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 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 9:54 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/29/2024 9:54 am 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 01/01/2023 and ending 12/31/2023 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	Jayna 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	2 Signatory Printed Name Jayna Friend				2
3	3 Signatory Title CONTROLLER				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	453, 430	116, 546	0	-114, 955	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-59, 062	-118		-30, 312	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	394, 368	116, 428	0	-145, 267	200.00
Tho ob	nove amounts represent "due to" or "due from"	the engliceble	program for t	ha alamant of	the chave comp	av 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.

HOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX	Provid	Provider CCN: 15-0059   Period:   Worksheet S- From 01/01/2023   Part I To 12/31/2023   Date/Time Pr 5/29/2024 9:					me Pre	pared:			
	1.00		2. 00		3. 00			4	1. 00	37 2 77 20	72.7.0	4 diii
1. 00	Hospital and Hospital Health Care Co Street: 395 WESTFIELD ROAD		dress: PO Box:									1.00
2. 00	City: NOBLESVILLE		State: IN	Zi p Cod	e: 460	060-	Count	y: HAMILTON				2.00
		Comp	onent Name	CCN Number	CB: Numl		Provi der Type	Date Certified	Ť,	nt Syst 0, or	N)	
			1. 00	2.00	3. (	00	4. 00	5. 00	V 6. 00	7. 00		
	Hospital and Hospital-Based Componen	t Identi		2.00			4.00			7.00	0.00	
3.00	Hospi tal Subprovider - IPF	RI VERVI E\	W HOSPITAL	150059	269	900	1	07/07/1966	N	P	0	3.00
4. 00 5. 00	Subprovi der - IRF	RI VERVI E\ REHAB	W HOSPITAL	15T059	269	900	5	01/01/1994	N	Р	0	4. 00 5. 00
6. 00												6.00
7. 00 8. 00	Swing Beds - SNF Swing Beds - NF					-						7. 00 8. 00
9. 00	Hospi tal -Based SNF											9.00
10.00										10.00		
11. 00 12. 00										11. 00 12. 00		
13. 00											13.00	
14.00	Hospi tal -Based Hospi ce											14.00
15. 00 16. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC											15. 00 16. 00
17. 00	Hospital -Based (CMHC) I											17. 00
18. 00	Renal Dialysis											18. 00
19. 00	Other							From:		To		19.00
								1.00		2. 0	00	
20.00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)							01/01/20	023	12/31/	′2023	20. 00 21. 00
21.00	Type of control (see Firstructions)							7				21.00
	Inpatient PPS Information						1. 00	2. 00		3. 0	00	
22. 00	Does this facility qualify and is it	currentl	y receiving p	ayments fo	r		Υ	N				22. 00
	disproportionate share hospital adju				R							
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §											
	hospital?) In column 2, enter "Y" fo			meriamerit								
22. 01	Did this hospital receive interim UC						Υ	Y				22. 01
	this cost reporting period? Enter in for the portion of the cost reportin											
	1. Enter in column 2, "Y" for yes or											
	cost reporting period occurring on o	r after (	October 1. (se	е								
22. 02	instructions) Is this a newly merged hospital that	reaui res	s a final UCP	to be			N	N				22. 02
	determined at cost report settlement	? (see in	nstructions) E	nter in co	lumn							
	1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in				no							
	for the portion of the cost reportin	g period	on or after 0	ctober 1.								
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar						N	N		N		22. 03
	adopted by CMS in FY2015? Enter in c											
	for the portion of the cost reportin	g period	prior to Octo	ber 1. Ent								
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft											
	Does this hospital contain at least											
	counted in accordance with 42 CFR 41	2. 105)? E	Enter in colum	n 3, "Y" f	or							
22. 04	yes or "N" for no. Did this hospital receive a geograph	ic reclas	ssification fr	om urhan t	0							22. 04
22.01	rural as a result of the revised OMB	delineat	tions for stat	istical ar	eas							22.01
	adopted by CMS in FY 2021? Enter in											
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for				er							
	reporting period occurring on or aft	er Octobe	er 1. (see ins	tructions)								
	Does this hospital contain at least											
	counted in accordance with 42 CFR 41 yes or "N" for no.	∠. 105) ?	Enter in colu	IIII1 3, "Y"	ıor							
23. 00	Which method is used to determine Me							3 N				23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method											
	reporting period different from the				cost							
	reporting period? In column 2, ente	r "Y" for	yes or "N" f	or 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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 9: 54 am 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 23.00 60.01 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. 0.00 61.20 61.20 Of the FTEs in line 61.05, specify each expanded 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

	nancial Systems		ERVIEW HOSPITAL			u of Form CMS-2	
HOSPI TAL	AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider C		eriod: rom 01/01/2023 o 12/31/2023	Worksheet S-2 Part I Date/Time Pre	
						5/29/2024 9:5	
				Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1 +	
				Nonprovi der Si te	Hospi tal	col. 2))	
				1.00	2. 00	3. 00	
	ction 5504 of the ACA Base Yea			-This base year	is your cost	reporti ng	
64.00 Enter	riod that begins on or after J ter in column 1, if line 63 is the base year period, the num sident FTEs attributable to ro ttings. Enter in column 2 the sident FTEs that trained in yo	yes, or your facili ber of unweighted no tations occurring in number of unweighte	ty trained residents n-primary care all nonprovider d non-primary care	0.00	0.00	0. 000000	64. 00
of	(column 1 divided by (column	1 + column 2)). (see Program Name	instructions) Program Code	Upwai ahtad	Upwoi abtod	Ratio (col.	
		Program Name	Program code	Unwei ghted FTEs	Unweighted FTEs in	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
		1. 00	2.00	Si te 3. 00	4. 00	5.00	
65. 00 En	ter in column 1, if line 63	1.00	2.00	0.00			65.00
tra yea ass FTII pro res the col univ res you you 5, div	yes, or your facility ained residents in the base ar period, the program name sociated with primary care Es for each primary care ogram in which you trained sidents. Enter in column 2, e program code. Enter in lumn 3, the number of weighted primary care FTE sidents attributable to tations occurring in all n-provider settings. Enter in lumn 4, the number of weighted primary care sident FTEs that trained in ur hospital. Enter in column the ratio of (column 3 vided by (column 3 + column ). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
Sec	ction 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settin	1.00 asEffective f	2.00 for cost report	3.00 ina periods	
beg	ginning on or after July 1, 20	10	<u> </u>				
FTI En FTI	ter in column 1 the number of Es attributable to rotations o ter in column 2 the number of Es that trained in your hospit olumn 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
1(00	C. G. I. I. G. V. GCG Dy (COI GIIII I +	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
		1. 00	2.00	Si te 3.00	4. 00	5. 00	
67. 00 En	ter in column 1, the program	1.00	2.00	0.00			67.00
nai you whi En coo nui cai to noi col uni res you 5, di	me associated with each of ur primary care programs in ich you trained residents. ter in column 2, the program de. Enter in column 3, the mber of unweighted primary re FTE residents attributable rotations occurring in all n-provider settings. Enter in lumn 4, the number of weighted primary care sident FTEs that trained in ur hospital. Enter in column the ratio of (column 3 vided by (column 3 + column). (see instructions)						

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	HOSPI TAL			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CO	CN: 15-0059	Period: From 01/ To 12/	/01/2023 /31/2023		epared:
						1. 00	_
147.00 Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no.			1.00 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	ied cost finding method?					N	149. 00
		Part A	Part B		le V	Title XIX	
		1.00	2.00		. 00	4. 00	
Does this facility contain a provor charges? Enter "Y" for yes or							
155. 00Hospi tal	N TOT THE TOT CUCH COMPC	N N	N N	). (566 12	N STI	N N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156.00
157.00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N	1	N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N	1	N	N	160. 00
161. 00 CMHC			l N		N	N	161. 00
						1.00	
Multicampus						1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	ne or more camp	ouses in dif	ferent CBS	SAs?	N	165. 00
, , , , , , , , , , , , , , , , , , , ,	Name	County	State 2	ip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4.00	5. 00	
166.00 ffline 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)						0.0	0 166. 00
						4.00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Reinvestr	nent Act		1. 00	
167.00 Is this provider a meaningful use				icit Act		Υ	167. 00
168.00 If this provider is a CAH (line 1				"), enter	the		168.00
reasonable cost incurred for the							
168.01 If this provider is a CAH and is					shi p		168. 01
exception under §413.70(a)(6)(ii)							
169.00 If this provider is a meaningful transition factor. (see instructi		d is not a CAH	(Tine 105 i	s "N"), en	iter the	9. 9	9169.00
transition ractor. (see instructi	ons)			Regi	nni ng	Endi ng	
					. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	date for the r	eporting		. 00	2.100	170.00
portion respectively (milliduryyyyy)				1	00	2.00	
171.00 If line 167 is "Y", does this pro	vider have any days for i	ndi vi dual s. opro	lled in		. 00 N	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, Pt umn 1. If column 1 is yes	. I, line 2, co	ol. 6? Enter	,	IN		0171.00

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 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 9:54 am 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 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 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 17.00 Υ 02/23/2024 Υ 02/23/2024 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.

Heal th	Financial Systems RIVERVIEW	HOSPI TAL		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0059	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/29/2024 9	6-2 Prepared:
			i pti on	Y/N 1,00	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
	Report data for Other? Describe the other adjustments:	Y/N	Data	Y/N	Da+o	
		1.00	2.00	3.00	<u>Date</u> 4.00	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
21.00	records? If yes, see instructions.	14		14		21.00
		1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS	HOSPI TALS)			
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions	<u> </u>			22.00
23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost		23. 00
20.00	reporting period? If yes, see instructions.	ing the cost		20.00		
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost r	eporting period?		24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repo	orting period	? If yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	If yes, see		26. 00
07.00	i nstructi ons.					
27. 00	Has the provider's capitalization policy changed during the copy.	ie cost reporti	ng period? i	r yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntorod into d	uning the sec	t roporting		28. 00
20.00	period? If yes, see instructions.	antered Tilto do	irrig the cos	t reporting		28.00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service	Reserve Fund)		29. 00
30. 00	Has existing debt been replaced prior to its scheduled mat		debt? If ye	s, see		30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of now	dobt2 lf vo	5 500		31.00
31.00	instructions.	33dance of new	debt: 11 ye	3, 300		31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	ervi ces furni sh	ed through c	ontractual		32.00
	arrangements with suppliers of services? If yes, see instr	ructions.	· ·			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	pplied pertaini	ng to compet	itive bidding? If	7	33.00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-	based physicians?	•	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	disting agreeme	ents with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see i			·		1
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
36, 00	Were home office costs claimed on the cost report?					36.00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office	?	•	37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	fice different	from that o	f		38. 00
	the provider? If yes, enter in column 2 the fiscal year en	nd of the home	offi ce.			
39. 00	If line 36 is yes, did the provider render services to oth see instructions.	ner chain compo	onents? If ye	S,		39.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see			40.00
	Cost Depart Draparar Contact Information	1.	. 00	2.	00	
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position	TI NA		SEVERS		41.00
41.00	held by the cost report preparer in columns 1, 2, and 3,	I I IVA		41.00		
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42.00
	preparer.		•			
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEAN	DCO. COM	43.00
		•		•		

Heal th	Financial Systems RIVERVI	HOSPI TAL	In Lieu	of Form CMS-2	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 15-0059		Worksheet S-2 Part II Date/Time Pre 5/29/2024 9:5	pared:
			3.00			
	Cost Report Preparer Contact Information		3.00			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3 respectively.		MANAGER			41.00
42. 00	Enter the employer/company name of the cost report preparer.					42.00
43. 00	Enter the telephone number and email address of the cosreport preparer in columns 1 and 2, respectively.	t				43.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Heal th Fi nancial SystemsRIVEHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0059

					1	o 12/31/2023	Date/Time Pre 5/29/2024 9:5	
							I/P Days /	4 (1111
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		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							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			106	38, 690	0. 00	0	7. 00
	beds) (see instructions)	04.00		4.5	- 4			
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)	42.00					0	12.00
13. 00 14. 00	NURSERY	43. 00		101	44 145	0.00	0	13. 00 14. 00
	Total (see instructions)			121	44, 165	0.00	0	15.00
15. 00 15. 10	CAH visits REH hours and visits					0. 00	0	15. 00
16. 00	SUBPROVIDER - IPF					0.00	U	16.00
17. 00	SUBPROVIDER - I RF	41. 00		14	5, 110		0	17.00
18. 00	SUBPROVI DER	41.00		14	5, 110	,	U	18.00
19. 00	SKILLED NURSING FACILITY	44. 00		0	(		0	
20. 00	NURSING FACILITY	44.00		U			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	00.00						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	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	(			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	(	)[	0	34.00

Provi der CCN: 15-0059

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				''	0 12/31/2023	5/29/2024 9: 5	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
		.,. baye	, ,, ,, ,, ,,	,ps		equi vai onto	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	· · · · · ·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 885	391	11, 885			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)	3, 265	2, 265				2.00
3.00	HMO I PF Subprovi der	ol	. 0				3.00
4.00	HMO IRF Subprovider	725	156				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	o	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	2, 885	391	11, 885			7.00
	beds) (see instructions)	_, -,		,			
8.00	INTENSIVE CARE UNIT	610	0	2, 507			8.00
9. 00	CORONARY CARE UNIT			,			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	0			13.00
14. 00	Total (see instructions)	3, 495	391	14, 392	0.00	1, 041. 21	14.00
15. 00	CAH vi si ts	0	0	1		.,	15.00
15. 10	REH hours and visits	o	0	0			15. 10
16. 00	SUBPROVI DER - I PF		_	_			16.00
17. 00	SUBPROVI DER - I RF	2, 200	7	3, 870	0.00	18. 05	ł
18. 00	SUBPROVI DER	2,200	•	0,0.0	0.00		18.00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20.00	NURSING FACILITY		_	_			20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			127			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	
27. 00	Total (sum of lines 14-26)	Ĭ	ŭ	Ĭ	0.00	l	•
28. 00	Observation Bed Days		102	3, 659	0.00	1,007.20	28. 00
29. 00	Ambul ance Trips	0	102	0,007			29.00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days (see Thisti detroit)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	140				32.00
32. 01	Total ancillary labor & delivery room		140	0			32.00
52. 51	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days	n					33.00
33. 01	LTCH site neutral days and discharges	ا					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	ol	0	0			34.00
0	1 - 1 - 3	١	ŭ	'	II.	I	

 Health Financial Systems
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					12/31/2023	5/29/2024 9:5	
		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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	881	83	3, 956	1.00
2.00	HMO and other (see instructions)			623	788		2.00
3. 00	HMO IPF Subprovider			020	0		3.00
4. 00	HMO IRF Subprovider				15		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6, 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	881	83	3, 956	
15. 00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF	0. 00	0	209	1	357	17.00
18.00	SUBPROVI DER	0.00					18.00
19.00	SKILLED NURSING FACILITY	0. 00					19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						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 Trips						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			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00
		·		,			

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0059

					T	o 12/31/2023	Date/Time Pre 5/29/2024 9:5	
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	
		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	99, 273, 957	92, 527	99, 366, 484	2, 203, 268. 26	45. 10	1.00
	instructions)							
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2.00
3.00	Non-physician anesthetist Part		0	О	0	0. 00	0. 00	3.00
4. 00	Physician-Part A -		0	0	0	0. 00	0. 00	4.00
4 04	Admi ni strati ve		0			0.00	0.00	
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	О	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)		_	_				
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8.00
9. 00	SNF	44. 00	0	О	0	0. 00	0. 00	
10. 00	Excluded area salaries (see instructions)		33, 450, 679	470, 565	33, 921, 244	549, 896. 22	61. 69	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		4, 624, 277	0	4, 624, 277	42, 842. 00	107. 94	11.00
12. 00	Contract Labor: Top Level		0	0	0	0. 00	0. 00	12.00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part		494, 312	0	494, 312	3, 800. 00	130. 08	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	0.00		
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	О	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
	- Teachi ng		_	_				
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
47.00	WAGE-RELATED COSTS		10.040.004		10.010.001			1
17. 00	Wage-related costs (core) (see instructions)		13, 869, 306	0	13, 869, 306			17.00
18. 00	Wage-related costs (other)							18.00
19. 00	(see instructions) Excluded areas		5, 636, 009	О	5, 636, 009			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	О	О			22.00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	0	0			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
	approved program)		J	ļ				
25. 50	Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	0			25. 52
	- Administrative -		J					
	wage-related (core)				I			I

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0059 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 9:54 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 723, 232 723, 232 16, 582. 25 43. 61 26.00 27.00 Administrative & General 5.00 9, 550, 726 -224, 968 9, 325, 758 268, 072. 07 34. 79 27.00 28.00 228, 878 228, 878 1, 709. 00 133. 93 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 2, 421, 372 2, 421, 372 74, 121. 50 32.67 30.00 0 . Laundry & Linen Service 8.00 88, 318 88, 318 4, 576. 00 19. 30 31.00 31.00 0 22. 79 32.00 Housekeepi ng 9.00 1, 237, 066 Ω 1, 237, 066 54, 288. 00 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 1, 446, 109 -1, 118, 819 327, 290 14, 761. 66 22. 17 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 948, 638 948, 638 42, 786. 19 22. 17 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 0 Nursing Administration 53. 04 38.00 38.00 13.00 669, 154 669, 154 12, 615. 00 39.00 Central Services and Supply 14.00 832, 549 832, 549 28, 288. 50 29. 43 39.00 2, 919, 386 2, 619, 002 40.00 Pharmacy 15.00 -300, 384 58, 161. 00 45.03 40.00 Medical Records & Medical Records Library 41.00 16.00 756, 733 756, 733 26, 825. 75 28. 21 41.00

771, 926

17.00

18.00

C

0

0

771, 926

19, 369. 50

0.00

39. 85 42. 00

0.00 43.00

42.00

Social Service

43.00 Other General Service

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HOSPITAL WAGE INDEX INFORMATION			Provi der Co		Peri od:	Worksheet S-3	
					From 01/01/2023	Part III	
					To 12/31/2023	Date/Time Pre	pared:
						5/29/2024 9: 5	4 am
	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)	

							0/2//2021 /. 0	ı um
		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		99, 502, 835	92, 527	99, 595, 362	2, 204, 977. 26	45. 17	1.00
	instructions)							
2.00	Excluded area salaries (see		33, 450, 679	470, 565	33, 921, 244	549, 896. 22	61. 69	2.00
	instructions)							
3.00	Subtotal salaries (line 1		66, 052, 156	-378, 038	65, 674, 118	1, 655, 081. 04	39. 68	3.00
	minus line 2)							
4.00	Subtotal other wages & related		5, 118, 589	0	5, 118, 589	46, 642. 00	109. 74	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		13, 869, 306	0	13, 869, 306	0. 00	21. 12	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		85, 040, 051	-378, 038	84, 662, 013	1, 701, 723. 04	49. 75	6.00
7.00	Total overhead cost (see		21, 645, 449	-695, 533	20, 949, 916	622, 156. 42	33. 67	7.00
	instructions)							

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-1			
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0059	Peri od:	Worksheet S-3		
		From 01/01/2023			
		T 40 /04 /0000	Dala (Time Dana I		

	To 12/31/2023	B Date/Time Prep 5/29/2024 9:54	
		Amount	T CIII
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 661, 688	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	o	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	10, 264, 675	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	3	230, 788	10.00
11. 00		33, 639	11.00
12.00		0	12.00
13.00		0	13.00
14.00	1 · 3 · · · · · · · · · · · · · · · · ·	257, 267	14.00
15. 00		337, 655	
16. 00		0	16.00
	Noncumulative portion)		
47.00	TAXES	1 ((0.400	47.00
17. 00		6, 669, 499	
18.00		0	18.00
19. 00		0	19.00
20. 00		0	20.00
	OTHER		
21. 00		e 0	21.00
22.00	instructions))		22.00
22. 00		50, 104	22. 00 23. 00
23. 00 24. 00			
24.00	Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	19, 505, 315	24. 00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
23.00	Totale who keeple oosts (steelin)	1 1	25.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/29/2024 9:54 am		
Cost Contor Doscription		Contract	Ponofit Cost		

		10 12/31/2023	5/29/2024 9:5	
	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	4, 624, 277	19, 505, 315	1.00
2.00	Hospi tal	4, 624, 277	19, 505, 315	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	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14. 00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16. 00
17. 00	RENAL DIALYSIS I	0	0	
18. 00	Other	0	0	18. 00

