wkst. E or Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E or Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E or Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E or Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 5.00 Citransfer to Wkst. E-3, line and column as appropriate) 6.00 Citransfer to Wkst. E-3, line and column as appropriate) 6.00 Citransfer to Wkst. E-3, line and column as appropriate) 6.00 Citransfer to Wkst. E-3, line and column as appropriate) 7.00 Citransfer to Wkst. E-3, line and column as appropriate) 8.00 Citransfer to Wkst. E-3, line and column as appropriate) 8.00 Citransfer to Wkst. E-3, line and column as appropriate) 8.00 Citransfer to Wkst. E-3, line and column as appropriate) 8.00 Citransfer to Wkst. E-3, line and column as appropriate) 8.00 C		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02	3 01		12/21/2022	75.57	/8 12/21/2022	135 121	3 01
3. 04		A SOCIAL PROPERTY OF THE PROPE	12,21,2022	1			
ADJUSTMENTS TO PROGRAM	3.03				0	0	3.03
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.53 3.51 3.52 0 0 0 3.53 3.51 3.52 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 3.59 3.50 3.59 3.50 3.99 3.50 3.50 3.99 3.50 3.50 3.99 3.50 3.50 3.99 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50	3.04				0	0	3.04
ADJUSTMENTS TO PROGRAM	3. 05				0	0	3.05
3.51 3.52 3.53 0							
3.52 3.53 3.54 3.99 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50		ADJUSTMENTS TO PROGRAM			-		
3.53 3.54 0 0 0 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 10,353,661 15,021,232 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR					-		
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 135, 121 3.99 10, 353, 661 15, 021, 232 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR					-	_	
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98) 135, 121 3.99 3.50-3.98) 10, 353, 661 15, 021, 232 4.00 10 10 10 10 10 10 10				1	-		
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 10,353,661 15,021,232 4.00		Subtotal (sum of lines 3.01-3.49 minus sum of lines			-	_	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			10, 353, 66	1	15, 021, 232	4.00
TO BE COMPLÉTED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER O							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NoNE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
5. 02				•	•		
Solution Settlement 10 Program Settlement 20 Settlement 30 Settlemen		TENTATI VE TO PROVI DER			0		
Provider to Program							
TENTATI VE TO PROGRAM 0	5. 03				0	0	5. 03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	E E0			T			E E0
5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 566,751 16,323 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 10,920,412 15,037,555 7.00		TENTATIVE TO PROGRAM			-		
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 566, 751 16, 323 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 10, 920, 412 15, 037, 555 7. 00 Total Medicare program liability (see instructions) 10, 920, 412 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00					-		
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines					
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
6. 01 SETTLEMENT TO PROVIDER 566, 751 16, 323 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 7. 00 Total Medicare program liability (see instructions) 10, 920, 412 15, 037, 555 7. 00	6.00	Determined net settlement amount (balance due) based on					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 10,920,412 Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 10,920,412 15,037,555 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				566, 75	51		
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				10 000 11	U	·	
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	rotal weulcare program Hability (see Instructions)		10, 920, 41			7.00
0 1.00 2.00							
				0			
	8. 00	Name of Contractor					8.00

Component CCN: 15-T059

		Title	: XVIII	Subprovi der - I RF	PPS	
		I npati en	it 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		4, 226, 61		108	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02				o	0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3. 04
3. 05	Dravi dan ta Dragnam			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	ADJUSTINIENTS TO TROURAM			0		3. 51
3. 52				Ö	0	3. 52
3.53				0	0	3.53
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		4, 226, 61	7	108	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		4, 220, 01	'	100	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				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)					
	Program to Provider		l			
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5.02
5. 03				0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		I	ol	0	5. 50
5. 50 5. 51	TENTATIVE TO PROGRAM			0		5. 50 5. 51
5. 52				Ö	l ől	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			O	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		50, 09	2	28	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 276, 70	~	136	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor)	1. 00	2. 00	8. 00
6.00	INAME OF COTTLEACTOR			T	ı l	0.00

Heal th	Financial Systems RIVERVIEW HO	SPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0059	Peri od:	Worksheet E-1	
			From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narod:
			10 12/31/2022	5/25/2023 3:5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	e 14		1.00
2. 00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	line 31) (see instructio	ns)		32.00
					•

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2022	Worksheet E-3	
	Component CCN: 15-T059			
	Title XVIII	Subprovi der -	PPS	
		I RF		