	Financial Systems RIVERVIEW HOSPI TAL UNCOMPENSATED AND INDIGENT CARE DATA		CN: 15-0059	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	0 pared:	
					5/29/2024 9:5	4 am	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1. 00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1.00	Cost to charge ratio (see instructions)				0. 260119	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				1, 367, 165	2.00	
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplementations.	al navmont	ts from Medi	rai d2	Y Y	3. 00 4. 00	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from			zaru:	, 0	5.00	
6.00	Medi cai d charges				51, 481, 956	6.00	
7. 00	Medicaid cost (line 1 times line 6)				13, 391, 435	7. 00	
8. 00	Difference between net revenue and costs for Medicaid program (				12, 024, 270	8. 00	
9. 00	Children's Health Insurance Program (CHIP) (see instructions for Net revenue from stand-alone CHIP	r each iir	ie)		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 CHIP (				0	12.00	
	Other state or local government indigent care program (see insti						
13. 00 14. 00	Net revenue from state or local indigent care program (Not included Charges for patients covered under state or local indigent care				0	13. 00 14. 00	
14.00	10)	program (	(NOT THE TUDE	i ili ililes o oi	U	14.00	
15. 00	State or local indigent care program cost (line 1 times line 14	)			0	15. 00	
16.00	Difference between net revenue and costs for state or local ind	igent care			0	16. 00	
	Grants, donations and total unreimbursed cost for Medicaid, CHII	P and stat	e/Local indi	gent care progra	ıms (see		
17. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fu	ndi na char	si tu cara		0	17. 00	
18. 00	Government grants, appropriations or transfers for support of he				0	18.00	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local			ns (sum of lines	12, 024, 270		
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col. 2)		
			1. 00	2. 00	3. 00		
20.00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)		6, 245, 1	47 899, 996	7, 145, 143	20. 00	
21.00	Cost of patients approved for charity care and uninsured discounts	nts (see	1, 624, 4		.,	21.00	
21.00	instructions)		., 02.,	3.0,000	2, 1, 1, 0 11	21100	
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00	
00.00	charity care		4 (04 4	04/ 0/0	0 474 044	00.00	
23. 00	Cost of charity care (see instructions)		1, 624, 4	81 846, 860	2, 471, 341	23. 00	
					1. 00		
24. 00	Does the amount on line 20 col. 2, include charges for patient		nd a Length o	of stay limit	N	24. 00	
25. 00	imposed on patients covered by Medicaid or other indigent care program? 5.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 0:						
25. 01	stay limit 5.01 Charges for insured patients' liability (see instructions) 71,817						
26. 00					13, 850, 912	25. 01 26. 00	
27. 00	Medicare reimbursable bad debts (see instructions)				163, 563		
27. 01	Medicare allowable bad debts (see instructions)				251, 635		
28. 00	Non-Medicare bad debt amount (see instructions)			,	13, 599, 277	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amount of the cost of uncomposed to	unts (see	ı nstructi on:	5)	3, 625, 502	29. 00 30. 00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line)	ne 30)			6, 096, 843 18, 121, 113		
31.00	Trotal and or mode sed and uncompensated earle cost (Title 17 plus III)	110 00)			10, 121, 115	01.00	

	Financial Systems RIVERVIEW HO	_			u of Form CMS-2			
IUSPI TAL	L UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	:N: 15-0059	Peri od: From 01/01/2023 To 12/31/2023		pare		
					1. 00			
P	ART II - HOSPITAL DATA				11 00			
	ncompensated and Indigent Care Cost-to-Charge Ratio							
	Cost to charge ratio (see instructions)				0. 254226	1.		
	edicaid (see instructions for each line)							
	Net revenue from Medicaid					2.		
	Did you receive DSH or supplemental payments from Medicaid? fline 3 is yes, does line 2 include all DSH and/or supplem	ontal naumant	a from Madia	oi dO		3. 4.		
	fline 4 is no, then enter DSH and/or supplemental payments			ai u?		5.		
- 1	Medicaid charges	II OIII Wedi Cai	u			6.		
	Medicaid cost (line 1 times line 6)					7.		
	Difference between net revenue and costs for Medicaid progra	m (see instru	ictions)			8.		
	hildren's Health Insurance Program (CHIP) (see instructions							
	Net revenue from stand-alone CHIP					9.		
	Stand-alone CHIP charges					10.		
	Stand-alone CHIP cost (line 1 times line 10)					11.		
	Difference between net revenue and costs for stand-alone CHI					12.		
	ther state or local government indigent care program (see in							
	Wet revenue from state or local indigent care program (Not in					13.		
	Charges for patients covered under state or local indigent co 10)	are program (	Not included	in lines 6 or		14.		
	on State or local indigent care program cost (line 1 times line	14)				15.		
	Difference between net revenue and costs for state or local		program (se	e instructions)		16		
Gi	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	nstructions for each line)	6 . 11				1 4 7		
- 1	Private grants, donations, or endowment income restricted to		•			17.		
	Government grants, appropriations or transfers for support o Total unreimbursed cost for Medicaid , CHIP and state and Lo			s (sum of lines		18. 19.		
	3, 12 and 16)	car margent	care program	3 (3uii 01 111ie3		17.		
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
			1. 00	2. 00	3. 00			
	ncompensated care cost (see instructions for each line)	200	4 DAE 1	17 899, 996	7 145 140	   20.		
	Charity care charges and uninsured discounts (see instruction Cost of patients approved for charity care and uninsured dis	,	6, 245, 14 1, 587, 67		7, 145, 143 2, 434, 116			
	nstructions)	counts (see	1, 567, 0	040, 437	2,434,110	21.		
	Payments received from patients for amounts previously writte	en off as		0	0	22.		
	charity care							
	Cost of charity care (see instructions)		1, 587, 67	79 846, 437	2, 434, 116	23.		
	-							
. 00   0	) the amount on the 20 call 2 had also become for anti-			£ -+	1. 00	2.4		
	Opes the amount on line 20 col. 2, include charges for patien mposed on patients covered by Medicaid or other indigent ca		id a rength o	r Stay IImit	N	24.		
5. 00 I	imposed on parients covered by medicard or other indigent ca fline 24 is yes, enter the charges for patient days beyond stay limit		care progra	m's length of	0	25.		
	Charges for insured patients' liability (see instructions)				71, 817	25.		
	Bad debt amount (see instructions)				13, 850, 912			
5. 01 C								
5. 01 C 6. 00 B								
5. 01 C 6. 00 B 7. 00 M	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·						
5. 01 C 6. 00 B 7. 00 M 7. 01 M	· · · · · · · · · · · · · · · · · · ·				13, 618, 143	28.		
5. 01 C 6. 00 B 7. 00 M 7. 01 M 8. 00 N	Medicare allowable bad debts (see instructions)	amounts (see	instructions	)				
5. 01 C 6. 00 B 7. 00 M 7. 01 M 8. 00 N 9. 00 C	Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	•	instructions	)	13, 618, 143			

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	RIVERVIEW H	Provi der C	CN: 15 0050 I	Peri od:	Worksheet A	2332-10
RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		From 01/01/2023	worksneet A	
					Γο 12/31/2023		
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	5/29/2024 9: 5 Recl assi fi ed	4 am
	cost center bescription	Sai ai i es	other	+ col . 2)	i ons (See	Trial Balance	
				1 001. 2)	A-6)	(col. 3 +-	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		27, 164, 331	27, 164, 33 <sup>-</sup>	-624, 114	26, 540, 217	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	723, 232	9, 364, 873				
5. 00	00500 ADMINISTRATIVE & GENERAL	9, 550, 726	42, 452, 428				
7.00	00700 OPERATION OF PLANT	2, 421, 372	6, 913, 684			9, 335, 056	
8.00	00800 LAUNDRY & LI NEN SERVI CE	88, 318	1, 862, 733			1, 951, 051	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 237, 066 1, 446, 109	1, 212, 197 2, 320, 917			2, 449, 263 847, 616	
11. 00	01100 CAFETERI A	1, 440, 109	2, 320, 917		2, 471, 144		1
13. 00	01300 NURSI NG ADMI NI STRATI ON	669, 154	88, 043			757, 197	
14. 00	01400 CENTRAL SERVICES & SUPPLY	832, 549	-9, 594				
15. 00	01500 PHARMACY	2, 919, 386	20, 724, 010			23, 322, 562	
16.00	01600 MEDICAL RECORDS & LIBRARY	756, 733	758, 805			1, 515, 538	
17.00	01700 SOCIAL SERVICE	771, 926	341, 629	1, 113, 55!	5 0	1, 113, 555	17.00
23.00	02300 PARAMED ED PRGM PHARMACY	0	0	(	310, 237	310, 237	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	9, 290, 412	3, 890, 942				
31.00	03100 INTENSIVE CARE UNIT	2, 339, 935	904, 463				
41.00	04100 SUBPROVI DER - I RF	1, 492, 395	1, 034, 835	2, 527, 230	-67, 261	2, 459, 969	
43. 00 44. 00	04300 NURSERY	0	0			0   0	
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	υ	0	1	<u>)</u> 0	0	44.00
50.00	05000 OPERATING ROOM	4, 846, 741	9, 976, 098	14, 822, 839	-4, 254, 453	10, 568, 386	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 040, 741	7, 770, 070		0	10, 300, 300	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 117, 479	726, 921		-		
55. 00	05500 RADI OLOGY-THERAPEUTI C	537, 595	639, 447				
57.00	05700 CT SCAN	479, 645	227, 921			593, 575	
57. 01	03630 ULTRA SOUND	467, 341	43, 785	511, 120	-1, 050	510, 076	57. 01
58.00	05800 MRI	355, 549	45, 896	401, 44!	-9, 822	391, 623	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	958, 007	2, 347, 489	3, 305, 49	-1, 420, 543	1, 884, 953	
60.00	06000 LABORATORY	3, 863, 261	5, 945, 922	9, 809, 18	-3, 894		
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	486, 661	486, 66	0	486, 661	
64.00	06400 I NTRAVENOUS THERAPY	1 5/0 220	0	1 041 40	07 151	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 569, 230 5, 191, 389	372, 265 796, 305			1, 844, 344 5, 976, 166	
67.00	06700 OCCUPATI ONAL THERAPY	0, 191, 369	790, 303 0	3, 907, 09	-11, 526	5, 976, 166	1
68. 00	06800 SPEECH PATHOLOGY	0	0			0	1
69. 00	06900 ELECTROCARDI OLOGY	679, 619	199, 152	878, 77	-	878, 498	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	О	11, 475, 829	11, 475, 829	9 0	11, 475, 829	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	07400 RENAL DIALYSIS	0	351, 090	351, 090	-3, 013	348, 077	74.00
	03020 OTHER ANCI LLARY	0	0		0		76.00
	03140 CARDI AC REHAB	884, 715	356, 635				1
76. 02	03070 WOMEN' S CENTER	510, 314	168, 771	679, 08!	. 1		1
	03330 ENDOSCOPY	0	0	1	0	0	
77. 00 78. 00	07700 ALLOGENEIC STEM CELL ACQUISITION   07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	
78.00	OUTPATIENT SERVICE COST CENTERS	υ	0	1	<u>)</u> 0	0	78.00
90.00	09000 CLINIC	366, 797	131, 719	498, 510	-80, 661	417, 855	90.00
90. 00	09001 OUTPATI ENT	565, 673	936, 452				
90. 02	09002 NEUROPSYCHOLOGY	368, 798	89, 813			409, 930	
91. 00	09100 EMERGENCY	9, 014, 207	22, 136, 687				
91. 01	09101 SHORT STAY	0	0		0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	39, 644	27, 003	66, 64			95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0	0	102. 00
440.00	SPECIAL PURPOSE COST CENTERS	(7.055.047	17/ 50/ 457			0.17 .10 050	
118.00		67, 355, 317	176, 506, 157	243, 861, 47	4 3, 581, 378	247, 442, 852	1118.00
100 00	NONREI MBURSABLE COST CENTERS	100.045	107 007	227.05	1	227 051	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   19200 PHYSICIANS' PRIVATE OFFICES	100, 965 25, 723, 761	126, 886 11, 811, 268			227, 851 33, 831, 091	1
	19201 FOUNDATION	243, 547	13, 444			256, 991	1
	19202 CLINICS	1, 206, 666	261, 843			1, 418, 326	1
	19206 HOME HEALTH PARTNERSHIP	1, 200, 000	-995				192.03
	19207 WESTFI ELD SCHOOLS	1, 405, 880	202, 340	•			
	19203 PRACTI CE MANAGEMENT	709, 933	571, 836			1, 206, 604	
	19204 MOB - NOBLESVILLE SQUARE	0	266, 330			266, 330	
	19208 PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.07
192. 08	19205 RIVERVIEW MEDICAL ARTS	О	3, 742	3, 74:	2 0	3, 742	192. 08
		'					

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der C		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	pared: 4 am
Cost Center Description	Sal ari es	Other	Total (col. 1	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	
192. 09 19209 BEHAVI OR CARE	498, 561	118, 666	617, 22	7 -66, 290	550, 937	192. 09
193. 00 19300 NONPALD WORKERS	0	0		0	0	193. 00

69, 430

256, 252

56, 259

695, 609

591, 222

360, 555

99, 273, 957

5, 835

51, 505

16, 483

114, 273

267, 220

5, 468, 174

195, 805, 007

0 193. 00 0 193. 01

75, 265 193. 02

273, 112 193. 03 65, 136 193. 04 726, 605 193. 05

6, 059, 396 193. 06

625, 448 194. 00 443, 312 194. 01 295, 078, 964 200. 00

0

0

75, 265

307, 757

72, 742

809, 882

627, 775

6, 059, 396

295, 078, 964

0

-34, 645

-7, 606

-83, 277

-2, 327

443, 312

193. 01 19301 PHYSI CI AN SERVI CES-LYONS

193. 02 19302 UNI VERSI TY HS ATHLETI CS

193. 04 19304 OB/GYN SPEC GATHERS 193. 05 19305 OB SPECIALISTS DAVENPORT

194. 01 07951 MEALS ON WHEELS 200. 00 TOTAL (SUM OF LINES 118 through 199)

193. 03 19303 OB/GYN SPEC NEMUNALTI

193. 06 19306 RETAIL PHARMACY

194. 00 07950 WORKMED

 Health Financial
 Systems
 RIVERVI

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0059

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			To 12/31/2023 Date/lime Pre 5/29/2024 9:5	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
	6. 00	Allocation 7.00		
GENERAL SERVICE COST CENTERS	6.00	7.00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-39, 104	26, 501, 113		1.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	-59, 187	14, 684, 836		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-21, 596, 126	30, 957, 321		5.00
7. 00   00700   OPERATION OF PLANT	0	9, 335, 056		7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	0	1, 951, 051		8. 00 9. 00
10. 00   01000   DI ETARY	-135, 148	2, 449, 263 712, 468	•	10.00
11. 00   01100   CAFETERI A	-897, 596	1, 573, 548	•	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	757, 197	•	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	9, 176, 122		14.00
15. 00   01500   PHARMACY	0	23, 322, 562		15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	-1, 220	1, 514, 318	1	16.00
17. 00   01700   SOCIAL SERVICE 23. 00   02300   PARAMED ED PRGM PHARMACY	0	1, 113, 555	1	17. 00 23. 00
23. 00   02300   PARAMED ED PRGM PHARMACY   I NPATIENT ROUTINE SERVICE COST CENTERS	U	310, 237		23.00
30. 00 03000 ADULTS & PEDI ATRI CS	O	12, 624, 098		30.00
31.00 03100 INTENSIVE CARE UNIT	o	3, 021, 094	1	31.00
41. 00   04100   SUBPROVI DER - 1 RF	o	2, 459, 969		41.00
43. 00   04300   NURSERY	0	0	l .	43.00
44.00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		44.00
50. 00 05000 OPERATING ROOM	-2, 596, 367	7, 972, 019		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	l .	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-4, 139	2, 831, 971		54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	1, 175, 273	•	55.00
57. 00   05700   CT   SCAN	-3, 234	590, 341		57.00
57. 01   03630   ULTRA SOUND	-553 0	509, 523	•	57. 01
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON	-735, 000	391, 623 1, 149, 953	l .	58. 00 59. 00
60. 00   06000 LABORATORY	-55, 650	9, 749, 639	•	60.00
60. 01 06001 BLOOD LABORATORY	0	0	l .	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	486, 661		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 844, 344	•	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY	-83, 968 0	5, 892, 198 0	1	66. 00 67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	-103, 238	775, 260		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 475, 829		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74. 00   07400   RENAL DI ALYSI S 76. 00   03020   OTHER ANCI LLARY	0	348, 077		74. 00 76. 00
76. 00   03020   OTHER ANCI LLARY 76. 01   03140   CARDI AC   REHAB	-18, 679	1, 037, 970		76.00
76. 02   03070   WOMEN' S CENTER	-10,079	596, 807	•	76.01
76. 03   03330   ENDOSCOPY	ō	0	l .	76. 03
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0		77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
90. 00 O9000 CLINIC COST CENTERS	ol	417, 855		90.00
90. 01   09001   0UTPATI ENT	-6, 935	1, 119, 376		90.00
90. 02 09002 NEUROPSYCHOLOGY	-159, 991	249, 939	•	90.02
91. 00 09100 EMERGENCY	-14, 496, 156	15, 305, 448		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	0	66, 647		95.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	00, 047	l .	102.00
SPECIAL PURPOSE COST CENTERS	-,	-		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-40, 992, 291	206, 450, 561		118. 00
NONREI MBURSABLE COST CENTERS	ما	227 051	T	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0 -17, 248, 509	227, 851 16, 582, 582	•	190. 00 192. 00
192. 01 19201 FOUNDATION	-17, 248, 309	256, 991	•	192.00
192. 02 19202 CLINICS	-418, 923	999, 403		192.01
192. 03 19206 HOME HEALTH PARTNERSHIP	0	-995		192.03
192. 04 19207 WESTFI ELD SCHOOLS	-2, 639	1, 604, 322	•	192. 04
192. 05 19203 PRACTI CE MANAGEMENT	-45, 371	1, 161, 233	•	192. 05
192. 06 19204 MOB - NOBLESVILLE SQUARE	0	266, 330	l e e e e e e e e e e e e e e e e e e e	192.06
192.07 19208 PHYSI CLANS' PRI VATE OFFICES 192.08 19205 RI VERVI EW MEDI CAL ARTS	0	0 3, 742	1	192. 07 192. 08
192.09 19209 BEHAVI OR CARE	-387, 738		•	192.00
1 1 21 21 21 21	, , 50	, ,	1	

Heal th Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0059
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
RIVERVIEW HOSPITAL
In Lieu of Form CMS-2552-10
Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			5/29/2024 9:54 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
193. 00 19300 NONPALD WORKERS	0	0	193.00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	75, 265	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	-264, 205	8, 907	193. 03
193.04 19304 OB/GYN SPEC GATHERS	-58, 005	7, 131	1 193.04
193. 05 19305 OB SPECIALISTS DAVENPORT	-717, 197	9, 408	193. 05
193.06 19306 RETAIL PHARMACY	0	6, 059, 396	193.06
194. 00 07950 WORKMED	-12, 500	612, 948	194.00
194.01 07951 MEALS ON WHEELS	0	443, 312	194. 01
200.00   TOTAL (SUM OF LINES 118 through 199)	-60, 147, 378	234, 931, 586	200.00

Health Financial Systems RECLASSIFICATIONS RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0059

					10	12/31/2023	Date/IIme Prepared: 5/29/2024 9:54 am
		Increases			<u> </u>		072772021 7. 01 dill
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - CAFETERIA RECLASS	44.00	0.40 (0.0	1 500 504			1.00
1. 00	CAFETERI A	<u>11.</u> 00	948, 638	1, 52 <u>2, 5</u> 06 1, 522, 506			1.00
	B - MEALS ON WHEELS RECLASS		948, 638	1, 522, 506			
1. 00	MEALS ON WHEELS	194. 01	170, 181	273, 131			1.00
1.00	0			273, 131			1.66
	C - INSURANCE RECLASS	,					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	624, 114			1.00
	0		0	624, 114			
	D - MEDICAL SUPPLY RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8, 353, 167			1.00
2.00		0.00	0	0			2.00
3. 00 4. 00	1	0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	o	0			5.00
6. 00		0. 00	o	0			6.00
7. 00		0.00	o	0			7. 00
8.00		0.00	0	0			8.00
9. 00		0.00	0	0			9. 00
10.00		0. 00	0	0			10.00
11. 00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13.00
14. 00 15. 00		0. 00 0. 00	0	0			14. 00 15. 00
16. 00		0.00	o	0			16. 00
17. 00		0.00	Ö	0			17. 00
18. 00		0.00	o	0			18.00
19.00		0.00	0	0			19.00
20.00		0.00	0	0			20.00
21.00		0. 00	0	0			21.00
22. 00		0. 00	0	0			22. 00
23.00		0.00	0	0			23.00
24. 00 25. 00		0. 00 0. 00	0	0			24. 00 25. 00
26. 00		0.00	O O	0			26.00
27. 00		0.00	0	0			27.00
27.00		— — <del></del>	— — <del> </del>	8, 353, 167			27.00
	E - RSMA RECLASS	<u>'</u>	- '	.,			
1.00	OPERATING ROOM	50.00	317, 495				1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1 <u>8, 9</u> 19			2.00
	0		317, 495	18, 919			
1 00	F - PARAMED ED RECLASS	22 00	200 204	0.053			1 00
1. 00	PARAMED ED PRGM PHARMACY	23. 00	300, 384 300, 384	<u>9, 853</u> 9, 853			1.00
	G - COMMUNITY RELATIONS RECLA	ASS L	300, 304	7, 000			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	ol	224, 968			1.00
	0			224, 968			
	H - ALLOCATED BENEFITS RECLAS						
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 640, 018			1.00
2. 00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
5. 00 6. 00		0. 00 0. 00	0	0			5. 00 6. 00
7. 00		0.00	O O	0			7.00
8. 00		0.00	0	0			8.00
9. 00		0. 00	ol	Ö			9. 00
10.00		0.00	ō	0			10.00
11.00		0.00	o	0			11.00
12.00		000	0_	0			12.00
E00 -	0		0	4, 640, 018			
500.00	Grand Total: Increases		1, 736, 698	15, 666, 676			500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0059

		Decreases				5/29/2024 9	7. 0
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	- CAFETERIA RECLASS				1	1	
1.00 DIE	ETARY	1000	948, 638	<u>1,522,506</u>		<u>)</u>	1.00
D	- MEALS ON WHEELS RECLASS		948, 638	1, 522, 506			
	ETARY	10.00	170, 181	273, 131	0		1.00
1.00	LIANI — — —		170, 181	27 <u>3, 1</u> 31 273, 131			1.00
C -	- INSURANCE RECLASS		170, 101	270, 101			
	P REL COSTS-BLDG & FLXT	1.00	0	624, 114	12		1.00
0				624, 114			
D -	- MEDICAL SUPPLY RECLASS						
	PLOYEE BENEFITS DEPARTMENT	4. 00		3, 019		l .	1.00
	ETARY	10. 00		4, 954			2. 00
	ARMACY	15. 00		10, 597	0	l .	3.00
	ULTS & PEDI ATRI CS	30. 00		557, 256		l .	4.00
	TENSIVE CARE UNIT BPROVIDER - IRF	31. 00 41. 00		223, 304	0	l .	5. 00 6. 00
	ERATING ROOM	50.00		67, 261 4, 145, 801	0	l .	7.00
	DI OLOGY-DI AGNOSTI C	54.00		8, 290		l .	8.00
	DI OLOGY-THERAPEUTI C	55. 00		1, 769		l .	9. 00
	SCAN	57. 00		113, 991	0	l .	10.00
11. 00 ULT	TRA SOUND	57. 01		1, 050	0		11.00
12.00 MRI	I	58. 00		9, 822	. 0		12. 00
	RDIAC CATHETERIZATION	59. 00		1, 420, 543		l .	13.00
	BORATORY	60. 00		3, 894		l e e e e e e e e e e e e e e e e e e e	14. 00
	SPI RATORY THERAPY	65. 00		97, 151	0	l .	15. 00
	YSI CAL THERAPY	66. 00		11, 528		l .	16.00
	ECTROCARDI OLOGY	69.00		273		l .	17.00
	NAL DIALYSIS RDIAC REHAB	74. 00 76. 01		3, 013 184, 701		l .	18. 00 19. 00
	MEN'S CENTER	76. 01 76. 02		82, 278		l .	20.00
	INIC	90. 00		31, 242		l .	21.00
	TPATI ENT	90. 01		375, 814		l e e e e e e e e e e e e e e e e e e e	22.00
	ERGENCY	91.00		525, 845			23.00
24. 00 PHY	YSICIANS' PRIVATE OFFICES	192. 00		465, 158	0		24.00
25. 00 CLI	INICS	192. 02		1, 027	0		25. 00
	STFIELD SCHOOLS	192. 04		1, 259		l e e e e e e e e e e e e e e e e e e e	26. 00
27. 00 WOF	RKMED	1 <u>94.</u> 00		2, 327		<u> </u>	27. 00
0	DOMA DEGLACO		0	8, 353, 167			
	- RSMA RECLASS ERATING ROOM	50.00	0	224 414	. 0	ı	1 00
1. 00 OPE 2. 00	ERATING ROOM	0.00	0	336, 414 0		l .	1. 00 2. 00
2.00	- — — — — +			336, 414			2.00
F -	- PARAMED ED RECLASS		<u> </u>	000, 111			
	ARMACY	15. 00	300, 384	9, 853	0		1.00
0	+		300, 384	9, 853			
G -	- COMMUNITY RELATIONS RECLAS	iS .					
1.00 ADM	MINISTRATIVE & GENERAL		224, 968	0			1.00
0			224, 968	0			
	- ALLOCATED BENEFITS RECLASS		.1				
	MINISTRATIVE & GENERAL	5.00	0	73, 821			1.00
	ERATING ROOM	50. 00 90. 00	0	89, 733			2.00
	I NI C UROPSYCHOLOGY	90. 00 90. 02	0	49, 419 48, 681		l .	3. 00 4. 00
	ERGENCY	91. 00	0	823, 445		ł	5.00
	YSICIANS' PRIVATE OFFICES	192. 00	0	3, 238, 780		l e e e e e e e e e e e e e e e e e e e	6.00
	INICS	192. 02	o	49, 156		l .	7.00
	ACTICE MANAGEMENT	192. 05	o	75, 165	_		8.00
	HAVI OR CARE	192. 09	ó	66, 290			9. 00
	/GYN SPEC NEMUNALTI	193. 03	o	34, 645			10.00
	/GYN SPEC GATHERS	193. 04	o	7, 606		l e	11.00
12.00 <u>OB</u>	SPECIALISTS DAVENPORT	193. 05		8 <u>3, 2</u> 77		1	12. 00
0	Talal Bas		0	4, 640, 018		1	500.00
500.00  Gra	and Total: Decreases		1, 644, 171	15, 759, 203	il .	I	500.00

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

				10	) 12/31/2023	5/29/2024 9:5	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	16, 050, 414	0	0	0	0	1.00
2.00	Land Improvements	3, 330, 308	139, 030		139, 030		2.00
3.00	Buildings and Fixtures	166, 686, 771	273, 743		273, 743		3.00
4.00	Building Improvements	18, 834, 183	17, 671, 126		17, 671, 126		4.00
5.00	Fi xed Equipment	52, 683, 867	10, 407, 262	0	10, 407, 262	0	5.00
6. 00	Movable Equipment	125, 643, 510	2, 175, 102	0	2, 175, 102	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	383, 229, 053	30, 666, 263	0	30, 666, 263	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	383, 229, 053		0	30, 666, 263	0	10.00
		Endi ng	Ful I y				
		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, 469, 338	0				2.00
3.00	Buildings and Fixtures	166, 960, 514	0				3.00
4.00	Building Improvements	36, 505, 309	0				4.00
5. 00	Fixed Equipment	63, 091, 129	0				5.00
6.00	Movable Equipment	127, 818, 612	0				6.00
7.00	HIT designated Assets		0				7. 00
8.00	Subtotal (sum of lines 1-7)	413, 895, 316	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	413, 895, 316	0				10.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0059	Peri od: From 01/01/2023 To 12/31/2023		pared:	
SUMMARY OF CAPITAL								
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10. 00	11. 00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FLXT	27, 164, 331	0	)	0 0	0	1.00	
3.00	Total (sum of lines 1-2)	27, 164, 331	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1)	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	27, 164, 331		-		1.00	
3.00	Total (sum of lines 1-2)	0	27, 164, 331				3.00	
				•			•	

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lieu of Form CMS-255		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	1	Period: From 01/01/2023 Fo 12/31/2023		
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	T GIII
	Cost Center Description		Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	413, 895, 316	0	413, 895, 316	1. 000000	0	1.00
3.00	Total (sum of lines 1-2)	413, 895, 316	0	413, 895, 316	1. 000000	0	3.00
		ALLOCATION OF OTHER CAPITAL			SUMMARY O		
	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. 00	CAP REL COSTS-BLDG & FIXT	0	0	(	27, 164, 331		1. 00
3.00	Total (sum of lines 1-2)	0	0		27, 164, 331	0	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other Capi tal -Rel at	Total (2)	
			instructions)	I i i i i i i i i i i i i i i i i i i	ed Costs (see		
			l listi deti olis)		instructions)	/ till ough 14)	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	-39, 104	-624, 114		0	26, 501, 113	1.00
3.00	Total (sum of lines 1-2)	-39, 104	· ·	•	o		3. 00

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

				Fr To	om 01/01/2023 12/31/2023	Date/Time Pre	
				Expense Classification on	Worksheet A	5/29/2024 9: 5	4 am
				To/From Which the Amount is t			
		5 / 6 /					
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00		1. 00	2. 00	3.00	4. 00	5. 00	1 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2. 00	Investment income - CAP REL		C	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2)		C		0. 00	0	3. 00
4 00	(chapter 2)				0.00	0	4.00
4. 00	Trade, quantity, and time discounts (chapter 8)		C		0. 00	0	4. 00
5. 00	Refunds and rebates of		C		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		C		0. 00	0	6. 00
7 00	suppliers (chapter 8)				0.00	0	7.00
7. 00	Tel ephone servi ces (pay stati ons excluded) (chapter		C		0. 00	0	7. 00
8. 00	21) Tel evi si on and radio service		C		0. 00	0	8. 00
8.00	(chapter 21)		C	,	0.00	Ü	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-22, 121, 715		0. 00	0	9. 00 10. 00
10.00	adj ustment	A-0-2	-22, 121, 713			Ü	10.00
11. 00	Sale of scrap, waste, etc.		C		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	235, 994	ı l		0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		C		0. 00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-619, 083	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		C		0. 00	0	15. 00
16. 00	Sale of medical and surgical		C		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		C		0. 00	0	17. 00
18. 00	patients Sale of medical records and		C		0. 00	0	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		C		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		C		0. 00 0. 00	0	
	interest, finance or penalty		_			_	
22. 00	charges (chapter 21) Interest expense on Medicare		C		0. 00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	C	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		C	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		2	)*** Cost Center Deleted ***	2. 00	0	27. 00
	COSTS-MVBLE EQUIP					Ü	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		C	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	C	OCCUPATI ONAL THERAPY	67. 00	0	30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)						l

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0059 Peri od: Worksheet A-8 From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To	12/31/2023	Date/Time Pre 5/29/2024 9:5	
				Expense Classification on	Worksheet A	372772024 7.3	4 dili
				To/From Which the Amount is			
					,		
		5 , (0 ,					
	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	
31. 00	Adjustment for speech	A-8-3	2. 00	3.00 SPEECH PATHOLOGY	4.00	5.00	31.00
31.00	pathology costs in excess of	A-0-3	0	SPEECH PATHOLOGY	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
02.00	Depreciation and Interest				0.00	J	02.00
33. 00	HAF EXPENSE	Α	-14, 945, 936	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33. 01	ADMI NI STRATI ON	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
	RECRUI TMENT/SPECI AL E		.,			_	
33. 02	OTHER REV MEDICAL REPORT	В	-1, 220	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 02
33. 03	OTHER REVENUES ->PURCHASE	В	-41, 800	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
	DI SCOUNTS						
33.04	RADI OLOGY- OTHER REVENUE-CDS	В	-4, 039	RADI OLOGY-DI AGNOSTI C	54.00	0	33.04
	FOR LEG						
33. 05	AMBULANCE OTHER REVENUE	В	0	AMBULANCE SERVICES	95. 00	0	33. 05
33. 06	LABORATORY -> OTHER REVENUE	В		LABORATORY	60. 00	0	33.06
33. 07	EDUCATION -> OTHER REVENUE	В	-23, 958	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	DIETARY SALES PR DEDUCT	В	-278, 513	CAFETERI A	11. 00	0	33. 08
33. 09	WELLNESS SERVICES -	В	-23, 262	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 09
	EXTERNAL->-OTHER						
33. 10	WESTFIELD BISTRO-OTHER REVENUE		-135, 148		10. 00	0	33. 10
33. 11	NON-OP REV -> MI SCELLANEOUS	В	-39, 104	CAP REL COSTS-BLDG & FIXT	1. 00	11	33. 11
00.40	I NTEREST		0 44/ 555	ADMINISTRATIVE & CENEDAL	F 00		00.40
33. 12	COMMUNITY RELATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	COMMUNITY RELATIONS BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 13
33. 14	CRNA	A		OPERATING ROOM	50. 00	0	33. 14
33. 15	I HA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 15
33. 16	CT SCAN-OTHER REVENUE	B B		CT SCAN	57.00	0	33. 16
33. 17	FISCAL SERVICES COMMERCE BANK REBATE	В	- 109, 635	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	ULTRASOUND - OTHER REVENUE	В	_553	ULTRA SOUND	57. 01	0	33. 18
33. 19	WOUND CARE-OTHER REVENUE	В		OUTPATI ENT	90. 01	0	33. 19
33. 20	NON-OP EXPENSE INVESTMENT FEES			ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	OTHER MISC REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	NEUROPSYCHOLOGY OTHER REVENUE	В		NEUROPSYCHOLOGY	90. 02	0	33. 22
33. 23	OTHER REV RADIOLOGY FILM	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 23
33. 24	ADMIN DONATIONS	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 24
33. 25	CENTRAL PROCESSING OTHER	В		CENTRAL SERVICES & SUPPLY	14. 00	0	33. 25
	REVENUE						
33. 26	PHYSICIAN WAGES-PHYSICIANS'	А	-17, 248, 509	PHYSICIANS' PRIVATE OFFICES	192. 00	0	33. 26
	PRI VATE						
	PHYSICIAN WAGES-CLINICS	Α	-418, 923		192. 02	0	
33. 28	PHYSICIAN WAGES-WESTFIELD	Α	-2, 639	WESTFIELD SCHOOLS	192. 04	0	33. 28
	SCH00LS						
33. 29	PHYSICIAN WAGES-PRACTICE	A	-45, 371	PRACTICE MANAGEMENT	192. 05	0	33. 29
	MANAGEMENT					_	
33. 30	PHYSI CI AN WAGES-BEHAVI OR CARE	A		BEHAVI OR CARE	192. 09	0	
33. 31	PHYSICIAN WAGES-OB/GYN SPEC	А	-264, 205	OB/GYN SPEC NEMUNAITI	193. 03	0	33. 31
22 22	NEMUNAI T	۸	F0 00F	OD (CVAL ODEC CATHEDO	102.04	0	22.22
33. 32	PHYSICIAN WAGES-OB/GYN SPEC	А	-58,005	OB/GYN SPEC GATHERS	193. 04	0	33. 32
22 22	GATHERS	Λ	717 107	OB SPECIALISTS DAVENPORT	102 05	0	22 22
33. 33	PHYSICIAN WAGES-OB SPECIALISTS DAVEN	А	-/1/, 19/	OD SPECIALISIS DAVENPUKI	193. 05	0	33. 33
33. 34	PHYSICIAN WAGES-WORKMED	А	_12 500	WORKMED	194. 00	0	33. 34
33. 35	OTHER ADJUSTMENTS (SPECIFY)	Α	-12,300	WORKWIED	0.00	0	33. 35
55. 55	(3)				0.00	U	55.55
50.00	TOTAL (sum of lines 1 thru 49)		-60, 147, 378				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) De	scription - all chapter referen	res in this co	lumn nertain t	o CMS Pub 15-1			

<sup>(1)</sup> 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	TED ORGANIZATION(S) AND/OR HO	OME 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:

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 Syste	ems	RI VERVI EW HOSPI TAL			In Lieu of Form CMS-2552-10				
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED ORGANI ZATI ONS	AND HOME	Provi der	CCN: 15-	-0059	Peri od:	Worksheet A-	8-1
OFFICE	COSTS							From 01/01/2023	Doto/Time Do	anarad.
								To 12/31/2023	Date/Time Pr 5/29/2024 9:	
	Net	Wkst. A-7 Ref.							0,2,,202.	1
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RES	SULT OF TRA	NSACTI ONS	WITH RI	ELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:									
1.00	235, 994	0								1.00
2.00	0	0								2.00
3.00	0	0								3.00
4.00	0	0								4.00
5. 00	235, 994									5.00
* The	amounts on lin	es 1-4 (and sub	bscripts as appropriate	e) are tran	sferred in	n detail	to Wor	rksheet A, column	6, lines as	
appropr	i ate. Posi ti ve	amounts increas	se cost and negative am	mounts decr	ease cost.	For rel	ated or	rganization or ho	me office cos	t which
has not	been posted t	o Worksheet A,	columns 1 and/or 2, th	ne amount a	llowables	should b	e indio	cated in column 4	of this part	
	Related Orga	ani zati on(s)								
	and/or Ho	me Office								
	Type of	Busi ness								

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:

6. 00

- 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

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						10 12/31/2023	5/29/2024 9:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	•		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	12, 500	12, 500	0	0	0	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	4, 525, 093	4, 525, 093	3 0	0	0	2.00
3.00	50.00	OPERATING ROOM	1, 956, 361	1, 956, 36°	1 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	83, 968	83, 968	3 0	0	0	5.00
6.00	69. 00	ELECTROCARDI OLOGY	103, 238	103, 238	3 0	0	0	6.00
7.00	76. 01	CARDI AC REHAB	18, 679	18, 679	9 0	0	0	7. 00
8. 00	90. 02	NEUROPSYCHOLOGY	190, 720			0	0	8. 00
9. 00		EMERGENCY	14, 496, 156	14, 496, 156	6 0	0	0	9. 00
10.00	0.00		0		0	0	0	10.00
200.00			22, 121, 715	22, 121, 71	5 0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadiusted RCE			Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCI	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	4. 00	EMPLOYEE BENEFITS DEPARTMENT	0	(	0	0	0	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	0	(	0	0	0	2.00
3.00	50. 00	OPERATING ROOM	0	(	0	0	0	3.00
4.00	59. 00	CARDIAC CATHETERIZATION	0	(	0	0	0	4.00
5.00	66. 00	PHYSI CAL THERAPY	0	(	0	0	0	5. 00
6.00	69. 00	ELECTROCARDI OLOGY	0	(	0	0	0	6. 00
7.00	76. 01	CARDI AC REHAB	0	(	0	0	0	7. 00
8.00	90. 02	NEUROPSYCHOLOGY	0	(	0	0	0	8. 00
9. 00	91. 00	EMERGENCY	0	(	0	0	0	9. 00
10.00	0. 00		0	(	0	0	0	10.00
200.00			0	,	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		EMPLOYEE BENEFITS DEPARTMENT	0		0	,		1.00
2.00		ADMINISTRATIVE & GENERAL	0		0	1,020,070		2.00
3. 00		OPERATING ROOM	0	1	0	1, 956, 361		3. 00
4. 00		CARDIAC CATHETERIZATION	0	(	0	735, 000		4. 00
5. 00		PHYSI CAL THERAPY	0		0	83, 968		5. 00
6. 00		ELECTROCARDI OLOGY	0	(	0	103, 238	•	6. 00
7. 00		CARDI AC REHAB	0		0	18, 679	•	7. 00
8. 00		NEUROPSYCHOLOGY	0		0			8. 00
9. 00		EMERGENCY	0		ار 0	14, 496, 156		9.00
10.00	0. 00		0	(	0	0		10.00
200. 00			0	l (	0	22, 121, 715	l	200. 00