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4, 094, 847	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0109	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	142, 091	3.00
4.00	Outlier Payments	154, 827	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period 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)	10. 923288	
11.00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4, 391, 765	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)	0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17. 00	Subtotal (see instructions)	4, 391, 765	
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4, 391, 765	
20.00	Deductibles	49, 720	
21.00	Subtotal (line 19 minus line 20)	4, 342, 045	
22. 00	Coi nsurance	14, 004	
23.00	Subtotal (line 21 minus line 22)	4, 328, 041	
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27. 00	Subtotal (sum of lines 23 and 25)	4, 328, 041	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	
29. 00	Other pass through costs (see instructions)	3, 242	
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 98	Recovery of accelerated depreciation.	0	
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	4, 331, 283	
32. 01	Sequestration adjustment (see instructions)	54, 574	
32. 02	Demonstration payment adjustment amount after sequestration	0	
33.00	Interim payments	4, 226, 617	
34.00	Tentative settlement (for contractor use only)	0	
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	50, 092	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36.00
	§115. 2		
FO 00	TO BE COMPLETED BY CONTRACTOR	454 007	FO 00
	Original outlier amount from Wkst. E-3, Pt. III, line 4	154, 827	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0. 00	
53. 00	Time Value of Money (see instructions)	0	53. 00
00.00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		00.00
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	99.01

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od:	Worksheet E-3
		From 01/01/2022	

			From 01/01/2022 To 12/31/2022		
		Title XIX	Hospi tal	Cost	
		<u> </u>	I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		1, 374, 287		1.00
2. 00	Medical and other services			0	2.00
3. 00	Organ acquisition (certified transplant programs only)		0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		1, 374, 287	0	
5. 00	Inpatient primary payer payments		0	_	5.00
6. 00	Outpatient primary payer payments		4 074 007	0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		1, 374, 287	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
8. 00	Reasonable Charges Routine service charges		1, 642, 886		8.00
9. 00	Ancillary service charges		1, 764, 993	0	1
	Organ acquisition charges, net of revenue		1, 704, 773	O	10.00
11 00	Incentive from target amount computation				11.00
	Total reasonable charges (sum of lines 8 through 11)		3, 407, 879	0	1
12.00	CUSTOMARY CHARGES		3, 407, 077		12.00
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
101.00	basi s	oo. v. ood o a oa. ge		ŭ	10.00
14.00	Amounts that would have been realized from patients liable for	r payment for services o		0	14.00
	a charge basis had such payment been made in accordance with				
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)		3, 407, 879	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	2, 033, 592	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)			_	
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instr	*	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		1, 374, 287	0	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	completed for PPS provid	iers.	0	22.00
	Outlier payments		0	0	23.00
	Program capital payments			O	24.00
	Capital exception payments (see instructions)				25.00
	Routine and Ancillary service other pass through costs		Ö	0	1
	Subtotal (sum of lines 22 through 26)		o	0	
	Customary charges (title V or XIX PPS covered services only)		o	0	1
	Titles V or XIX (sum of lines 21 and 27)		1, 374, 287	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		<u> </u>		
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))	1, 374, 287	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
	Utilization review		0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	1, 374, 287	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
	Subtotal (line 36 ± line 37)		1, 374, 287	0	00.00
	Direct graduate medical education payments (from Wkst. E-4)		0	_	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		1, 374, 287	0	
	Interim payments		1, 562, 894	0	
	Balance due provider/program (line 40 minus line 41)	acc with CMS Dub 1E 2	-188, 607	0	
43. 00	Protested amounts (nonallowable cost report items) in accordar chapter 1, §115.2	ICE WI LII CWS PUD 15-2,	0	0	43.00
	Chapter 1, 3110.2		1		I

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2022	Worksheet E-3
	Component CCN: 15-T059		Date/Time Prepared: 5/25/2023 3:52 pm
	Title XIX	Subprovi der -	Cost