| Period: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0059

Cost Center Description							o 12/31/2023	Date/Time Pre	pared:
Control Control Description					CAPLTAI			5/29/2024 9:5	4 am
Cost Center Bescription									
CENERAL SERVICE COST CENTERS			Cost Center Description	Net Expenses		EMPLOYEE	Subtotal	ADMINISTRATIV	
								E & GENERAL	
Col. 77						DEPARTMENT			
DEBURGAL SERVICE COST CENTERS   DEPURT   20.501   13   0.500   4A   DO   AD   DO   DO   DOD									
1.00					1.00	4. 00	4A	5. 00	
4.00   GORDO   EMPLOYMER BRIFET IS DEPARTMENT   14, 614, 816   91, 77   14, 776, 948   3.47, 858   3.433, 990   34, 333, 990   3.0000   3.0000   000000	-								
5.00 000000 ADMINISTRATIVE & CENERAL 90,907, 321 1,979,699 1,399,900 34,333,900 50,000 8.00 00000 LAURINEY & LINEN SERVICE 1,951,051 6,84,447 13,230 2,055,028 34,333,900 5,000 8.00 00000 LAURINEY & LINEN SERVICE 1,951,051 6,1,447 13,230 2,055,028 34,333,900 5,000 10.00 00000 LAURINEY & LINEN SERVICE 1,951,051 6,1,447 13,230 2,055,028 34,333,900 5,000 10.00 00000 LAURINEY & LINEN SERVICE NO. 7,7197 0 10,238 857,65 14,755,652 29,000 11.00 00000 LAURINEY & LINEN SERVICE NO. 7,7197 0 10,238 857,65 14,775,652 29,000 11.00 0000 LAURINEY & LINEN SERVICE NO. 7,7197 0 10,000 88,000 11.00 000 11.00									
7.00   000000   000000		1	•					24 222 000	
8.00   00800  AUMORY & LI NEN SERVICE   1,951,051   61,447   13,230   2,025,728   346,720   8,00   1000   10000   DETARY   712,468   535,023   40,027   1,971,118   222,012   10,00   10000   DETARY   712,468   535,023   40,027   1,971,118   222,012   10,00   1000   01000   DETARY   712,468   712,468   712,468   712,468   712,478   712,									
10.00   01000   DETARY		1			1				
11.00   01100  CAFETERIA   1.573,548   0   142,104   1.715,652   293,648   11 0.07   14.00   01300  MURSING ADMINISTRATION   757,197   0   10.0238   837,551   146,757   13.00   14.00   01400  CINIRAL, SERVICES & SUPPLY   9,176,122   178,471   124,714   9,479,307   1.002,731   16.00   01500  MEDICAL ELEGRORY   23,225,652   315,565   30,232   24,203,007   34,172.09   15.00   16.00   01500  MEDICAL ELEGRORY & 1.514,518   79,197   113,357   1,725,272   255,294   15.00   16.00   01500  MEDICAL ELEGRORY & 1.514,518   79,197   113,357   1,725,272   255,294   15.00   16.00   01500  MEDICAL ELEGRORY & 1.310,237   130,237   144,997   177,572   277,572   147,922   23.00   16.00   01500  MEDICAL ELEGRORY & 1.02,624,098   4.077,585   1,391,68   18,093,86   3,696,685   30.00   16.00   01300  MINTENSITY CARE UNIT   3,021,094   4.01,715   350,518   3,973,37   680,067   31.00   16.00   01300  MERCHY   4.077,585   4.077,585   4.077,585   3,301,61   566,625   41.00   16.00   01300  MERCHY   4.077,585   4.0					l .		1		
13.00 (0 1300) NIRSHIRG AMININ STRATION (757, 197) 0 100, 238 (857, 435) 1 146, 757   13.00 (1500) PIRAMACY (23, 322, 562   315, 560   392, 321   24, 030, 733   71, 622, 489   14.00 (1500) PIRAMACY (23, 322, 562   315, 560   392, 321   24, 030, 733   71, 622, 489   16.00 (1500) PIRAMACY (23, 322, 562   315, 560   392, 321   24, 030, 733   71, 622, 489   16.00 (1500) PIRAMACY (23, 322, 562   315, 560   392, 321   24, 030, 733   72, 222   295, 295, 489   16.00 (1500) PIRAMACY (23, 322, 562   315, 560   392, 321   24, 030, 733   72, 222   295, 295   16.00 (2300) PIRAMACY (23, 322, 562   315, 560   310, 237   361, 780   361									
14.00 01400 (FRITAL SERVICES & SUPPLY 9, 176, 172) 178, 471 124, 711 24, 713 49, 479, 307 1, 622, 459 14, 00 1600 (BEDI CAL RECORDS & LIBRARY 1.514, 318 97, 597, 113, 357, 1.725, 272 205, 204 16, 00 10 00 1600 (BEDI CAL RECORDS & LIBRARY 1.514, 318 97, 597, 113, 357, 1.725, 272 205, 204 16, 00 170, 00 1700 (DITAL SERVICE MINIMARY 310, 237) 6, 646 44, 977, 818 171, 473, 171, 171, 171, 171, 171, 171, 171, 1		1			l e				
15.00   01500   PHARBMACY   23, 222, 262   315, 880   392, 321   24, 030, 733   4, 112, 997   150, 00   170   01700   SOCIAL SERVICE   1, 114, 318   97, 597   113, 337   1, 725, 272   29-294   1, 00   170   01700   SOCIAL SERVICE   1, 114, 318   31, 336   627   237, 332   17, 00   230   02300   PARAMET DE PROMI PHARBMACY   1, 114, 315   157, 439   115, 633   1, 386, 627   237, 332   17, 00   230   02300   PARAMET DE PROMI PHARBMACY   10, 222   23, 00   03, 00   04,					l e				
17.00   01700   SOCIAL SERVICE   1.113,5555   157,439   115,638   1,396,272   237,332   17.00   230,000									
23.00									
IMPATT ENT ROUTINE SERVICE COST CENTERS   1, 201, 698   1, 391, 685   18, 993, 368   3, 096, 825   30, 00   30. 00   30100   AURIS & PEDIATRICS   12, 624, 1998   4, 077, 585   1, 391, 685   3, 973, 327   680, 607   31. 00   43. 00   43. 00   430, 00   43. 00   44. 00   4					l .			1	
0.000   0.0000   ADULT S   PEDIATRICS   1.2 o.24, 0.98   4.077, 585   1.391, 685   1.8, 0.93, 568   3.096, 823   3.000   41.00   0.1000   0.1000   0.1000   0.1000   0.1000   0.1000   0.1000   0.10	23.00			310, 237	0, 540	44, 997	301, 780	01, 922	23.00
41.00   04100   SUBPROVIDER - I RF   2.459, 969   6.27, 054   223, 558   3, 310, 591   5.66, 532   41.00   04300   04300   04500   05.00   0   0   0   0   0   0   0   0   0	30.00			12, 624, 098	4, 077, 585	1, 391, 685	18, 093, 368	3, 096, 825	30.00
43.00   0.4500   NURSERY   0   0   0   0   0   0   0   44.00   A40.00   SILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0				3, 021, 094	601, 715				
44.00   0.00				2, 459, 969	1			1	
MOLILLARY SERVICE COST CENTERS				0				l e	
50.00	44.00			0	0		)  0	<u> </u>	44.00
54. 00   05400  RADIOLOGY-DI AGNOSTIC   2, 831, 971   566, 030, 305   317, 194   3, 715, 195   635, 885   54, 00   57, 00   05700  CT SCAN   590, 341   00   71, 850   662, 191   113, 339   57, 00   70, 01   03630  UIRTAR SOUND   599, 523   0   70, 007   579, 530   692, 191   131, 339   57, 00   70, 007   579, 530   679, 191   57, 00   70, 007   579, 530   682, 191   70, 007   579, 530   662, 191   70, 007   579, 530   662, 191   70, 007   579, 530   662, 191   70, 007   579, 530   682, 191   70, 007   579, 530   682, 191   70, 007   579, 530   682, 191   70, 007   679, 530   682, 191   70, 007   682, 191   70, 007	50.00			7, 972, 019	2, 135, 144	773, 592	10, 880, 755	1, 862, 328	50.00
55.00   05500   RADIOLOGY-THERAPEUTIC   1,175,273   303,054   80,531   1,558,858   266,811   55.00   57.00   5700   CT SCAM   590,941   0   71,850   662,191   113,339   57.00   5700   5700   5700   67500   570,530   99,191   57.00   5700   570,530   99,191   57.00   5700   570,530   99,191   57.00   570,000   570,000   570,530				0	· -	1			
57.00   05700   CT SCAN   590, 341   0   71, 850   662, 191   113, 393   57.00   70.01   03630   UIRTA SOUND   599, 523   0   70, 007   579, 530   99, 191   57.01   58.00   05800   CARDIAC CATHETERI ZATI ON   1, 149, 953   99, 667   141, 508   1, 393, 128   238, 445   59.00   60.00   06000   LABORATORY   9, 749, 639   612, 538   578, 709   10, 940, 706   1, 872, 589   60.00   06000   LABORATORY   0   0   0   0   0   0   0   0   0									
57.0					1			l	
58. 00   05800   MRI   391,623   0   53,261   444,884   76,145   58,00						•			
60.00   0.0000   LABORATORY   9,749,639   612,358   578,709   10,40,706   1,872,589   60.00	58.00				ł		444, 884	76, 145	58. 00
0					l .	•			
63.00 06300 BLOOD STORING, PROCESSING & TRANS.				9, 749, 639				1	
64.00   06400   INTRAVENDUS THERAPY   1, 844, 344   62, 165   235, 068   2, 141, 1577   366, 548   65, 066   65, 00   6500   06500				486 661	· -	1			
66.00   06600   PHYSI CAL THERAPY   5,892,198   198,404   777,660   6,868,262   1,175,558   66.00   67.00   06700   0CUPATIONAL THERAPY   0 0 0 0 0 0 0 0 0 0 67.00   68.00   06800   SPEECH PATHOLOGY   775,260   338,908   101,806   1,215,974   208,124   69.00   69.00   06900   LELCTROCARDIOLOGY   775,260   338,908   101,806   1,215,974   208,124   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   11,475,829   0 0 0 11,475,829   1,964,180   72.00   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   11,475,829   0 0 0 11,475,829   1,964,180   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   11,475,829   0 0 0 11,475,829   1,964,180   72.00   74.00   07400   RENAL DI ALYSIS   348,077   36,530   0 384,607   65,829   74.00   76.01   03140   CARDIAC REHAB   1,037,970   464,505   132,529   1,635,004   279,844   76.01   76.02   03070   WOMEN'S CENTER   596,807   389,248   76,444   1,062,499   181,855   76.02   77.00   07700   ALLOGENEI C STEM CELL ACQUISITION   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	1		0	
67:00   06700   06200								1	
68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   0   0		1		5, 892, 198	· ·				
69.00   06900   ELECTROCARDI OLOGY   775, 260   338, 908   101, 806   1, 215, 974   208, 124   69.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   11, 475, 829   0   0   11, 475, 829   1, 964, 180   72.00   73.00   07200   IMPL. DEV. CHARGED TO PATIENTS   11, 475, 829   0   0   11, 475, 829   1, 964, 180   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   348,077   36,530   0   384,607   65, 829   74.00   76.00				0	0			1	
77. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   0   0   0				775, 260	338, 908	101, 806	1, 215, 974		
73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   73.00	71. 00			0	0		0		
74. 00 07400 RENAL DIALYSIS 348,077 36,530 0 384,607 65,829 74.00 76.00 03020 OTHER ANCILLARY 0 0 0 0 0 0 0 0 0 76.00 76.00 76.00 103140 CARDIAC REHAB 1,037,970 464,505 132,529 1,635,004 279,844 76.01 76.01 03140 CARDIAC REHAB 1,037,970 464,505 132,529 1,635,004 279,844 76.01 76.02 03070 WOMEN'S CENTER 596,807 389,248 76,444 1,062,499 181,855 76.02 76.03 03330 ENDOSCOPY 0 0 0 0 0 0 0 0 0 77.00 77.00 77.00 77.00 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 77.00 78.00 ORROGICAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 77.00 78.00 ORROGICAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 78.00 ORROGICAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 78.00 ORROGICAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				11, 475, 829	l				
76. 00   03020   OTHER ANCI LLARY   0   0   0   0   0   76. 00   76. 00   76. 01   03140   CARDIA C REHAB   1,037,970   464,505   132,529   1,635,004   279,844   76. 01   76. 02   76. 03   03070   WOMEN'S CENTER   596,807   389,248   76,444   1,062,499   181,855   76. 02   76. 03   03330   ENDOSCOPY   0   0   0   0   0   0   0   0   0				249 077					
76. 01   03140   CARDI AC REHAB   1, 037, 970   464, 505   132, 529   1, 635, 004   279, 844   76. 01   76. 02   03070   WOMEN'S CENTER   596, 807   389, 248   76, 444   1, 062, 499   181, 855   76. 02   77. 00   03330   ENDOSCOPY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				340,077				1	
76. 03   03330   ENDOSCOPY   0   0   0   0   0   0   76. 03   77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0   0   0   0   0   0   0   77. 00   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   78. 00   00TPATIENT SERVICE COST CENTERS   90. 00   09000   CLINIC   417, 855   101, 820   54, 945   574, 620   98, 351   90. 00   90. 01   00TPATIENT   1, 119, 376   148, 275   84, 737   1, 352, 388   231, 472   90. 01   90. 02   09002   NEUROPSYCHOLOGY   249, 939   71, 709   55, 245   376, 893   64, 508   90. 02   91. 00   09100   EMERGENCY   15, 305, 448   895, 394   1, 350, 310   17, 551, 152   3, 004, 020   91. 01   09101   SHORT STAY   0   0   0   0   0   0   91. 01   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0   0   0   0   0   0   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   66, 647   11, 529   5, 939   84, 115   14, 397   95. 00   102. 00   10200   OPI 01 D TREATMENT PROGRAM   0   0   0   0   0   0   0   09500   AMBULANCE SCRVICES   0   0   0   0   0   0   0   09500   AMBULANCE SCRVICES   0   0   0   0   0   0   0   0   00   00   0				1, 037, 970	· -	-		l e	
77. 00				596, 807	389, 248	76, 444	1, 062, 499	1	
78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0				0					
90. 00   09000   CLI NI C   417, 855   101, 820   54, 945   574, 620   98, 351   90. 00				0	ŀ	•			
90. 00	70.00						,		70.00
90. 02	90.00	09000	CLINIC	417, 855	101, 820	54, 945	574, 620	98, 351	90.00
91. 00									
91. 01								l	
92. 00   09200   0BSERVATI ON BEDS   (NON-DI STI NCT PART   0   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   66, 647   11, 529   5, 939   84, 115   14, 397   95. 00   10200   0PI OI D TREATMENT PROGRAM   0   0   0   0   0   0   0   0   0				15, 305, 448					
95. 00		1					_		
102. 00   10200   OPI OI D TREATMENT PROGRAM   O   O   O   O   O   O   102. 00									
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   206, 450, 561   24, 301, 650   9, 969, 724   199, 444, 259   28, 259, 880   118. 00   NONREI MBURSABLE COST CENTERS					l .				
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   206, 450, 561   24, 301, 650   9, 969, 724   199, 444, 259   28, 259, 880   118. 00   NONREI MBURSABLE COST CENTERS   250, 391   15, 124   493, 366   84, 444   190. 00   19200	102.00			0	0		)	0	102.00
NONRE I MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 227, 851 250, 391 15, 124 493, 366 84, 444 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 227, 851 250, 391 15, 124 493, 366 84, 444 190. 00 19000 PHYSI CI ANS' PRI VATE OFFI CES 16, 582, 582 1, 897, 845 3, 853, 367 22, 333, 794 3, 822, 608 192. 00 192. 01 19201 FOUNDATI ON 256, 991 0 36, 483 293, 474 50, 230 192. 01 192. 02 19202 CLI NI CS 999, 403 0 180, 756 1, 180, 159 201, 994 192. 02 192. 03 19206 HOME HEALTH PARTNERSHI P -995 0 0 -995 0 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 604, 322 0 210, 598 1, 814, 920 310, 638 192. 04	118.00			206, 450, 561	24, 301, 650	9, 969, 724	199, 444, 259	28, 259, 880	118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 16, 582, 582 1, 897, 845 3, 853, 367 22, 333, 794 50, 230 192. 00 192. 01 19201 FOUNDATI ON 256, 991 0 36, 483 293, 474 50, 230 192. 01 192. 02 19202 CLI NI CS 999, 403 0 180, 756 1, 180, 159 201, 994 192. 02 192. 03 1920 HOME HEALTH PARTNERSHI P -995 0 0 -995 0 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 604, 322 0 210, 598 1, 814, 920 310, 638 192. 04		NONRE	IMBURSABLE COST CENTERS	,, 301			, , 20 ,	.,,	
192. 01     19201     FOUNDATI ON     256, 991     0     36, 483     293, 474     50, 230     192. 01       192. 02     19202     CLI NI CS     999, 403     0     180, 756     1, 180, 159     201, 994     192. 02       192. 03     19206     HOME HEALTH PARTNERSHIP     -995     0     0     -995     0     192. 03       192. 04     19207     WESTFI ELD SCHOOLS     1, 604, 322     0     210, 598     1, 814, 920     310, 638     192. 04								1	
192. 02 19202 CLINICS 999, 403 0 180, 756 1, 180, 159 201, 994 192. 02 192. 03 19206 HOME HEALTH PARTNERSHIP -995 0 0 -995 0 192. 03 192. 04 19207 WESTFI ELD SCHOOLS 1, 604, 322 0 210, 598 1, 814, 920 310, 638 192. 04									
192. 03   19206   HOME   HEALTH   PARTNERSHI   P   P95   0   0   -995   0   192. 03   192. 04   19207   WESTFI   ELD   SCHOOLS   1, 604, 322   0   210, 598   1, 814, 920   310, 638   192. 04									
192. 04   19207   WESTFI ELD   SCHOOLS   1, 604, 322   0   210, 598   1, 814, 920   310, 638   192. 04								0	192. 03
192. 05 19203  PRACTI CE MANAGEMENT   1, 161, 233  0  106, 347  1, 267, 580  216, 956   192. 05	192. 04	19207	WESTFIELD SCHOOLS						
	192. 05	19203	PRACTI CE MANAGEMENT	1, 161, 233	0	106, 347	1, 267, 580	216, 956	192. 05

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

					5/29/2024 9: 5	
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost		BENEFI TS		E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1. 00	4. 00	4A	5. 00	
192.06 19204 MOB - NOBLESVILLE SQUARE	266, 330	0	0	266, 330	45, 585	192. 06
192.07 19208 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 07
192.08 19205 RIVERVIEW MEDICAL ARTS	3, 742	0	0	3, 742	640	192. 08
192. 09 19209 BEHAVI OR CARE	163, 199	0	74, 683	237, 882	40, 715	192. 09
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0	0	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	75, 265	0	10, 400	85, 665	14, 662	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	8, 907	0	38, 386	47, 293	8, 095	193. 03
193.04 19304 OB/GYN SPEC GATHERS	7, 131	0	8, 427	15, 558	2, 663	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	9, 408	0	104, 201	113, 609	19, 445	193. 05
193.06 19306 RETAIL PHARMACY	6, 059, 396	51, 227	88, 564	6, 199, 187	1, 061, 040	193. 06
194. 00 07950 WORKMED	612, 948	0	54, 010	666, 958	114, 155	194.00
194.01 07951 MEALS ON WHEELS	443, 312	0	25, 493	468, 805	80, 240	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)	234, 931, 586	26, 501, 113	14, 776, 563	234, 931, 586	34, 333, 990	202.00

Provi der CCN: 15-0059

				10	) 12/31/2023	Date/lime Pre   5/29/2024 9:5	
	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	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 00
1. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT	21, 877, 139					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	87, 022	2, 459, 470				8.00
9.00	00900 HOUSEKEEPI NG	70, 395	0				9.00
10.00	01000 DI ETARY	758, 560	0	339, 712	2, 617, 402		10.00
11. 00	01100 CAFETERI A	0	0	0	0	2, 009, 300	11.00
13. 00	01300 NURSING ADMINISTRATION	0	0	0	0	20, 487	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	252, 754	19, 932		0	45, 942	14.00
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	447, 313	0	97, 307	O O	94, 455 43, 566	1
16. 00 17. 00	01700 SOCIAL SERVICE	138, 219 222, 969	0	19, 387	0	31, 457	
23. 00	02300 PARAMED ED PRGM PHARMACY	9, 270	0		0	4, 520	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	,,,,,,		<u> </u>	<u> </u>	1,7 02.0	20.00
30.00	03000 ADULTS & PEDIATRICS	5, 774, 761	831, 190	1, 970, 972	1, 833, 757	326, 315	30.00
31.00	03100 INTENSIVE CARE UNIT	852, 162	193, 773	0	199, 406	77, 731	31.00
41.00	04100 SUBPROVI DER - I RF	888, 047	207, 182	0	584, 239	60, 981	41.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2 022 025	257 272	(0.002	٥	222 015	FO 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 023, 835	257, 373 0		0	222, 815 0	50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	801, 623	155, 287	_	0	87, 160	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	429, 191	21, 454	· ·	0	20, 130	55.00
57. 00	05700 CT SCAN	427, 171	21, 434	121, 264	Ö	17, 726	1
57. 01	03630 ULTRA SOUND	o	0	0	ō	14, 200	57. 01
58.00	05800 MRI	o	0	121, 264	o	12, 749	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	141, 150	68, 420	0	o	24, 245	59.00
60.00	06000 LABORATORY	867, 234	0	149, 542	0	179, 138	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	147, 729	0	0	0	0	63.00
64. 00	06400   NTRAVENOUS THERAPY	0 00 000	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	88, 039 280, 984	22.240	0	O O	55, 811	65.00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	280, 984	22, 360	51, 741	0	206, 930 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	479, 969	22, 758	0	Ö	28, 927	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0	o	0	73. 00
74.00	07400 RENAL DIALYSIS	51, 735	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	657, 842	1, 957		0	42, 230	
76. 02	03070 WOMEN' S CENTER	551, 262	13, 227	0	0	26, 567	76. 02
	03330   ENDOSCOPY   07700   ALLOGENEIC   STEM   CELL   ACQUISITION	0	0	0	U O	0	76. 03 77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u>ا</u>	0	1			70.00
90.00	09000 CLI NI C	144, 200	3, 588	0	0	11, 898	90.00
90. 01	09001 OUTPATI ENT	209, 990	72, 044	0	o	27, 037	90. 01
90. 02	09002 NEUROPSYCHOLOGY	101, 556	0	0	0	10, 043	
91. 00	09100 EMERGENCY	1, 268, 075	357, 938	0	0	285, 850	
91. 01	09101 SHORT STAY	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVI CES	16, 328	0	ol	ما	2 12/	95.00
	10200 OPI OI D TREATMENT PROGRAM	10, 328	0	- 1	0	2, 136	102.00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	<u> </u>		102.00
118.00		18, 762, 214	2, 248, 483	3, 211, 888	2, 617, 402	1, 981, 046	118 00
	NONREI MBURSABLE COST CENTERS	10//02/211	2/2/0/100	0,211,000	2/01//102	177017010	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	354, 609	0	2, 223	0	8, 015	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2, 687, 767	209, 175	0	o	0	192.00
192.0	1 19201 FOUNDATI ON	0	0	0	0	7, 773	192. 01
	2 19202 CLI NI CS	0	942	0	0		192. 02
	19206 HOME HEALTH PARTNERSHIP	0	0	0	0		192. 03
	1 19207 WESTFI ELD SCHOOLS	0	0	0	0		192.04
	5 19203 PRACTICE MANAGEMENT	0	870		0		192. 05 192. 06
	5 19204 MOB - NOBLESVILLE SQUARE 7 19208 PHYSICIANS' PRIVATE OFFICES		0		0		192.06 192.07
	19208 PHYSICIANS PRIVATE OFFICES 19205 RIVERVIEW MEDICAL ARTS		0		٥		192.07
	19209 BEHAVI OR CARE		n		ol Ol		192.00
	19300 NONPALD WORKERS	o o	Ö	Ö	ől		193.00
	1	, -1			-1		