	lit	TE XIX	Subprovi der -	Cost	
			I RF	Outpotiont	
			Inpati ent 1.00	Outpati ent	
	DADT VILL CALCULATION OF DELMDIDSEMENT ALL OTHER HEALTH SERVICES FOR	TITLES V OD VI		2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR COMPUTATION OF NET COST OF COVERED SERVICES	IIILES V UR AI	A SERVICES		-
1. 00	Inpatient hospital/SNF/NF services		49, 536		1.00
2. 00	Medical and other services		47, 550	0	
3. 00	Organ acquisition (certified transplant programs only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		49, 536	0	
5. 00	Inpatient primary payer payments		0		5.00
6. 00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		49, 536	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		906, 395		8. 00
9.00	Ancillary service charges		153, 307	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	y , y ,		1, 059, 702	0	12.00
40.00	CUSTOMARY CHARGES		1 0		10.00
13. 00	Amount actually collected from patients liable for payment for services	on a charge	0	0	13. 00
14 00	basis	For comiless on		0	14 00
14. 00	Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §41		0	0	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	s. 13(e)	0. 000000	0.000000	15.00
16. 00	Total customary charges (see instructions)		1, 059, 702	0.000000	
17. 00	Excess of customary charges over reasonable cost (complete only if line	16 exceeds	1, 010, 166	0	
17.00	line 4) (see instructions)	TO CACCCUS	1,010,100	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line	4 exceeds Line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		O	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		49, 536	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed	for PPS provid	ers.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00			49, 536	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
	Excess of reasonable cost (from line 18)		40 524	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		49, 536 0	0	
	Coinsurance			0	
34. 00	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0	U	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		49, 536	0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
38. 00	Subtotal (line 36 ± line 37)		49, 536	0	1
			0	_	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		49, 536	0	
	Interim payments		487, 463	0	1
42.00	Balance due provider/program (line 40 minus line 41)		-437, 927	0	42.00
43.00		MS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Heal th	Financial Systems RIVERVIEW HO	SPI TAL	In Lieu	of Form CMS-2	552-10
				Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/25/2023 3:52	pared: 2 pm
		Title XVIII		PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR					
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	1.00	
2.00 Capital outlier from Wkst. L, Pt. I, line 2			0	2.00	
3.00 Operating outlier reconciliation adjustment amount (see instructions)			0	3.00	
4.00 Capital outlier reconciliation adjustment amount (see instructions)			0	4.00	
5.00 The rate used to calculate the time value of money (see instructions)			0. 00	5.00	
6.00	Time value of money for operating expenses (see instructions))		0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

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

Provider CCN: 15-0059

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared:

Cubits Asset State Cubits Asset Cubits Asset Cubits Asset Cubits Asset Cubits Asset	onl y)			10	12/31/2022	5/25/2023 3: 5	
DEBENT ASSETS 1.00 2.00 3.00 4.00			General Fund				
CIBRENT ASSETS			1. 00			4. 00	
Imagenery Investments		CURRENT ASSETS					
Notes received Notes received 1.00			4, 387, 097		_		
Accounts receivable			0		_		
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All Joseph Carlos Company Comp					0		
Propose of expenses 3,123,585 0 0 0 0 0 0 0 0 0					0		
9.00 0 ther current assets 0 0 0 0 0 0 0 10.00 0 11.00 0 0 10.00 0 0 10.00 0 11.00 0 11.00 0 11.00 0 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00		1		1	0		•
10.00 Due from other funds			3, 123, 585	0	0		•
11.00 Total current assets (sum of lines 1-10) 62,734,665 0 0 11.00			0		0		1
FixED_ASSETS			62 734 656		0		1
13.00 Land Improvements	00		02/ / 0 1/ 000	1	<u> </u>		
14.00		Land		- 1	0		
15.00 bull dings				1	-		1
16.00 Accumul ated depreciation -87, 200, 599 0 0 0 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.0		•		1	0	-	1
17.00 Leasehold Learner 18.834.183 0 0 0 17.00 17.00 18.00 17.00 0 0 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00				1 4	0		1
18.00 Accumul ated depreciation 52,683,867 0 0 18.00				1	0		1
20.00 Accumulated depreciation -39, 741, 687 0 0 0 0 20.00		· ·	0		0	0	•
21.00 Automobiles and trucks 0 0 0 0 0 21.00					0	-	•
22.00 Accumulated depreciation 0 0 0 22.00		'	-39, 741, 687		0	-	
23.00 Major movable equipment 125, 643, 510 0 0 0 23.00			0		0	-	
24.00 Accumulated depreciation -98,879,439 0 0 0 24.00		· ·	125 643 510		0		•
25.00 Minor equipment depreciable 0 0 0 25.00					0		1
27.00 HIT designated Assets 0 0 0 0 27.00 28.00 Accumulated depreciation 0 0 0 0 28.00 29.00 Minor equipment-nondepreciable 0 0 0 0 28.00 30.00 Total fixed assets (sum of lines 12-29) 153,175,116 0 0 0 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 153,175,116 0 0 0 0 0 31.00 Deposits on leases 0 0 0 0 32.00 32.00 Deposits on leases 0 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 33.00 34.00 Other assets (sum of lines 31-34) 63,432,722 0 0 0 35.00 35.00 Total other assets (sum of lines 31) 279,342,494 0 0 0 36.00 36.00 Total assets (sum of lines 31) 279,342,494 0 0 0 37.00 38.00 Salaries, wages, and fees payable 9,680,512 0 0 0 38.00 39.00 Payroll taxes payable 9,680,512 0 0 0 39.00 40.00 Notes and Loans payable (short term) 14,089,424 0 0 0 0 39.00 40.00 Notes and Loans payable (short term) 14,089,424 0 0 0 0 0 40.00 40.00 Accelerated payments 0 0 0 0 0 0 40.00 Accelerated payments 0 0 0 0 0 0 40.00 Deformed in the sum of lines 37 thru 44) 168,663,267 0 0 0 0 0 0 40.00 Domor current liabilities (sum of lines 37 thru 44) 168,663,267 0 0 0 0 0 0 40.00 Total current liabilities (sum of lines 46 thru 49) 58,674,935 0 0 0 0 0 0 40.00 Total long term liabilities (sum of lines 46 thru 49) 58,674,935 0 0 0 0 0 0 40.00 Total liabilities (sum of lines 45 and 50) 227,338,202 0 0 0 0 0 40.00 Total liabilities (sum of lines 45 and 50) 227,338,202 0 0 0 0 0 40.00 Total liabilities (sum of lines 45 and 50) 227,338,202 0 0 0 0 0 40.00 Total liabilities (sum of lines 45 and 50) 227,338,202 0 0 0 0 40.00 Total liabilities (sum of lines 52 thru 58) 0 0 0 0 0 0 40.00 T		· •	0	0	0	0	1
28. 00 Accumulated depreciation 0 0 0 0 28. 00 0 0 0 29. 00 0 0 0 0 29. 00 0 0 0 0 29. 00 0 0 0 0 0 29. 00 0 0 0 0 0 0 0 0 0			0	0	0		
29. 00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0			0	1	0		
30, 00 Total fixed assets (sum of lines 12-29) 153, 175, 116 0 0 0 30, 00		'	0	1	0		
OTHER ASSETS			153 175 116		_		
22 00 Deposits on Leases 0 0 0 0 0 32 00 33 00 Due from owners/officers 79,827 0 0 0 33.00 34 00 Other assets (sum of Lines 31-34) 63,432,722 0 0 0 35.00 50 0 Total other assets (sum of Lines 31-34) 63,432,722 0 0 0 35.00 50 0 Total assets (sum of Lines 31, 30, and 35) 279,342,494 0 0 0 0 36.00 50 0 CURRENT LIABILITIES	00.00		100, 170, 110	<u> </u>	<u> </u>	<u> </u>	00.00
33.00 Due from owners/officers 0 0 0 0 0 33.00 34.00 Other assets 79,827 0 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 63,432,722 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 279,342,494 0 0 0 0 0 Other assets (sum of lines 11, 30, and 35) 279,342,494 0 0 0 0 0 Other assets (sum of lines 11, 30, and 35) 279,342,494 0 0 0 0 0 Other assets (sum of lines 11, 30, and 35) 279,342,494 0 0 0 0 0 Other assets (sum of lines 11, 30, and 35) 279,342,494 0 0 0 0 0 0 Other assets (sum of lines 37, 00 0 0 0 0 0 0 0 Other assets (sum of lines 37, 40, 40, 40, 40, 40, 40, 40, 40, 40, 40	31.00	Investments	63, 352, 895	0	0		31.00
34.00 Other assets 79,827 0 0 0 0 34.00			0		0		
35.00 Total other assets (sum of lines 31-34) 63,432,722 0 0 0 35.00			70.027		0		1
36.00 Total assets (sum of lines 11, 30, and 35) 279, 342, 494 0 0 0 36.00				1	0		
CURRENT LIABILITIES		1		1	0		1
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39.00 Payrol taxes payable					0		1
A0.			9, 680, 512	0	0		1
41.00 Deferred income 0 0 0 0 0 41.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 42.00 43.00 44.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00 45.00			14 080 424		0		1
42. 00 Accelerated payments 0 0 0 42. 00 43. 00 Due to other funds 129, 374, 513 0 0 0 43. 00 44. 00 Other current liabilities 5,905,593 0 0 0 0 45. 00 Total current liabilities (sum of lines 37 thru 44) 168, 663, 267 0 0 0 0 45. 00 LONG TERM LIABILITIES		, , , , , , , , , , , , , , , , , , , ,	14, 007, 424		0		1
44.00 Other current liabilities			0				•
Total current liabilities (sum of lines 37 thru 44) 168, 663, 267 0 0 0 0 45.00	43.00		129, 374, 513	0	0		
LONG TERM LIABILITIES					•	-	
46.00 Mortgage payable 0 0 0 0 0 0 46.00 47.00 Notes payable 45,940,185 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 48.00 49.00 Other long term liabilities 12,734,750 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 58,674,935 0 0 0 50.00 51.00 Total liabilities (sum of lines 45 and 50) 227,338,202 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund bal ance 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund bal ance - restricted 0 55.00 Donor created - endowment fund bal ance 0 55.00 56.00 Governing body created - endowment fund bal ance 0 55.00 57.00 Plant fund bal ance - invested in plant 0 57.00 58.00 Total fund bal ance - reserve for plant improvement, replacement, and expansion 59.00 Total fund bal ances (sum of lines 52 thru 58) 52,004,292 0 0 0 0 0 59.00 60.00 Total liabilities and fund bal ances (sum of lines 51 and 279,342,494 0 0 0 0 0 60.00	45.00		168, 663, 267	0	O	0	45.00
47. 00 Notes payable 45, 940, 185 0 0 0 47. 00 48. 00 Unsecured I oans 0 0 0 0 0 48. 00 49. 00 Other long term liabilities (sum of lines 46 thru 49) 58, 674, 935 0 0 0 0 50. 00 50. 00 Total liabilities (sum of lines 45 and 50) 227, 338, 202 0 0 0 51. 00 CAPITAL ACCOUNTS 52. 00 Specific purpose fund 55. 00 Donor created - endowment fund balance - restricted 55. 00 Donor created - endowment fund balance 0 55. 00 Governing body created - endowment fund balance 0 56. 00 57. 00 Plant fund balance - invested in plant 0 57. 00 58. 00 Total liabilities and fund balances (sum of lines 52 thru 58) 52, 004, 292 0 0 0 0 59. 00 60. 00 Total liabilities and fund balances (sum of lines 51 and 279, 342, 494 0 0 0 0 60. 00	46 00		0	0	0	0	46 00
48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 52.00 General fund balance 52.00 Specific purpose fund 53.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 279, 342, 494) 50.00 O O O O O O O O O O O O O O O O O O		3 3 1 3	45, 940, 185		_		1
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Total liabilities (sum of lines 45 and 50) 227, 338, 202 0 0 0 51.00				1	-		•
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	59. 00		52, 004, 292	0	0		59.00
59)	60.00		279, 342, 494	0	0	0	60.00
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Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10