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 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

					5/29/2024 9:5	4 am
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. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0	0	193. 01
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 RETALL PHARMACY	72, 549	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	12, 466	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)	21, 877, 139	2, 459, 470	3, 214, 111	2, 617, 402	2, 009, 300	202. 00

Provider CCN: 15-0059

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				10	) 12/31/2023	Date/lime Pre   5/29/2024 9:5	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		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				,		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	1 004 (70					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 024, 679	11, 569, 936				13. 00 14. 00
15. 00	01500 PHARMACY	o	0	28, 782, 797			15. 00
	01600 MEDICAL RECORDS & LIBRARY	O	0	0	2, 202, 351		16.00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	1, 897, 772	17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	445, 305	O	O	1, 236, 408	1, 615, 725	20.00
	03100 INTENSIVE CARE UNIT	106, 075	0	0	1, 230, 406	1, 615, 725	30. 00 31. 00
41. 00	04100 SUBPROVI DER – I RF	83, 217	Ö	0	o	157, 084	
43.00	04300 NURSERY	0	О	0	О	0	43.00
44. 00		0	0	0	0	0	44.00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	O	O	ol	0	   E0 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	50. 00 52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	l o	o	0	o	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	o	0	55.00
57. 00	05700 CT SCAN	0	0	0	0	0	57.00
57. 01	03630 ULTRA SOUND	0	0	0	0	0	57. 01
58. 00 59. 00	05800 MRI   05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	58. 00 59. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	o	o	Ö	Ö	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	ő	0	Ö	0	68.00
69.00	06900 ELECTROCARDI OLOGY	O	0	0	O	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11, 569, 936	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	28, 782, 797	0	0	73. 00 74. 00
76.00	03020 OTHER ANCI LLARY	0	0	0	0	0	76.00
76. 01	03140 CARDI AC REHAB	0	Ö	0	o	0	76. 01
	03070 WOMEN' S CENTER	O	О	0	О	0	76. 02
76. 03	03330 ENDOSCOPY	0	0	0	0	0	,
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	U U	U <sub>I</sub>	U	<u> </u>	0	78.00 
90.00	09000 CLINIC	0	0	0	0	0	90.00
	09001 OUTPATI ENT	o	0	0	О	0	ı
	09002 NEUROPSYCHOLOGY	0	0	0	0	0	90. 02
	09100 EMERGENCY	390, 082	0	0	965, 943	0	
	09101 SHORT STAY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	O	Ü	U	0	91. 01 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	10200 OPIOID TREATMENT PROGRAM	0	0	0	О	0	102.00
	SPECIAL PURPOSE COST CENTERS	, ,					
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1, 024, 679	11, 569, 936	28, 782, 797	2, 202, 351	1, 897, 772	118. 00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	٥	0	٥	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	19201 FOUNDATION	o	o	0	o		192. 01
	19202 CLINICS	0	Ō	0	Ö		192. 02
	19206 HOME HEALTH PARTNERSHIP	0	o	0	o		192. 03
	19207 WESTFI ELD SCHOOLS	0	0	0	O		192.04
	5 19203 PRACTICE MANAGEMENT 5 19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192. 05 192. 06
	7 19208 PHYSICIANS' PRIVATE OFFICES			0	0		192. 06 192. 07
	19205 RI VERVI EW MEDI CAL ARTS		ő	o	ol		192.08
	19209 BEHAVI OR CARE	0	O	0	o		192. 09
_							

| Period: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: | 5/29/2024 9:54 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS RI VERVI EW HOSPI TAL Provider CCN: 15-0059

					5/29/2024 9:54 am
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. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0	0 193. 01
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 RETAIL PHARMACY	0	0	0	0	0 193. 06
194. 00 07950 WORKMED	0	0	0	0	0 194. 00
194.01 07951 MEALS ON WHEELS	0	0	0	0	0 194. 01
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	1, 024, 679	11, 569, 936	28, 782, 797	2, 202, 351	1, 897, 772 202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems RI VERVI EW HOSPI TAL Provi der CCN: 15-0059 COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 9:54 am Cost Center Description PARAMED ED Total Subtotal Intern & 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 & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17 00 17 00 23.00 02300 PARAMED ED PRGM PHARMACY 437, 492 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 35, 224, 626 0 0 35, 224, 626 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 6, 207, 504 6, 207, 504 31.00 04100 SUBPROVI DER - I RF 0 0 41.00 5, 857, 963 5, 857, 963 41.00 0 04300 NURSERY 0 43.00 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 16, 316, 999 16, 316, 999 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 5, 516, 414 5, 516, 414 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 296, 444 2, 296, 444 55.00 57.00 05700 CT SCAN 0 0 914, 520 0 914, 520 57.00 03630 ULTRA SOUND 692, 921 57 01 692, 921 57 01 58.00 05800 MRI 655, 042 655, 042 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0000 1, 865, 388 1, 865, 388 59.00 14, 009, 209 60.00 06000 LABORATORY 14, 009, 209 60.00 06001 BLOOD LABORATORY 60.01 0 60 01 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 839, 852 0 839, 852 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 2, 651, 975 2, 651, 975 65.00 06600 PHYSI CAL THERAPY 8, 605, 835 66.00 66.00 8,605,835 67.00 06700 OCCUPATIONAL THERAPY 67.00 68 00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0 1, 955, 752 1, 955, 752 69.00 69.00 |07100| MEDICAL SUPPLIES CHARGED TO PATIENT 11, 569, 936 0 11, 569, 936 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 13, 440, 009 13, 440, 009 72.00 07300 DRUGS CHARGED TO PATIENTS 437, 492 29, 220, 289 29, 220, 289 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 502, 171 502, 171 0 74.00 76.00 03020 OTHER ANCI LLARY 0 0 76.00 76 01 03140 CARDI AC REHAB 0 2, 616, 877 2, 616, 877 76.01 03070 WOMEN'S CENTER 0 0 1,835,410 1, 835, 410 76.02 76.02 0 76.03 03330 ENDOSCOPY 0 76.03 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 832, 657 0 832, 657 90.00 1, 892, 931 90.01 09001 OUTPATI ENT 0 0 1, 892, 931 90.01 0 90. 02 09002 NEUROPSYCHOLOGY 553,000 0 553, 000 90.02 09100 EMERGENCY 0 0 91.00 23, 823, 060 23, 823, 060 91.00 91.01 09101 SHORT STAY 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 116, 976 0 116, 976 102. 00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 437, 492 190, 013, 760 0 190, 013, 760 118 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 942, 657 942, 657 190.00 0 0 29, 053, 344 0 29, 053, 344 192.00 192. 01 19201 FOUNDATI ON 0 351, 477 0 192 01 351, 477 192. 02 19202 CLI NI CS 0 1, 383, 095 0 1, 383, 095 192.02 192. 03 19206 HOME HEALTH PARTNERSHIP 0 0 0 -995 0 -995 192.03 192. 04 19207 WESTFI ELD SCHOOLS 2, 125, 558 0 2, 125, 558 192.04 192. 05 19203 PRACTICE MANAGEMENT 0 1, 485, 406 1, 485, 406 192.05

311, 915

0

311, 915

192.06

192.07

192.06 19204 MOB - NOBLESVILLE SQUARE

192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0059	
		From 01/01/2023 Part I

				To 12/31/2023	
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM PHARMACY		Resi dents		
			Cost & Post		
			Stepdown		
			Adjustments		
	23. 00	24. 00	25. 00	26.00	
192.08 19205 RI VERVI EW MEDICAL ARTS	0	4, 382	(	4, 382	
192. 09 19209 BEHAVI OR CARE	0	278, 597	(	278, 597	192. 09
193. 00 19300 NONPALD WORKERS	0	0	(	0	193. 00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	0	(	0	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	100, 327	(	100, 327	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	55, 388	(	55, 388	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	18, 221	(	18, 221	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	133, 054	(	133, 054	193. 05
193.06 19306 RETAIL PHARMACY	0	7, 332, 776	(	7, 332, 776	193. 06
194. 00 07950 WORKMED	0	781, 113	(	781, 113	194. 00
194.01 07951 MEALS ON WHEELS	0	561, 511	(	561, 511	194. 01
200.00 Cross Foot Adjustments	0	0	(	0	200. 00
201.00 Negative Cost Centers	0	0	(	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	437, 492	234, 931, 586		234, 931, 586	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | P Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0059

Cost Center Description					10	5 12/31/2023	Date/lime Pre 5/29/2024 9:5	
EVENENT, SERVICE COST CENTERS  1.00 00100 CAP REL COSTS-ERRET IS DEPARTMENT  1.00 00100 CAPE ILL COSTS CENTERS  1.00 0010		Cost Center Description	Assigned New Capital	RELATED COSTS	Subtotal	BENEFI TS	ADMI NI STRATI V	
1.00   DOTOD CAP REL COSTS - BLOG & FIXT     0   17.77   91, 727				1. 00	2A	4. 00	5. 00	
4.00   0.000   DOUGNETONEE BEREFITS DEPARTMENT   0   91,727   91,727   91,727   70   70   70   70   70   70   70								
0.000   0.1000   DETARY	4. 00 5. 00 7. 00 8. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0 0	1, 979, 689 8, 982, 148 61, 447	1, 979, 689 8, 982, 148 61, 447	8, 673 2, 252 82	1, 988, 362 185, 155 20, 079	1.00 4.00 5.00 7.00 8.00 9.00
14.00 0 1400 CENTRAL SERVICES & SUPPLY 0 178, 471 178, 471 774 93, 959 91 4.1 1 178, 471 774 93, 959 91 4.1 1 178, 471 774 93, 959 91 4.1 1 170.0 10 1700 0 1600 UEDI CAL RECORDS & LIBRARY 0 97, 979 979 97, 979 776 171, 101 16, 10 1700 1700 0 1700	10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	535, 623 0	535, 623 0	304 882	12, 857 17, 006	10. 00 11. 00 13. 00
23.0   0   02000   PARAMED ED PROM PHARMACY   0   0   0   0   0   0   0   0   0	14. 00 15. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 0	315, 850 97, 597	315, 850 97, 597	774 2, 436 704	93, 959 238, 222 17, 101	14. 00 15. 00 16. 00
31.00   03100   INTENSIVE CARE UNIT   0   601,715   601,715   39,384   31,410.0   04100 SUBPROVIDES - I.R F   0   627,054   627,054   1,388   33,814   43.00   04200 NURSERY   0   0   0   0   0   0   43.44   44.00   04400   SHILLED NURSING FACILITY   0   0   0   0   0   0   43.44   44.00   04400   SHILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0	23. 00	02300 PARAMED ED PRGM PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	0 0	6, 546	6, 546	279	3, 586	17. 00
11.00   04100 SUBPROVIDER - I.RF   0   6.27, 054   6.27, 054   1, 388   32, 814   41, 41. 00   0430 NURSERY   0   0   0   0   0   0   0   0   0			1	., ,				30. 00 31. 00
ANCILLARY SERVICE COST CENTERS	41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	627, 054 0	627, 054 0	1, 388 0	32, 814 0	41. 00 43. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   566, 030   567, 00   570, 00	44.00		<u> </u>	0	l O	0		44.00
55.00   05500   AADIOLOGY-THERAPEUTI C	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	50.00 52.00
SB. 00   OSBOO   MRI	55.00	05500 RADI OLOGY-THERAPEUTI C	0	303, 054	303, 054	500	15, 451	54.00 55.00 57.00
60.00   06000   LABORATORY   0   612, 358   612, 358   3, 593   108, 444   60, 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0	58. 00	05800 MRI	0	0	0	331	4, 410	•
64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   64.65   65.00   06500   RESPIRATORY THERAPY   0   0   62.165   62.165   1.459   21.227   66.00   06600   PHYSI CAL THERAPY   0   198.404   198.404   4.828   68.078   66.167   67.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   0   67.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   67.00   06800   SPECH PATHOLOGY   0   338.908   338.908   632   12.053   69.17   67.00   07000   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   67.00   06800   SPECH PATHOLOGY   0   338.908   338.908   632   12.053   69.17   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71.00   07100   DATE ON THE ONLY OF THE ONLY O	60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	612, 358 0	612, 358 0	3, 593	108, 444 0	60. 00 60. 01
66.00   06600   PMYSICAL THERAPY   0   198,404   198,404   4,828   68,078   66,67.00   06700   06700   06700   06700   06700   06700   06800	64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00 65. 00
69.00   06900   ELECTROCARDI OLOGY   0   338,908   338,908   632   12,053   69.071.00   71.00	66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	198, 404	198, 404	4, 828 0	68, 078 0	66. 00 67. 00
73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73.74     74.00   07400   RENAL DI ALYSIS   0   36,530   36,530   0   3,812     74.00   03020   OTHER ANCI LLARY   0   0   0   0   0   0     76.01   03140   CARDI AC REHAB   0   464,505   464,505   823   16,206   76.07     76.02   03070   WOMEN'S CENTER   0   389,248   389,248   475   10,531     76.03   03330   ENDOSCOPY   0   0   0   0   0   0     77.00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0   0   0   0     78.00   7800   CART -CELL I IMMUNOTHERAPY   0   0   0   0   0   0     78.00   07800   CART -CELL I IMMUNOTHERAPY   0   0   0   0   0   0     90.01   OUTPATIENT SERVI CE COST CENTERS     90.02   09002   EUROPSYCHOLOGY   0   71,709   71,709   343   3,736   90.0     90.02   09002   EUROPSYCHOLOGY   0   71,709   71,709   343   3,736   90.0     91.01   09101   SHORT STAY   0   0   0   0   0   0   0     92.00   09500   DEBERGENCY   0   895,394   895,394   8,383   173,967   91.0     91.01   09101   SHORT STAY   0   0   0   0   0   0   0     92.00   09500   DEBERGENCY   0   11,529   37   834   95.0     95.00   09500   DISENVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS      95.00   09500   AMBULANCE SERVI CES   0   11,529   37   834   95.0     102.00   10200   OPIOL TREATMENT PROGRAM   0   0   0   0   0   0     102.00   10200   OPIOL TREATMENT PROGRAM   0   0   0   0   0     192.00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   1,897,845   1,897,845   23,914   221,373   192.0     192.01   19201   FOUNDATION   0   0   0   0   0   0   0     192.02   192.03   19204   HONDATION   0   0   0   0   0   0     192.04   192.04   192.01   192.01   192.01   192.01   10000   10000   1,122   11,698   192.01     192.04   192.04   192.01   192.01   192.01   100000   10000   10000   1,122   11,698   192.01     192.04   192.04   192.01   192.01   192.01   100000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   10000   100000   100000   100000   100000   100000000	69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	338, 908 0	0	632 0	12, 053 0	69. 00 71. 00
76. 01 03140 CARDI AC REHAB 0 464,505 464,505 823 16, 206 76. 07. 02 03070 WOMEN'S CENTER 0 389,248 389,248 475 10,531 76. 076. 076. 0770 030330 ENDOSCOPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0		0 36, 530	0	0 3, 812	73. 00 74. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 77. 078. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 78. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 01 76. 02	03140 CARDI AC REHAB 03070 WOMEN' S CENTER	0	464, 505	464, 505	823	16, 206	76. 01 76. 02
90. 00	77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0 0	0 0 0		0	0	76. 03 77. 00 78. 00
90. 02		09000 CLI NI C	0					•
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   O   11,529   11,529   37   834   95. 01   92. 00   91. 01 D TREATMENT PROGRAM   O   O   O   O   O   O   O   O   O	91.00	09100 EMERGENCY	0	71, 709	71, 709 895, 394	343 8, 383	3, 736 173, 967	90. 02 91. 00
102.00   10200   OPI OI D TREATMENT PROGRAM   O   O   O   O   O   O   102.00		09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	-	0	0	91. 01 92. 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   0   24, 301, 650   24, 301, 650   61, 895   1, 636, 602   118.00		10200 OPIOLD TREATMENT PROGRAM						95. 00 102. 00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES		SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0					
192. 03 19206 HOME HEALTH PARTNERSHIP 0 0 0 0 192. 0 192. 04 19207 WESTFI ELD SCHOOLS 0 0 1, 307 17, 989 192. 0 192. 05 19203 PRACTI CE MANAGEMENT 0 0 0 660 12, 564 192. 0	192. 00 192. 01	19200 PHYSICIANS' PRIVATE OFFICES 19201 FOUNDATION	0 0			23, 914	221, 373 2, 909	192. 00 192. 01
192. 05   19203   PRACTI CE MANAGEMENT 0 0 0 660 12, 564   192. 0	192. 03	19206 HOME HEALTH PARTNERSHIP	0	0	0	0	0	192. 03
192. 06 19204 MOB - NOBLESVILLE SQUARE   0  0  0  0  2, 640 192. 0	192. 05	19203 PRACTICE MANAGEMENT	0 0	0	0	660	12, 564	192. 05

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RI VERVI EW HOSPI TAL Provider CCN: 15-0059

					5/29/2024 9:5	4 am
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Di rectl y	BLDG & FIXT	Subtotal	EMPLOYEE	ADMI NI STRATI V	
	Assigned New			BENEFI TS	E & GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1. 00	2A	4. 00	5. 00	
192. 07 19208 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 07
192.08 19205 RIVERVIEW MEDICAL ARTS	0	0	0	0		192. 08
192. 09 19209 BEHAVI OR CARE	0	0	0	464	2, 358	192. 09
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 PHYSI CLAN SERVI CES-LYONS	0	0	0	0	0	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS	0	0	0	65	849	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI	0	0	0	238	469	193. 03
193.04 19304 OB/GYN SPEC GATHERS	0	0	0	52	154	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT	0	0	0	647	1, 126	193. 05
193.06 19306 RETAIL PHARMACY	0	51, 227	51, 227	550	61, 446	193. 06
194. 00 07950  WORKMED	0	0	0	335	6, 611	194.00
194.01 07951 MEALS ON WHEELS	0	0	0	158	4, 647	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)	0	26, 501, 113	26, 501, 113	91, 727	1, 988, 362	202. 00

Provider CCN: 15-0059

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/29/2024 9:54 am

				) 12/31/2023	5/29/2024 9: 5	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
·		LINEN SERVICE				
	7. 00	8. 00	9. 00	10. 00	11. 00	
GENERAL SERVICE COST CENTERS						
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	0.440.555					5.00
7. 00   00700   OPERATION OF PLANT	9, 169, 555	440.000				7.00
8. 00   00800 LAUNDRY & LINEN SERVICE	36, 474	118, 082				8.00
9. 00   00900   HOUSEKEEPI NG	29, 505	0	,	070 000		9.00
10. 00   01000   DI ETARY	317, 942	0	11, 306	878, 032	47.000	10.00
11. 00   01100   CAFETERI A	0	0	0	0	17, 888	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	182	13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY	105, 939	957		0	409	14.00
15. 00   01500   PHARMACY	187, 486	0	-,	0	841	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	57, 933	0	0	0	388	16.00
17. 00 01700 SOCIAL SERVICE	93, 455	0	645	0	280	17.00
23. 00 O2300 PARAMED ED PRGM PHARMACY	3, 886	0	0	U	40	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	2 420 427	20.00/	/F F0/	/15 150	2 005	1 20 00
30. 00   03000   ADULTS & PEDI ATRI CS	2, 420, 426	39, 906		615, 150	2, 905	30.00
31. 00   03100   NTENSI VE CARE UNI T	357, 174	9, 303		66, 893	692	31.00
41. 00   04100   SUBPROVI DER -   RF	372, 215	9, 947		195, 989	543	•
43. 00   04300   NURSERY	0	0	0	0	0	43.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	U	0	44.00
	1 2/7 40/	12, 357	2 224	Ol	1 004	FO 00
1	1, 267, 406		2, 326	-1	1, 984	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	225 001	7 455	-	0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	335, 991	7, 455		0	776	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	179, 891	1, 030		0	179	55.00
57. 00   05700   CT   SCAN	0	0	4, 036	0	158	57.00
57. 01   03630   ULTRA SOUND	0	0	0	0	126	•
58. 00   05800   MRI	0	0	4, 036	0	113	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	59, 161	3, 285		0	216	59. 00
60. 00   06000   LABORATORY	363, 491	0	4, 977	0	1, 595	•
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	61, 919	0	0	0	0	63.00
64.00   06400   I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	36, 901	0	0	0	497	65.00
66. 00   06600   PHYSI CAL THERAPY	117, 771	1, 074	1, 722	0	1, 842	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	201, 174	1, 093	l o	o	258	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	O	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	o	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	O	o	0	73.00
74.00 07400 RENAL DIALYSIS	21, 684	0	l o	ol	0	74.00
76. 00   03020 OTHER ANCI LLARY	0	0	o	o	0	76.00
76. 01   03140   CARDI AC   REHAB	275, 727	94	l o	0	376	76. 01
76. 02   03070   WOMEN' S CENTER	231, 055	635		0	237	76. 02
76. 03   03330   ENDOSCOPY	0	0		0	0	76. 03
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	Ö	0	l o	0	0	78.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		70.00
90. 00 09000 CLINIC	60, 440	172	0	0	106	90.00
90. 01   09001   0UTPATI ENT	88, 015	3, 459		0	241	•
90. 02   09002   NEUROPSYCHOLOGY	42, 566	3, <del>4</del> 37		٥	89	90.01
91. 00   09100   EMERGENCY	531, 499	17, 185	0	0	2, 545	•
91. 01   09101   SHORT   STAY	0	17, 103		0	2, 343	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	٩	O		J	O	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	6, 844	0	O	ol	19	95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0, 044	0		0		102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		١	<u> </u>		102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 863, 970	107, 952	106, 895	878, 032	17 637	118. 00
NONREI MBURSABLE COST CENTERS	7,003,770	107, 732	100, 075	070,032	17,037	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	148, 630	0	74	ol	71	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 126, 547	10, 043		0		192.00
192. 00 19200 PHTST CTAINS PRI VATE OFFI CES	1, 120, 347	10, 043	0	0		192.00
192. 01 19201 FOUNDATION 192. 02 19202 CLINICS	0	45	_	o o		192.01
	0	45		o o		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	O <sub>1</sub>	0		O O		
192. 04 19207 WESTFI ELD SCHOOLS	0	0		0		192.04
192. 05 19203 PRACTI CE MANAGEMENT	0	42	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	0	0	0	0		192.07
192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	0	0	0		192.08
192. 09 19209 BEHAVI OR CARE	0	0	0	0		192.09
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193. 00

Health Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0059 | Period: | Worksheet B | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | From 01/01/2023 | Date/Time Prepa

					5/29/2024 9:5	4 am
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. 01 19301 PHYSI CI AN SERVI CES-LYONS	0	0	0	0	0	193. 01
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 RETAIL PHARMACY	30, 408	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	111	194. 01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	9, 169, 555	118, 082	106, 969	878, 032	17, 888	202.00

Provider CCN: 15-0059

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | P

			10	12/31/2023	Date/lime Pre   5/29/2024 9:5	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	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. 00   00100   CAP REL COSTS-BLDG & FLXT						1.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						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 O1300 NURSING ADMINISTRATION	9, 303					13.00
14. 00   01400   CENTRAL SERVICES & SUPPLY	0	385, 486	7.40 070			14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	0	748, 073 0	173, 723		15. 00 16. 00
17. 00   01700   SOCIAL SERVICE	0	0	0	173, 723	266, 281	17.00
23. 00 02300 PARAMED ED PRGM PHARMACY	0	0	0	o	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		-,	-,	-,		
30. 00 03000 ADULTS & PEDIATRICS	4, 042	0	0	97, 529	226, 706	30.00
31.00 03100 INTENSIVE CARE UNIT	963	0	0	0	17, 534	31.00
41. 00   04100   SUBPROVI DER -   RF	756	0	0	0	22, 041	41.00
43. 00   04300   NURSERY	0	0	0	0	0	43.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	U_	U	U	U	0	44.00
50. 00 05000 OPERATING ROOM	0	ol	0	ol	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	o	0	o	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	О	0	o	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	0	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	Ö	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	O	0	o	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	o	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	0	0	0	0	0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	385, 486	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	O	748, 073	o	0	73.00
74. 00   07400   RENAL DI ALYSI S	0	0	0	O	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 76. 03   03330   ENDOSCOPY	0	0	0	O O	0	76. 02 76. 03
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	o	o	0	ol	0	78.00
OUTPATIENT SERVICE COST CENTERS	•	'	<u>'</u>			
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01   09001   0UTPATI ENT	0	0	0	0	0	90. 01
90. 02   09002   NEUROPSYCHOLOGY	2 542	0	0	7/ 104	0	90.02
91. 00   09100   EMERGENCY 91. 01   09101   SHORT STAY	3, 542	0	0	76, 194	0	91. 00 91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o <sub>l</sub>	o <sub>l</sub>	U	ď	U	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 303	385, 486	748, 073	173, 723	266, 281	118. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	ما		ما	0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190. 00 192. 00
192. 01 19201 FOUNDATION	0	0	0	0		192.00
192. 02 19202 CLI NI CS	o	ő	Ö	ő		192. 02
192. 03 19206 HOME HEALTH PARTNERSHIP	o	ő	Ö	o		192. 03
192. 04 19207 WESTFI ELD SCHOOLS	0	o	0	o	0	192. 04
192. 05 19203 PRACTI CE MANAGEMENT	0	0	0	0		192.05
192. 06 19204 MOB - NOBLESVILLE SQUARE	0	0	0	0		192.06
192. 07 19208 PHYSICIANS' PRIVATE OFFICES 192. 08 19205 RIVERVIEW MEDICAL ARTS	0	0	0	0		192. 07 192. 08
192. 08 19205 RI VERVI EW MEDI CAL ARTS	0	0	0	O O		192. 08 192. 09
3/1./20/182 010 0/102	١	<u> </u>	O <sub>I</sub>	<u> </u>	0	1. / 2. 0 /

In Lieu of Form CMS-2552-10

Period:
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/29/2024 9:54 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RI VERVI EW HOSPI TAL Provider CCN: 15-0059

					5/29/2024 9:5	04 alli
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. 00 19300 NONPALD WORKERS	0	0	0	0	C	193.00
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 RETALL 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)	9, 303	385, 486	748, 073	173, 723	266, 281	202.00

Health Financial Systems In Lieu of Form CMS-2552-10 RI VERVI EW HOSPI TAL Provi der CCN: 15-0059 ALLOCATION OF CAPITAL RELATED COSTS Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 9:54 am Cost Center Description PARAMED ED Subtotal Intern & Total PRGM PHARMACY Resi dents Cost & Post Stepdown Adjustments 23. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17 00 23.00 02300 PARAMED ED PRGM PHARMACY 14, 337 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 737, 826 0 0 7, 737, 826 30.00 31.00 03100 INTENSIVE CARE UNIT 1,095,834 1, 095, 834 31.00 04100 SUBPROVI DER - I RF 0 41.00 1, 262, 747 1, 262, 747 41.00 04300 NURSERY 0 43.00 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 3, 531, 870 3, 531, 870 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 953, 082 953, 082 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 500, 105 500, 105 55.00 0 57.00 05700 CT SCAN 11, 204 11, 204 57.00 03630 ULTRA SOUND 0 57 01 6, 305 6.305 57 01 58.00 05800 MRI 8,890 8, 890 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 177, 029 177, 029 59.00 60.00 06000 LABORATORY 1, 094, 458 0 1, 094, 458 60.00 60.01 06001 BLOOD LABORATORY 0 60 01 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 172, 089 0 172, 089 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 122, 249 0 122, 249 65.00 0 06600 PHYSI CAL THERAPY 66.00 66.00 393, 719 393, 719 67.00 06700 OCCUPATIONAL THERAPY 67.00 68 00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 0 554, 118 554, 118 69.00 69.00 οĺ |07100| MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 385, 486 385, 486 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 113, 748 0 113, 748 72.00 07300 DRUGS CHARGED TO PATIENTS 0 748, 073 73.00 748.073 73.00 0 74.00 07400 RENAL DIALYSIS 62,026 62, 026 74.00 76.00 03020 OTHER ANCI LLARY 0 76.00 76 01 03140 CARDI AC REHAB 757, 731 757, 731 76.01 03070 WOMEN'S CENTER 0 76.02 632, 181 632, 181 76.02 0 76.03 03330 ENDOSCOPY C 0 76.03 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 168, 575 0 168, 575 90.00 90.01 09001 OUTPATI ENT 253, 921 0 253, 921 90.01 90.02 09002 NEUROPSYCHOLOGY 118, 443 0 118, 443 90.02 09100 EMERGENCY 0 91.00 1, 708, 709 1, 708, 709 91.00 0 91.01 09101 SHORT STAY 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 19, 263 0 19, 263 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 22, 589, 681 ol 0 22, 589, 681 118 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 404, 150 0 404, 150 190.00 3, 279, 722 0 3, 279, 722 192.00 192. 01 19201 FOUNDATI ON 0 3, 204 192 01 3.204 192. 02 19202 CLI NI CS 12, 865 0 12, 865 192.02 192. 03 19206 HOME HEALTH PARTNERSHIP 0 0 192.03 192. 04 19207 WESTFI ELD SCHOOLS 19, 296 0 19, 296 192.04

0

0

0

13, 266

2,640

192.05

192.06

192.07

13, 266

2,640

192. 05 19203 PRACTICE MANAGEMENT

192.06 19204 MOB - NOBLESVILLE SQUARE

192. 07 19208 PHYSICIANS' PRIVATE OFFICES

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0059	Period: Worksheet B From 01/01/2023 Part II

				To 12/31/2023	Date/Time Prepared: 5/29/2024 9:54 am
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM PHARMACY		Resi dents		
			Cost & Post		
			Stepdown		
			Adjustments		
	23. 00	24. 00	25. 00	26.00	
192.08 19205 RIVERVIEW MEDICAL ARTS		37	(	37	192. 08
192. 09 19209 BEHAVI OR CARE		2, 822	(	2, 822	192. 09
193. 00 19300 NONPALD WORKERS		0	(	0	193. 00
193. 01 19301 PHYSI CI AN SERVI CES-LYONS		0	(	0	193. 01
193. 02 19302 UNI VERSI TY HS ATHLETI CS		914	(	914	193. 02
193. 03 19303 OB/GYN SPEC NEMUNALTI		707	(	707	193. 03
193.04 19304 OB/GYN SPEC GATHERS		206	(	206	193. 04
193. 05 19305 OB SPECIALISTS DAVENPORT		1, 773	(	1, 773	193. 05
193. 06 19306 RETAIL PHARMACY		143, 631	(	143, 631	193. 06
194. 00 07950 WORKMED		6, 946	(	6, 946	194. 00
194.01 07951 MEALS ON WHEELS		4, 916	(	4, 916	194. 01
200.00 Cross Foot Adjustments	14, 337	14, 337	(	14, 337	200.00
201.00 Negative Cost Centers	0	0	(	0	201.00
202.00 TOTAL (sum lines 118 through 201)	14, 337	26, 501, 113	(	26, 501, 113	202. 00

COSTA	ALLOCA	TION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre 5/29/2024 9:5	
		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	4 (3))
			1. 00	4. 00	5A	5. 00	7. 00	
1 00		AL SERVICE COST CENTERS	(27 510		ı			1.00
1. 00 4. 00		CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	627, 519 2, 172	98, 643, 252				4.00
5. 00		ADMINISTRATIVE & GENERAL	46, 877	9, 325, 758		200, 598, 591		5.00
7. 00	1	OPERATION OF PLANT	212, 688	2, 421, 372			365, 782	7. 00
8.00		LAUNDRY & LINEN SERVICE	1, 455	88, 318		,	1, 455	8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	1, 177 12, 683	1, 237, 066 327, 290			1, 177 12, 683	9. 00 10. 00
11. 00		CAFETERI A	0	948, 638			0	11.00
13.00		NURSING ADMINISTRATION	o	669, 154			0	13.00
14.00		CENTRAL SERVICES & SUPPLY	4, 226	832, 549			4, 226	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	7, 479 2, 311	2, 619, 002 756, 733			7, 479 2, 311	15. 00 16. 00
17. 00	1	SOCIAL SERVICE	3, 728	756, 753 771, 926			3, 728	17.00
23. 00		PARAMED ED PRGM PHARMACY	155	300, 384			155	
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	96, 553	9, 290, 412			96, 553	30.00
31. 00 41. 00		SUBPROVI DER – I RF	14, 248 14, 848	2, 339, 935 1, 492, 395			14, 248 14, 848	
43.00		NURSERY	0	1, 472, 373		.,	0	43.00
44.00		SKILLED NURSING FACILITY	0	0	C	0	0	44.00
<b>50.00</b>		LARY SERVICE COST CENTERS		- 1/1 00 <i>/</i>	1	10.000 755	50 550	
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50, 558 0	5, 164, 236 0	1		50, 558 0	50. 00 52. 00
54.00		RADI OLOGY-DI AGNOSTI C	13, 403	2, 117, 479			13, 403	
55. 00		RADI OLOGY-THERAPEUTI C	7, 176	537, 595			7, 176	
57. 00	1	CT SCAN	0	479, 645	1		0	57.00
57. 01		ULTRA SOUND	0	467, 341	0		0	57. 01
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	2, 360	355, 549 958, 007			0 2, 360	58. 00 59. 00
60.00		LABORATORY	14, 500	3, 863, 261			14, 500	
60. 01	1	BLOOD LABORATORY	0	0			0	60. 01
63.00		BLOOD STORING, PROCESSING & TRANS.	2, 470	0			2, 470	
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	1, 472	1, 569, 230	0		0 1, 472	64. 00 65. 00
66. 00		PHYSI CAL THERAPY	4, 698	5, 191, 389			4, 698	
67. 00	1	OCCUPATI ONAL THERAPY	o	0	O	0	0	67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	8, 025	679, 619 0			8, 025 0	69. 00 71. 00
	1	IMPL. DEV. CHARGED TO PATIENTS		0			0	
	07300	DRUGS CHARGED TO PATIENTS	0	0				73. 00
74.00		RENAL DIALYSIS	865	0	1	384, 607	865	
76. 00 76. 01		OTHER ANCI LLARY CARDI AC REHAB	0 10, 999	0 884. 715		0 1, 635, 004	0 10, 999	76. 00 76. 01
76. 01		WOMEN' S CENTER	9, 217	510, 314		1, 062, 499	9, 217	
76. 03	1	ENDOSCOPY	0	0	1	0	0	76. 03
77. 00		ALLOGENEIC STEM CELL ACQUISITION	O	0			0	
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	2, 411	366, 797	0	574, 620	2, 411	90.00
90. 01		OUTPATI ENT	3, 511	565, 673			3, 511	
90. 02		NEUROPSYCHOLOGY	1, 698	368, 798		376, 893	1, 698	
91.00		EMERGENCY	21, 202	9, 014, 207	1	17, 551, 152	21, 202	
91. 01 92. 00		SHORT STAY OBSERVATION BEDS (NON-DISTINCT PART	O	0		0	0	91. 01 92. 00
92.00		REIMBURSABLE COST CENTERS						72.00
95.00	09500	AMBULANCE SERVICES	273	39, 644	C	84, 115	273	95.00
102.00		OPIOID TREATMENT PROGRAM	0	0	C	0	0	102. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	575, 438	66, 554, 431	-34, 333, 990	165, 110, 269	212 701	110 00
110.00		IMBURSABLE COST CENTERS	373, 436	00, 334, 431	-34, 333, 990	105, 110, 209	313, 701	116.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 929	100, 965	C	493, 366	5, 929	190. 00
		PHYSICIANS' PRIVATE OFFICES	44, 939	25, 723, 761			44, 939	
		FOUNDATION CLINICS		243, 547				192. 01 192. 02
		CLINICS HOME HEALTH PARTNERSHIP		1, 206, 666 0		,		192. 02 192. 03
		WESTFI ELD SCHOOLS		1, 405, 880				192. 04
		PRACTICE MANAGEMENT	0	709, 933				192. 05

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0059 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 9:54 am 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 7. 00 4.00 5A 192.06 19204 MOB - NOBLESVILLE SQUARE 00 0 266, 330 0 192.06 192.07 19208 PHYSICIANS' PRIVATE OFFICES 0 192.07 192.08 19205 RI VERVI EW MEDICAL ARTS 0 3, 742 0 192.08 0000000 192. 09 19209 BEHAVI OR CARE 498, 561 0 237, 882 0 192.09 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 0 193. 01 19301 PHYSI CI AN SERVI CES-LYONS 0 193.01 193. 02 19302 UNI VERSI TY HS ATHLETI CS 69, 430 85, 665 0 193.02 0 193. 03 19303 OB/GYN SPEC NEMUNALTI 256, 252 47, 293 0 193.03 193.04 19304 OB/GYN SPEC GATHERS 0 15, 558 0 193.04 56, 259 193.05 19305 OB SPECIALISTS DAVENPORT 0 695, 609 113, 609 0 193.05 193. 06 19306 RETAIL PHARMACY 591, 222 0 6, 199, 187 1, 213 193. 06 1, 213 194. 00 07950 WORKMED 360, 555 666, 958 0 194.00 0 194.01 194.01 07951 MEALS ON WHEELS 0 170, 181 468, 805 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 26, 501, 113 21, 877, 139 202. 00 34, 333, 990 202.00 Cost to be allocated (per Wkst. B, 14, 776, 563 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 42. 231571 0.149798 0. 171158 59. 809228 203. 00 Cost to be allocated (per Wkst. B, 204.00 91, 727 1, 988, 362 9, 169, 555 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000930 0.009912 25. 068360 205. 00 II) 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)

Health Financial Systems RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0059 COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 9:54 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (MEALS ADMI NI STRATI O (HOURS OF (MAN HOURS) (POUNDS OF SERVIC) SERVED) (DI RECT I AUNDR) NRSING HR) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 67,867 00900 HOUSEKEEPI NG 9.00 26,028 64, 790 10.00 01000 DI ETARY 0 2, 751 11.00 01100 CAFETERI A 0 1, 237, 234 0 01300 NURSING ADMINISTRATION 13.00 0 462, 356 0 12,615 14.00 01400 CENTRAL SERVICES & SUPPLY 550 1, 211 0 28, 289 0 15.00 01500 PHARMACY 0 788 0 58, 161 0 01600 MEDICAL RECORDS & LIBRARY 0 0 26, 826 16.00 0 C 01700 SOCIAL SERVICE 0 0 17 00 157 19, 370 0 23.00 02300 PARAMED ED PRGM PHARMACY 2,783 0 INPATIENT ROUTINE SERVICE COST CENTERS

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

				Ť.	0 12/31/2023	Date/Time Pre 5/29/2024 9:5	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	4 am
	5551 5511t51 55551 Ft. 511	LINEN SERVICE	(HOURS OF	(MEALS	(MAN HOURS)	ADMI NI STRATI O	
		(POUNDS OF	SERVIC)	SERVED)	()	N	
		LAUNDR)		,		(DI RECT	
						NRSING HR)	
		8. 00	9. 00	10.00	11.00	13. 00	
192. 08 19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192. 08
192. 09 19209	BEHAVI OR CARE	0	0	0	0	0	192. 09
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301	PHYSI CI AN SERVI CES-LYONS	0	0	0	0	0	193. 01
193. 02 19302	UNI VERSITY HS ATHLETICS	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	RETAIL 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	7, 676	0	194. 01
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	2, 459, 470	3, 214, 111	2, 617, 402	2, 009, 300	1, 024, 679	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	36. 239557	123. 486668	40. 398240	1. 624026	2. 216212	203. 00
204. 00	Cost to be allocated (per Wkst. B,	118, 082	106, 969	878, 032	17, 888	9, 303	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	1. 739903	4. 109766	13. 551968	0. 014458	0. 020121	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)						