Period: Worksheet G-1 From 01/01/2022 Provi der CCN: 15-0059

					To 12/31/2022	Date/Time Pre 5/25/2023 3:5	pared: 2 pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0	88, 790, 859 -36, 786, 567 52, 004, 292		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 52, 004, 292 0 52, 004, 292		0 0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

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

		T	o 12/31/2022	Date/Time Pre 5/25/2023 3:5	
	Cost Center Description	I npati ent	Outpati ent	Total	2 p
		1, 00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	52, 706, 429		52, 706, 429	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	7, 155, 923		7, 155, 923	3.00
4.00	SUBPROVI DER				4. 00
5.00	Swi ng bed - SNF	0		0	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, 862, 352		59, 862, 352	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13, 023, 110		13, 023, 110	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	13, 023, 110		13, 023, 110	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	72, 885, 462		72, 885, 462	
18. 00	Ancillary services	99, 267, 095	382, 028, 911	481, 296, 006	18. 00
	Outpati ent servi ces	7, 862, 955	89, 702, 684	97, 565, 639	
	RURAL HEALTH CLINIC	0	0	0	20.00
21. 00		0	0	0	21.00
22. 00	HOME HEALTH AGENCY				22. 00
	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25. 00					25.00
26.00			50.040.000	50.040.000	26.00
27. 00	OTHER OUTPATIENT	0	58, 968, 338	58, 968, 338	
27. 01	PROF FEES	0	34, 930, 777	34, 930, 777	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	180, 015, 512	565, 630, 710	745, 646, 222	28. 00
	G-3, line 1)				
29. 00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)		277 525 702		20.00
30.00	ADD (SPECIFY)	0	277, 535, 793		29. 00 30. 00
30.00	ADD (SPECIFY)				31.00
32.00					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	0		36.00
37. 00	DEDUCT (SPECIFY)	0	J		37.00
38. 00	DEDUCT (SI ECTIT)	0			38.00
39.00		0			39.00
40.00		0			40.00
41. 00		0			41.00
	Total deductions (sum of lines 37-41)		n		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	fer	277, 535, 793		43.00
.0. 50	to Wkst. G-3, line 4)		_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		1			'

	Financial Systems	RI VERVI EW HOSPI TAL	_	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0059	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	narod:
			10 12/31/2022	5/25/2023 3:5	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line 28)		745, 646, 222	1.00
2.00	Less contractual allowances and discounts on	patients' accounts		512, 510, 479	
3.00	Net patient revenues (line 1 minus line 2)			233, 135, 743	3.00
4.00	Less total operating expenses (from Wkst. G-2	2, Part II, line 43)		277, 535, 793	
5.00	Net income from service to patients (line 3 m	ninus line 4)		-44, 400, 050	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			-8, 676, 259	7.00
8.00	Revenues from telephone and other miscellaneo	ous communication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
13.00	,			0	13.00
	Revenue from meals sold to employees and gues	sts		0	14.00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical sup			0	16. 00
	Revenue from sale of drugs to other than pati			0	
	Revenue from sale of medical records and abst			0	
	Tuition (fees, sale of textbooks, uniforms, e			0	
20.00	3	nd canteen		0	20.00
	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24. 00	OTHER OPERATING INCOME			13, 279, 672	•
24. 01	OTHER OPERATING REVENUE			23, 457	
	DSH REVENUE			2, 986, 613	
	COVI D-19 PHE Funding			0	
	Total other income (sum of lines 6-24)			7, 613, 483	
	Total (line 5 plus line 25)			-36, 786, 567	
	OTHER EXPENSES (SPECIFY)			0	
28.00	Total other expenses (sum of line 27 and subs	scripts)		0	28. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

-36, 786, 567 29. 00

0 28.00

Haal th	Financial Systems RIVERVIE	W HOSPITAL	Inlia	u of Form CMS-2	2552_10
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0059	Peri od: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			705, 274	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			106, 695	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00	Total inpatient days divided by number of days in the co	st reporting period (see ins	tructions)	44. 30	1
4. 00	Number of interns & residents (see instructions)			0.00	
5. 00 6. 00	Indirect medical education percentage (see instructions)		1 oolumna 1 ond	0.00	5. 00 6. 00
0.00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)	y the sum of filles I and 1.0	i, coruillis i and	U	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	t A patient days (Worksheet	E, part A line	1. 92	7. 00
8. 00	Percentage of Medicaid patient days to total days (see in	nstructions)		19. 12	8.00
9. 00	Sum of lines 7 and 8	,		21. 04	1
10.00	Allowable disproportionate share percentage (see instruc	tions)		4. 35	10.00
11.00	00 Disproportionate share adjustment (see instructions)			30, 679	11.00
12.00	2.00 Total prospective capital payments (see instructions)				12.00
	DART LL DAVMENT UNDER DEACONARLE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)		0	1.00
2. 00	Program inpatient ancillary capital cost (see instruction			0	
3. 00	Total inpatient program capital cost (line 1 plus line 2	•		0	
4.00	Capital cost payment factor (see instructions)	,		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circum:			0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2))		0	
4. 00 5. 00	Applicable exception percentage (see instructions)	`		0.00	4. 00 5. 00
6.00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (so			0. 00	
7. 00	Adjustment to capital minimum payment level for extraord		x line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	That'y errodinstances (Trile 2	X 11110 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as	appl i cabl e)		0	
10.00	Current year comparison of capital minimum payment level		less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level of Worksheet L, Part III, line 14)	ver capital payment (from pr	ior year	0	11.00
12.00	Net comparison of capital minimum payment level to capital			0	
13.00	Current year exception payment (if line 12 is positive,			0	
14. 00	Carryover of accumulated capital minimum payment level or (if line 12 is negative, enter the amount on this line)	1 1 3	following period	0	
15. 00	Current year allowable operating and capital payment (see			0	
16.00	3	ns)		0	
17.00	Current year exception offset amount (see instructions)			0	17. 00