	Financial Systems	RIVERVIEW H				u or Form CMS-2	
COST A	NLLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre	
						5/29/2024 9: 5	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	PARAMED ED	
		SERVI CES &	(COSTED	RECORDS &	SERVI CE	PRGM PHARMACY	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
		(COSTED		(TIME SPENT)		TIME)	
		REQUIS.)					
		14. 00	15. 00	16. 00	17. 00	23. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	100					14. 00
15. 00	01500 PHARMACY	0	100				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0				16. 00
17. 00	01700 SOCIAL SERVICE	0	0	1	.,		17. 00
23. 00	02300 PARAMED ED PRGM PHARMACY	0	0	C	0	100	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	0	192		0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	C	284	0	31.00
41. 00	04100 SUBPROVI DER - I RF	0	0	C	357	0	41.00
43.00	04300 NURSERY	0	0	C	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
57. 01	03630 ULTRA SOUND	0	0	C	0	0	57. 01
58. 00	05800 MRI	0	0	C	0	0	58. 00
59. 00	05900   CARDI AC   CATHETERI ZATI ON	0	0	C	0	0	59.00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C		0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	C	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	100	C	0		1
	07400 RENAL DI ALYSI S	0	0		0	0	74.00
	03020 OTHER ANCI LLARY	0	0		0	0	76.00
76. 01	03140 CARDI AC REHAB	0	0		0	0	76. 01
	03070 WOMEN' S CENTER	0	0		0	0	76. 02
76. 03		0	0		0	0	76. 03
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00	09000 CLINIC	0	0	C		0	90.00
90. 01	09001 OUTPATI ENT	0	0			0	90.01
	09002 NEUROPSYCHOLOGY	U	0	150	0	0	90.02
91.00	09100 EMERGENCY	U	0	150	0	0	91.00
	09101 SHORT STAY	U U	Ü		U	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS					0	05 00
	09500 AMBULANCE SERVICES	0	0				95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.00
110 00	SPECIAL PURPOSE COST CENTERS	100	100	240	4 212	100	110 00
118.00	9 /	100	100	342	4, 313	100	118. 00
100.00	NONREI MBURSABLE COST CENTERS					0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	ا ا	0		0		192.00
	19201 FOUNDATION	ا ا	0				192.01
	19202 CLINICS	0	0		0		192.02
	19206 HOME HEALTH PARTNERSHIP	اِ وَا	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	0	0		0		192.06
192.07	19208 PHYSI CLANS' PRI VATE OFFI CES	0	0	1 0	<u> </u>   0	0	192. 07

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0059 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 9:54 am 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. 08 19205 RI VERVI EW MEDICAL ARTS 0 192.08 0 192.09 192. 09 19209 BEHAVI OR CARE 0000000 0 0 0 C 0 0 193.00 193. 00 19300 NONPALD WORKERS 0 193. 01 19301 PHYSI CI AN SERVI CES-LYONS 0 193. 01 193. 02 19302 UNI VERSI TY HS ATHLETI CS 0 0 0 193.02 0 0 193. 03 19303 OB/GYN SPEC NEMUNALTI 0 0 193.03 0 0 193.04 193. 04 19304 OB/GYN SPEC GATHERS 0 0 193. 05 19305 OB SPECIALISTS DAVENPORT 0 0 0 193. 05 193. 06 19306 RETAIL PHARMACY 0 0 0 193.06 0 194. 00 07950 WORKMED 0 o 0 194.00 0 194.01 07951 MEALS ON WHEELS 0 0 0 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 437, 492 202. 00 11, 569, 936 Cost to be allocated (per Wkst. B, 28, 782, 797 2, 202, 351 1, 897, 772 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 115, 699. 36000 287, 827. 97000 6, 439. 622807 440. 012057 4, 374. 920000 203. 00 385, 486 14, 337 204. 00 204.00 Cost to be allocated (per Wkst. B, 748,073 173, 723 266, 281 Part II) 61. 739161 143. 370000 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 3, 854. 860000 7, 480. 730000 507. 961988 II) 0 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 207.00

Parts III and IV)

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

From 01/01/2023 To 12/31/2023 Part I Date/Time Prepared: 5/29/2024 9:54 am Title XVIII Hospi tal **PPS** Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 35, 224, 626 35, 224, 626 35, 224, 626 30.00 03100 INTENSIVE CARE UNIT 6, 207, 504 6, 207, 504 0 6, 207, 504 31.00 31.00 41.00 04100 SUBPROVI DER - I RF 5, 857, 963 5, 857, 963 0 5, 857, 963 41.00 04300 NURSERY 0 43.00 0 0 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 0 ANCILLARY SERVICE COST CENTERS 16, 316, 999 50.00 05000 OPERATING ROOM 50.00 16, 316, 999 16, 316, 999 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 Λ 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 516, 414 5, 516, 414 0 5, 516, 414 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 296, 444 2, 296, 444 0 2, 296, 444 55.00 0 914, 520 05700 CT SCAN 914, 520 57.00 914, 520 57.00 0 57.01 03630 ULTRA SOUND 692, 921 692, 921 692, 921 57.01 58.00 05800 MRI 655, 042 655, 042 0 655, 042 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 865, 388 1, 865, 388 0 0 1, 865, 388 59.00 06000 LABORATORY 60 00 14,009,209 14,009,209 14, 009, 209 60 00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 839, 852 839, 852 63.00 0 0 839, 852 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 0 2, 651, 975 65.00 06500 RESPIRATORY THERAPY 2, 651, 975 2, 651, 975 65.00 66.00 0 06600 PHYSI CAL THERAPY 8, 605, 835 8, 605, 835 8,605,835 66.00 67.00 06700 OCCUPATI ONAL THERAPY o 67.00 68 00 06800 SPEECH PATHOLOGY 0 0 68 00 0 0 0 1, 955, 752 1, 955, 752 69.00 06900 ELECTROCARDI OLOGY 1, 955, 752 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11, 569, 936 11, 569, 936 11, 569, 936 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 13, 440, 009 13, 440, 009 13, 440, 009 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 29, 220, 289 29, 220, 289 29, 220, 289 73.00 74.00 0 07400 RENAL DIALYSIS 502, 171 502, 171 502, 171 74.00 0 76.00 03020 OTHER ANCI LLARY 76.00 0 0 2, 616, 877 76 01 03140 CARDI AC REHAB 2 616 877 2, 616, 877 76 01 03070 WOMEN'S CENTER 76.02 1, 835, 410 1, 835, 410 1, 835, 410 76.02 76.03 03330 ENDOSCOPY 0 0 76.03 0 0 ol 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78 00 0 0 78 00 0 OUTPATIENT SERVICE COST CENTERS 90.00 0 09000 CLI NI C 832, 657 832, 657 832, 657 90.00 90.01 09001 OUTPATI ENT 1.892.931 1, 892, 931 0 1, 892, 931 90.01 09002 NEUROPSYCHOLOGY 90 02 0 553,000 553,000 553,000 90 02 91.00 09100 EMERGENCY 23, 823, 060 23, 823, 060 0 23, 823, 060 91.00 09101 SHORT STAY 91.01 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 8, 291, 733 8, 291, 733 8, 291, 733 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 116, 976 95.00 09500 AMBULANCE SERVICES 116, 976 116, 976 0 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 200.00 Subtotal (see instructions) 198, 305, 493 198, 305, 493 198, 305, 493 200. 00 0 0 201.00 Less Observation Beds 8, 291, 733 8, 291, 733 8, 291, 733 201. 00

190, 013, 760

190, 013, 760

190, 013, 760 202. 00

202.00

Total (see instructions)

Health Financial Systems RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 9:54 am Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 34 809 069 30.00 03000 ADULTS & PEDIATRICS 34, 809, 069 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 765, 619 9, 765, 619 31.00 04100 SUBPROVI DER - I RF 6, 110, 163 6, 110, 163 41.00 41.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 18, 638, 683 101, 114, 633 119, 753, 316 0 136255 0.000000 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 16, 992, 366 54.00 2,006,007 14, 986, 359 0.324641 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 122, 071 10, 769, 794 10, 891, 865 0.210840 0.000000 57.00 05700 CT SCAN 4, 232, 844 22, 842, 363 27, 075, 207 0.033777 0.000000 03630 ULTRA SOUND 1, 016, 798 57 01 9, 634, 131 0.071924 0.000000 8, 617, 333 58.00 05800 MRI 847, 823 8, 975, 107 9, 822, 930 0.066685 0.000000 05900 CARDI AC CATHETERI ZATI ON 20, 546, 597 31, 458, 028 59 00 10, 911, 431 0.059298 0.000000 06000 LABORATORY 17, 564, 490 54, 358, 056 71, 922, 546 0.194782 0.000000 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0.000000 06300 BLOOD STORING, PROCESSING & TRANS. 728, 449 1, 940, 605 0.432778 0.000000 63.00 1, 212, 156 64.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 06500 RESPIRATORY THERAPY 65.00 6, 146, 090 2, 460, 265 8, 606, 355 0.308141 0.000000 66.00 06600 PHYSI CAL THERAPY 7, 333, 404 22, 772, 511 30, 105, 915 0.285852 0.000000 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 13, 005, 358 06900 ELECTROCARDI OLOGY 9, 959, 403 69.00 3.045.955 0.150380 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 17, 091, 684 36, 182, 738 53, 274, 422 0.217176 0.000000 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 949, 511 31, 019, 485 0.433276 72.00 24, 069, 974 0.000000 07300 DRUGS CHARGED TO PATIENTS 16, 194, 923 81, 856, 679 98.051.602 0. 298009 0.000000 73.00 07400 RENAL DIALYSIS 74.00 883, 231 35, 224 918, 455 0.546756 0.000000 76.00 03020 OTHER ANCI LLARY 0.000000 0.000000 03140 CARDI AC REHAB 76.01 540,063 18, 378, 264 18, 918, 327 0.138325 0.000000 03070 WOMEN'S CENTER 76 02 26, 297 9, 397, 564 9, 423, 861 0 194762 0.000000

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 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:

5/29/2024 9:54 am 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 03100 INTENSIVE CARE UNIT 31 00 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. 136255 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 324641 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 210840 55.00 57. 00 05700 CT SCAN 0.033777 57.00 57.01 03630 ULTRA SOUND 0.071924 57.01 05800 MRI 0.066685 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0.059298 59.00 60.00 06000 LABORATORY 0. 194782 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0. 432778 63.00 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64 00 65.00 06500 RESPIRATORY THERAPY 0. 308141 65.00 06600 PHYSI CAL THERAPY 0. 285852 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. 150380 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0. 217176 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 433276 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 298009 73.00 74.00 07400 RENAL DIALYSIS 0. 546756 74.00 76.00 03020 OTHER ANCI LLARY 0.000000 76.00 03140 CARDI AC REHAB 76.01 0. 138325 76.01 76. 02 03070 WOMEN'S CENTER 0. 194762 76.02 03330 ENDOSCOPY 76.03 0.000000 76.03 77 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0. 134281 90.00 90.01 09001 OUTPATI ENT 0. 243975 90.01 90.02 09002 NEUROPSYCHOLOGY 0.210820 90.02 09100 EMERGENCY 91.00 0. 262856 91.00 91 01 09101 SHORT STAY 0.000000 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.848298 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 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 202.00

| Peri od: | Worksheet C | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0059

						10 12/31/2023	5/29/2024 9:5	
				Ti tl	e XIX	Hospi tal	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	
		ENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDI ATRI CS	35, 224, 626		35, 224, 62		35, 224, 626	
31.00		INTENSIVE CARE UNIT	6, 207, 504		6, 207, 50		6, 207, 504	1
41.00		SUBPROVI DER - I RF	5, 857, 963		5, 857, 96		5, 857, 963	
43.00		NURSERY	0			0	0	
44. 00	04400	SKILLED NURSING FACILITY	0			0	0	44. 00
FO 00		LARY SERVICE COST CENTERS	1/ 21/ 000		1/ 21/ 00/		1/ 21/ 000	 
50.00		OPERATING ROOM	16, 316, 999		16, 316, 99		16, 316, 999	•
52.00		DELIVERY ROOM & LABOR ROOM	F F1/ 414			0	0	52.00
54.00	1	RADI OLOGY - DI AGNOSTI C	5, 516, 414		5, 516, 41		5, 516, 414	1
55.00		RADI OLOGY-THERAPEUTI C	2, 296, 444		2, 296, 44		2, 296, 444	
57. 00 57. 01		CT SCAN ULTRA SOUND	914, 520 692, 921		914, 52 692, 92		914, 520 692, 921	57. 00 57. 01
58.00	05800		1 ' 1					
59. 00		CARDI AC CATHETERI ZATI ON	655, 042 1, 865, 388		655, 04. 1, 865, 38		655, 042 1, 865, 388	1
60.00		LABORATORY	14, 009, 209		14, 009, 20		14, 009, 209	60.00
60. 00		BLOOD LABORATORY	14,009,209		14, 009, 20	0	14, 009, 209	60.00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	839, 852		839, 85		839, 852	1
64. 00		INTRAVENOUS THERAPY	037, 032		037, 03.		037, 032	64.00
65. 00		RESPI RATORY THERAPY	2, 651, 975	0	2, 651, 97	5 0	2, 651, 975	
66. 00	1	PHYSI CAL THERAPY	8, 605, 835	0			8, 605, 835	•
67. 00		OCCUPATIONAL THERAPY	0,000,000	0			0, 003, 033	67.00
68. 00		SPEECH PATHOLOGY		0			0	68.00
69. 00		ELECTROCARDI OLOGY	1, 955, 752	ŭ	1, 955, 75		1, 955, 752	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	11, 569, 936		11, 569, 93		11, 569, 936	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	13, 440, 009		13, 440, 00		13, 440, 009	1
73. 00		DRUGS CHARGED TO PATIENTS	29, 220, 289		29, 220, 28		29, 220, 289	
74.00		RENAL DIALYSIS	502, 171		502, 17		502, 171	74.00
76.00	03020	OTHER ANCI LLARY	o			ol ol	0	76.00
76. 01		CARDI AC REHAB	2, 616, 877		2, 616, 87	7 0	2, 616, 877	76. 01
76. 02	03070	WOMEN'S CENTER	1, 835, 410		1, 835, 41	o	1, 835, 410	76. 02
76.03	03330	ENDOSCOPY	0			0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0			0	0	77.00
78.00		CAR T-CELL IMMUNOTHERAPY	0		(	0	0	78. 00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	832, 657		832, 65		832, 657	90.00
90. 01		OUTPATI ENT	1, 892, 931		1, 892, 93		1, 892, 931	
90. 02		NEUROPSYCHOLOGY	553, 000		553, 00		553, 000	1
91.00		EMERGENCY	23, 823, 060		23, 823, 06		23, 823, 060	
91. 01		SHORT STAY	0			0	0	91.01
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	8, 291, 733		8, 291, 73	3	8, 291, 733	92.00
05.00		REI MBURSABLE COST CENTERS	11/ 07/		11/ 07	/	11/ 07/	05.00
	1	AMBULANCE SERVICES	116, 976		116, 97	6 0	116, 976	
200.00		OPIOID TREATMENT PROGRAM	198, 305, 493	0	198, 305, 49	3 0	198, 305, 493	102.00
200.00		Subtotal (see instructions) Less Observation Beds	8, 291, 733	0	8, 291, 73		8, 291, 733	
201.00	1	Total (see instructions)	190, 013, 760	0			190, 013, 760	
202.00	<b>'</b> I	Trotal (See Fristructions)	170,013,700	U	170,013,70	기	170, 013, 700	1202.00

Health Financial Systems RI VERVI EW HOSPI TAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0059 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 9:54 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 34 809 069 30.00 03000 ADULTS & PEDIATRICS 34, 809, 069 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 765, 619 9, 765, 619 04100 SUBPROVI DER - I RF 6, 110, 163 6, 110, 163 41.00 41.00 43.00 04300 NURSERY 0 04400 SKILLED NURSING FACILITY 44.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 18, 638, 683 101, 114, 633 119, 753, 316 0 136255 0.000000 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 16, 992, 366 54.00 2,006,007 14, 986, 359 0.324641 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 122, 071 10, 769, 794 10, 891, 865 0.210840 0.000000 55.00 57.00 05700 CT SCAN 4, 232, 844 22, 842, 363 27, 075, 207 0.033777 0.000000 03630 ULTRA SOUND 1, 016, 798 57 01 9, 634, 131 0.071924 0.000000 8, 617, 333 57.01 58.00 05800 MRI 847, 823 8, 975, 107 9, 822, 930 0.066685 0.000000 05900 CARDI AC CATHETERI ZATI ON 20, 546, 597 31, 458, 028 59 00 59 00 10, 911, 431 0.059298 0.000000 06000 LABORATORY 17, 564, 490 54, 358, 056 71, 922, 546 0.194782 0.000000 60.00 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0.000000 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 728, 449 1, 940, 605 0.432778 0.000000 63.00 1, 212, 156 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 06500 RESPIRATORY THERAPY 65.00 6, 146, 090 2, 460, 265 8, 606, 355 0.308141 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 7, 333, 404 22, 772, 511 30, 105, 915 0.285852 0.000000 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 68.00 13, 005, 358 06900 ELECTROCARDI OLOGY 9, 959, 403 69.00 3.045.955 0.150380 0.000000 69 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 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 9:54 am

					5/29/2024 9:54 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
	04100 SUBPROVI DER - I RF				41.00
43.00	04300 NURSERY				43.00
	04400 SKILLED NURSING FACILITY				44.00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0. 000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
	05700 CT SCAN	0. 000000			57.00
	03630 ULTRA SOUND	0. 000000			57. 01
	05800 MRI	0. 000000			58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	06000 LABORATORY	0. 000000			60.00
	06001 BLOOD LABORATORY	0. 000000			60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
	06400 I NTRAVENOUS THERAPY	0. 000000			64.00
	06500 RESPIRATORY THERAPY	0. 000000			65. 00
	06600 PHYSI CAL THERAPY	0. 000000			66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
	06800 SPEECH PATHOLOGY	0. 000000			68.00
	06900 ELECTROCARDI OLOGY	0. 000000			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	07400 RENAL DIALYSIS	0. 000000			74.00
	03020 OTHER ANCI LLARY	0. 000000			76.00
	03140 CARDI AC REHAB	0. 000000			76. 01
	03070 WOMEN' S CENTER	0. 000000			76. 02
	03330 ENDOSCOPY	0. 000000			76. 02
	· ·	0. 000000			77.00
	07700 ALLOGENEIC STEM CELL ACQUISITION				78.00
	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0. 000000			78.00
	09000 CLINIC	0. 000000			90.00
	09000  CETNIC 09001  OUTPATI ENT	1			90.00
	l control of the cont	0. 000000			90.01
	09002 NEUROPSYCHOLOGY	0. 000000			
	09100 EMERGENCY	0. 000000			91.00
	09101 SHORT STAY	0.000000			
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
	OTHER REIMBURSABLE COST CENTERS	0.000000			05.00
	09500 AMBULANCE SERVICES	0. 000000			95.00
	10200 OPI OI D TREATMENT PROGRAM				102.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202. 00	Total (see instructions)				202. 00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co	1	Period: From 01/01/2023 Fo 12/31/2023		pared: 4 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7, 737, 826	0	7, 737, 826		497. 80	30.00
31.00 INTENSIVE CARE UNIT	1, 095, 834		1, 095, 834		437. 11	31.00
41. 00   SUBPROVI DER - I RF	1, 262, 747	0	1, 262, 74	3, 870	326. 29	41.00
43. 00 NURSERY	0			0	0.00	
44.00 SKILLED NURSING FACILITY	0			0	0.00	44.00
200.00 Total (lines 30 through 199)	10, 096, 407		10, 096, 40	7 21, 921		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 885					30.00
31.00 INTENSIVE CARE UNIT	610		•			31.00
41. 00   SUBPROVI DER - I RF	2, 200	717, 838				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)	5, 695	2, 420, 628				200. 00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co	CN: 15-0059	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/29/2024 9:5	pared: 4 am
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	O5000  OPERATI NG ROOM	3, 531, 870	119, 753, 316	0. 02949	5, 129, 214	151, 276	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	953, 082	16, 992, 366	0. 05608	633, 059	35, 508	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	500, 105	10, 891, 865	0. 04591	5 2, 295	105	55.00
57.00	05700 CT SCAN	11, 204	27, 075, 207	0. 00041	4 1, 178, 816	488	57.00
57. 01	03630 ULTRA SOUND	6, 305	9, 634, 131	0.00065	286, 712	188	57. 01
58.00	05800  MRI	8, 890	9, 822, 930	0. 00090	159, 456	144	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	177, 029	31, 458, 028	0. 00562	3, 072, 342	17, 288	59.00
60.00	06000 LABORATORY	1, 094, 458	71, 922, 546	0. 01521	7 4, 608, 672	70, 130	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	172, 089	1, 940, 605	0. 08867	78 200, 095	17, 744	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0. 00000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	122, 249	8, 606, 355	0. 01420	1, 867, 771	26, 532	65.00
66.00	06600 PHYSI CAL THERAPY	393, 719	30, 105, 915			11, 692	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	
68. 00	06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69. 00	06900 ELECTROCARDI OLOGY	554, 118	13, 005, 358			33, 157	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	385, 486	53, 274, 422			29, 354	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	113, 748	31, 019, 485				
	07300 DRUGS CHARGED TO PATIENTS	748, 073	98, 051, 602			32, 384	
	07400 RENAL DIALYSIS	62, 026	918, 455			20, 682	
	03020 OTHER ANCI LLARY	02, 020	710, 433	0. 00000		20,002	
76. 00	03140 CARDI AC REHAB	757, 731	18, 918, 327	1		6, 823	
76. 02	03070 WOMEN' S CENTER	632, 181	9, 423, 861	0.04008		0,023	76.01
76. 02	03330 ENDOSCOPY	032, 181	9,423,601	1		0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1		Ŭ	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	I			
76.00	OUTPATIENT SERVICE COST CENTERS	0	U	ı 0.00000	0	U	78.00
90. 00	09000 CLINIC	168, 575	6, 200, 853	0. 02718	36 25, 025	680	90.00
90.00	09001 OUTPATI ENT		7, 758, 711				
90.01	09002 NEUROPSYCHOLOGY	253, 921				1, 984 0	90.01
		118, 443	2, 623, 085				
91.00	09100 EMERGENCY	1, 708, 709	90, 631, 546			31, 529	
91. 01	09101 SHORT STAY	1 021 452	0 774 540	0.0000		105 140	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 821, 453	9, 774, 549	0. 18634	564, 260	105, 148	92.00
05.00	OTHER REIMBURSABLE COST CENTERS						05 00
	09500 AMBULANCE SERVICES	14 205 4/4	470 000 510		21 0/2 705	400 350	95.00
200.00	Total (lines 50 through 199)	14, 295, 464	679, 803, 518	1	31, 962, 785	600, 359	1200.00

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2023 To 12/31/2023		
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT 41.00   04100   SUBPROVI DER -   RF	0 0 0	0 0		0 0 0	0	31. 00 41. 00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING FACILITY	0	0		0 0	0	44.00
200.00   Total (lines 30 through 199)	0	0	T	0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	<u> </u>	•	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT	0	0	15, 5 <sup>2</sup> 2, 50			
41. 00   04100   SUBPROVI DER - I RF	0	0	3, 87			
43. 00   04300   NURSERY		0		0.00		
44.00 04400 SKILLED NURSING FACILITY		0	1	0.00		
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	U	21, 92	11	5, 695	200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   INTENSI VE CARE UNI T 41. 00   04100   SUBPROVI DER -   IRF	0 0 0					30. 00 31. 00 41. 00
43.00   04300   NURSERY 44.00   04400   SKILLED NURSING FACILITY	0					43. 00 44. 00
200.00   Total (lines 30 through 199)	0					200.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	In Lieu of Form CMS-2552-10	
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15_0050	Pari ad:	Workshoot D	

Peri od: Worksheet D From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: THROUGH COSTS

				10 12/31/2023	5/29/2024 9:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng		Allied Health	
, , , , , , , , , , , , , , , , , , ,	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57. 00   05700   CT   SCAN	0	0		0 0	0	57.00
57. 01   03630   ULTRA SOUND	0	0		0 0	0	57. 01
58. 00   05800   MRI	0	0		0 0	0	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00   06000   LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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	437, 492	73.00
74. 00   07400   RENAL DI ALYSI S	0	0		0 0	0	74.00
76. 00   03020   OTHER ANCI LLARY	0	0		0 0	0	76.00
76. 01   03140   CARDI AC REHAB	0	0		0 0	0	76. 01
76. 02   03070   WOMEN' S CENTER	0	0		0 0	0	76. 02
76. 03   03330   ENDOSCOPY	0	0		0 0	0	76. 03
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77.00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	)	0 0	0	90.00
90. 01  09001 0UTPATI ENT	0	0		0 0	0	90. 01
90. 02   09002   NEUROPSYCHOLOGY	0	0		0 0	0	90. 02
91. 00   09100   EMERGENCY	0	0		0 0	0	91.00
91. 01  09101 SHORT STAY	0	0		0 0	0	91.01
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	0	0	)	0 0	437, 492	200.00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | Part IV | Par Heal th Financial Systems RI VERVI EW HOSPI TAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0059 THROUGH COSTS

					0 12/31/2023	5/29/2024 9:5	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	•	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	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)	
			<b>,</b>	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	(	119, 753, 316	0.000000	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	O	0		0	0.000000	52.00
	D5400 RADI OLOGY-DI AGNOSTI C	0	0		16, 992, 366	0. 000000	
	D5500 RADI OLOGY-THERAPEUTI C	0	0			0.000000	
	05700 CT SCAN	0	0			0. 000000	
	03630 ULTRA SOUND	0	0	(		0. 000000	
	05800 MRI	0	0				
	D5900 CARDI AC CATHETERI ZATI ON	0	0		1		1
	06000 LABORATORY	0	0		1	0. 000000	1
	06001 BLOOD LABORATORY	0	0		) 71, 722, 340	0.000000	
	D6300 BLOOD STORING, PROCESSING & TRANS.	0	0		1, 940, 605	0.000000	
	06400 I NTRAVENOUS THERAPY	0	0		1, 740, 003	0.000000	
	06500 RESPIRATORY THERAPY	0	0		8, 606, 355	0.000000	
	06600 PHYSI CAL THERAPY	0	0		1	0.000000	
	06700 OCCUPATI ONAL THERAPY	0	0		30, 103, 913	0.00000	
		0	0			<b>l</b>	
	06800 SPEECH PATHOLOGY	U	0		12 005 250	0.000000	
	06900 ELECTROCARDI OLOGY	U	0	(		•	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	U	0	(		0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	U	407.400	()		0.000000	
	D7300 DRUGS CHARGED TO PATIENTS	0	437, 492			0.004462	
	07400 RENAL DIALYSIS	0	0	(			
	03020 OTHER ANCI LLARY	0	0	(		0.000000	
	D3140 CARDI AC REHAB	0	0	(		0.000000	
	03070 WOMEN' S CENTER	0	0	(	9, 423, 861	0.000000	
	D3330 ENDOSCOPY	0	0	(	0	0.000000	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(		0.000000	
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		6, 200, 853	l	
	09001 OUTPATI ENT	0	0	(	, ,	0.000000	1
	09002 NEUROPSYCHOLOGY	0	0	(	_,,		1
	D9100 EMERGENCY	0	0	(	, ,		
	09101 SHORT STAY	0	0			0.000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	9, 774, 549	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	437, 492	437, 492	679, 803, 518		200. 00

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

From 01/01/2023 Part IV
To 12/31/2023 Date/Time Prepared: THROUGH COSTS 5/29/2024 9:54 am Title XVIII Hospi tal PPS I npati ent Outpati ent Cost Center Description Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) 13.00 x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50 00 5, 129, 214 15, 914, 836 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 54.00 54.00 633, 059 2, 814, 749 0 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 2, 880, 332 55.00 2, 295 0 55.00 05700 CT SCAN 1, 178, 816 4, 425, 324 57.00 0.000000 0 57.00 57.01 03630 ULTRA SOUND 0.000000 286, 712 1, 949, 096 0 57.01 58.00 05800 MRI 0.000000 159, 456 1, 685, 199 58.00 05900 CARDIAC CATHETERIZATION 59.00 59 00 0.000000 3, 072, 342 0 5, 746, 945 0 60.00 06000 LABORATORY 0.000000 4, 608, 672 3, 941, 487 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 200, 095 0 63.00 63.00 54.644 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 0 0 65.00 06500 RESPIRATORY THERAPY 0.000000 1,867,771 4,096 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 894, 012 161, 498 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 0 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 778, 210 0 1, 673, 895 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 4, 056, 722 0 6, 495, 229 71.00 71.00 0 2, 051, 656 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 200, 994 72.00 0.000000 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.004462 4, 244, 864 18, 941 27, 516, 329 122, 778 73.00 07400 RENAL DIALYSIS 0.000000 74.00 306, 257 1, 818 0 74.00 76 00 03020 OTHER ANCILLARY 0.000000 0 Ω 76.00 03140 CARDI AC REHAB 0.000000 0 76.01 170, 344 6, 133, 131 0 76.01 76.02 03070 WOMEN'S CENTER 0.000000 428, 427 0 76.02 03330 ENDOSCOPY 0 76.03 0.000000 0 0 0 76.03 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77 00 0.000000 0 0 77 00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 25, 025 0 2, 014, 842 0 90.00 09001 OUTPATI ENT 0 2, 739, 234 90.01 90.01 0.000000 0 60,636 0 90.02 09002 NEUROPSYCHOLOGY 0.000000 890, 767 0 90.02 09100 EMERGENCY 0.000000 0 91.00 91.00 1, 672, 367 6, 239, 423 91.01 09101 SHORT STAY 0.000000 0 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 745<u>, 181</u> 0.000000 564, 260 0 92.00 92.00 0

31, 962, 785

18, 941

99, 657, 476

95 00

122, 778 200. 00

OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

09500 AMBULANCE SERVICES

95 00

200.00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APP0R1	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der C	CN: 15-0059	Peri od:	Worksheet D	
					From 01/01/2023	Part V	
					To 12/31/2023		pared:
						5/29/2024 9:5	<u>4 am</u>
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject 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 OPERATI NG ROOM	0. 136255	15, 914, 836		0 0	2, 168, 476	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 324641	2, 814, 749		o o	913, 783	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 210840	2, 880, 332		o o	607, 289	55.00
57. 00	05700 CT SCAN	0. 033777	4, 425, 324		0 0	149, 474	
57. 00	03630 ULTRA SOUND	0. 033777	1, 949, 096		0 0		57.00
58. 00	05800 MRI	1				140, 187	
		0. 066685	1, 685, 199	•		112, 377	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 059298	5, 746, 945		0 0	340, 782	•
60.00	06000 LABORATORY	0. 194782	3, 941, 487	1, 34		767, 731	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 432778	54, 644		0	23, 649	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 308141	4, 096		0 0	1, 262	65.00
66.00	06600 PHYSI CAL THERAPY	0. 285852	161, 498		0 0	46, 165	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 150380	1, 673, 895		ol ol	251, 720	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217176	6, 495, 229	73	6 0	1, 410, 608	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 433276	5, 200, 994	•	o o	2, 253, 466	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 298009	27, 516, 329		0 10, 575	8, 200, 114	
74. 00	07400 RENAL DI ALYSI S	0. 546756	1, 818	1	0 10, 373	994	74.00
76.00	03020 OTHER ANCI LLARY	0. 000000	1,010		0 0	0	76.00
76. 00	03140 CARDI AC REHAB	1	( 122 121		0 0	-	76.00
		0. 138325	6, 133, 131			848, 365	
76. 02	03070 WOMEN' S CENTER	0. 194762	428, 427		0 0	83, 441	76. 02
76. 03	03330 ENDOSCOPY	0. 000000	0		0 0	0	76. 03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	0. 134281	2, 014, 842		0	270, 555	90.00
90. 01	09001 OUTPATI ENT	0. 243975	2, 739, 234		0 0	668, 305	90. 01
90.02	09002 NEUROPSYCHOLOGY	0. 210820	890, 767		0 0	187, 791	90.02
91.00	09100 EMERGENCY	0. 262856	6, 239, 423		0 0	1, 640, 070	91.00
91. 01	09101 SHORT STAY	0. 000000	0		0 0	0	91.01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 848298	745, 181		o o	632, 136	
	OTHER REIMBURSABLE COST CENTERS					222, .00	
95. 00	09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00		3. 000000	99, 657, 476	2, 08	3 10, 575	21, 718, 740	
201.00	1 ,		77,037,470	2,00	0 10, 373	21,710,740	201.00
201.00	Only Charges				~  Y		201.00
202.00			99, 657, 476	2, 08	3 10, 575	21, 718, 740	202 00
202.00	Incr charges (True 200 - True 201)	1	77,037,470	1 2,00	10, 575	21, 710, 740	<sub> </sub> 202.00

Health Financial Systems RIVERVIEW APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10

Peri od: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 9:54 am Provi der CCN: 15-0059

						5/29/2024 9: 5	4 am
			Title	XVIII	Hospi tal	PPS	
		Cost	ts				
	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.)				
		6. 00	7.00				
ANCI	ILLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0	0				50.00
52. 00 0520	OO DELIVERY ROOM & LABOR ROOM	o	ol				52.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	o	ol				54.00
	00 RADI OLOGY-THERAPEUTI C	l	ol				55.00
	OO CT SCAN	o	o				57.00
	30 ULTRA SOUND	0	0				57. 01
	OO MRI		o				58. 00
•	OO CARDI AC CATHETERI ZATI ON		0				59.00
	OO LABORATORY	262	0				60.00
•	01 BLOOD LABORATORY	0	o				60. 01
•	00 BLOOD STORING, PROCESSING & TRANS.		ol				63.00
	00 I NTRAVENOUS THERAPY		0				64.00
•	00 RESPIRATORY THERAPY		ol				65.00
	00 PHYSI CAL THERAPY		0				66.00
•	OO OCCUPATI ONAL THERAPY		ol				67.00
	00 SPEECH PATHOLOGY		0				68. 00
	OO ELECTROCARDI OLOGY		0				69.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	160	0				71.00
	00 MPL. DEV. CHARGED TO PATIENTS	100	0				71.00
	OO DRUGS CHARGED TO PATIENTS		3, 151				73.00
	00 RENAL DIALYSIS	0	3, 131				74.00
	20 OTHER ANCILLARY	0	0				76.00
	40 CARDI AC REHAB	0	0				76. 00 76. 01
		0	-				
	70 WOMEN' S CENTER	0	0				76. 02
	30 ENDOSCOPY	0	-1				76.03
	OO ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
	OO CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
	PATIENT SERVICE COST CENTERS		ما				
	OO CLINIC	0	0				90.00
	01 OUTPATI ENT	0	0				90. 01
	02 NEUROPSYCHOLOGY	0	0				90. 02
•	OO EMERGENCY	0	0				91.00
	01 SHORT STAY	0	0				91.01
	OO OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
	ER REIMBURSABLE COST CENTERS	1					
•	00 AMBULANCE SERVICES	0					95.00
200. 00	Subtotal (see instructions)	422	3, 151				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	422	3, 151			l	202. 00

Heal th	Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0059 CCN: 15-T059	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D	pared:
			Title	: XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 531, 870	119, 753, 316			14, 387	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0.0000		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	953, 082				3, 347	1
55.00	05500 RADI OLOGY-THERAPEUTI C	500, 105				0	
57.00	05700 CT SCAN	11, 204				26	
57. 01	03630 ULTRA SOUND	6, 305		l .		17	
58. 00	05800  MRI	8, 890				15	
59. 00	05900 CARDI AC CATHETERI ZATI ON	177, 029				1, 058	1
60.00	06000 LABORATORY	1, 094, 458	71, 922, 546			9, 149	
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000		0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	172, 089					
64.00	06400 I NTRAVENOUS THERAPY	0	·	0.00000		0	
65.00	06500 RESPI RATORY THERAPY	122, 249			·		1
66.00	06600 PHYSI CAL THERAPY	393, 719				35, 820	
67.00	06700 OCCUPATI ONAL THERAPY	0	1			0	
68.00	06800 SPEECH PATHOLOGY	0				0	68.00
69. 00	06900 ELECTROCARDI OLOGY	554, 118				1, 091	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	385, 486				5, 388	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	113, 748				1, 004	1
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	748, 073				5, 242	
74. 00 76. 00	03020 OTHER ANCI LLARY	62, 026 0	l	1		3, 626 0	
76. 00 76. 01	03140 CARDI AC REHAB	-	1			460	
76. 01	03070 WOMEN' S CENTER	757, 731 632, 181	9, 423, 861	0. 04003		0	
76. 02	03330 ENDOSCOPY	032, 161		1			1
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0				0	
70.00	OUTPATIENT SERVICE COST CENTERS	0		0.00000	0		70.00
90.00	09000 CLINI C	168, 575	6, 200, 853	0. 02718	3, 036	83	90.00
90. 01	09001 OUTPATI ENT	253, 921		l .		579	
90. 02	09002 NEUROPSYCHOLOGY	118, 443		l .		0	
91. 00	09100 EMERGENCY	1, 708, 709				815	1
91. 01	09101 SHORT STAY	1, 700, 707	1	0. 00000		0 0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				Ö	
00	OTHER REIMBURSABLE COST CENTERS		, , , , , , , , , ,				1
95.00							95.00
200.00		12, 474, 011	679, 803, 518		6, 373, 425	88, 922	200. 00

	Financial Systems	RI VERVI EW				u of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PAS	Component (	CCN: 15-T059	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	pared:
			Title	XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program		Allied Health	
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						1
50. 00 52. 00 54. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	0		0 0	_	52.00
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	0		0 0	0	55. 00 57. 00
57. 01 58. 00	03630 ULTRA SOUND 05800 MRI	0	0		0 0	0	
59. 00 60. 00 60. 01	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY	0	0		0 0 0	0 0	59. 00 60. 00 60. 01
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0 0	0	65. 00 66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	0	67. 00 68. 00
69. 00 71. 00 72. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0 0	0 0	69.00 71.00 72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 0	437, 492 0	73.00
76. 00 76. 01	03020 OTHER ANCI LLARY 03140 CARDI AC REHAB	0	0		0 0	0	
76. 02 76. 03	03070 WOMEN' S CENTER 03330 ENDOSCOPY	0	0		0 0	0	76. 02 76. 03
77. 00 78. 00	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	77. 00 78. 00
00 00	000000 CLINIC						00 00

0

0

0

0

0

90.00

91.00

91. 01 92. 00

95.00

0

0 90.01

0 90.02

0

437, 492 200. 00

90.00

90. 01

90.02

95.00

200.00

09000 CLI NI C

91. 00 09100 EMERGENCY

09001 OUTPATI ENT

09002 NEUROPSYCHOLOGY

91. 01 | 09101 | SHORT STAY | 92. 00 | 09200 | 09SERVATION | BEDS (NON-DISTINCT PART

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES
0 Total (lines 50 through 199)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETHROUGH COSTS	RVICE OTHER PAS		CN: 15-0059 CCN: 15-T059	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
			and 4)		(see	
	4. 00	5. 00	6. 00	7. 00	instructions) 8.00	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	1
50. 00 05000 OPERATING ROOM	0	0		0 119, 753, 316	0.000000	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0		0 0 0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 992, 366	0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 10, 891, 865	0. 000000	
57. 00   05700 CT SCAN	0	0		0 27, 075, 207	0. 000000	
57. 01 03630 ULTRA SOUND	0	0		0 9, 634, 131	0. 000000	57.01
58. 00   05800 MRI	0	0		0 9, 822, 930	0.000000	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0		0 31, 458, 028	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 71, 922, 546	0.000000	60.00
60. 01 06001 BL00D LABORATORY	0	0		0 0	0.000000	60.01
33.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 940, 605	0.000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0.000000	
55. 00 06500 RESPI RATORY THERAPY	0	0		0 8, 606, 355	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 30, 105, 915	0. 000000	
57. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0.000000	
58. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	
59. 00 06900 ELECTROCARDI OLOGY	0	0		0 13, 005, 358	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 53, 274, 422	0.000000	
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	0	427 402	427 40	0 31, 019, 485	0.000000	1
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0	437, 492 0	437, 49	92 98, 051, 602 0 918, 455	0. 004462 0. 000000	
76. 00   03020   OTHER ANCI LLARY	0	0		0 910, 455	0.000000	
76. 01   03140   CARDI AC REHAB	0	0		0 18, 918, 327	0.000000	
76. 02   03070   WOMEN' S CENTER	0	0		0 9, 423, 861	0.000000	
76. 03   03330   ENDOSCOPY	0	0		0 7, 423, 661	0.000000	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0. 000000	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0. 000000	
OUTPATIENT SERVICE COST CENTERS					0.00000	1
90. 00 09000 CLI NI C	0	0		0 6, 200, 853	0.000000	90.00
90. 01 09001 OUTPATI ENT	0	0		0 7, 758, 711	0. 000000	90. 01
PO. 02 09002 NEUROPSYCHOLOGY	0	0		0 2, 623, 085	0. 000000	90.02
91.00 09100 EMERGENCY	0	0		0 90, 631, 546	0. 000000	91.00
91.01 09101 SHORT STAY	0	0		0	0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 9, 774, 549	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES					l	95.00
200.00 Total (lines 50 through 199)	0	437, 492	437, 49	92 679, 803, 518		200.00

Health Financial Systems	RIVERVIEW H				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS		Component (		From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/29/2024 9:5	epared:
		Title	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	9	Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col . 12)	
ANOLILIADV OFFICE COOT OFFITEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000	407.040				
50. 00 05000 OPERATING ROOM	0. 000000	487, 812		0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	59, 668		0 0	0	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	(2.552		0 0	0	
57. 00   05700   CT   SCAN 57. 01   03630   ULTRA   SOUND	0. 000000	62, 552		-	0	
	0.000000	26, 715				
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON	0.000000	16, 351		0 0	0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	0. 000000 0. 000000	188, 071 601, 221		0 0	0	
60. 01   06000   LABORATORY	0. 000000	001, 221		0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	28, 216			0	
64.00 06400 INTRAVENOUS THERAPY	0. 000000	20, 210			0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	303, 646			0	
66. 00   06600 PHYSI CAL THERAPY	0. 000000	2, 738, 945			0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 730, 743			0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0			0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	25, 614			0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	744, 589			0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	273, 854		ol ol	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 004462	687, 066	3, 06		0	
74. 00 07400 RENAL DIALYSIS	0. 000000	53, 699		o o	0	
76. 00 03020 OTHER ANCI LLARY	0. 000000	00,077		o o	0	
76. 01 03140 CARDI AC REHAB	0. 000000	11, 484		ol ol	0	
76. 02   03070   WOMEN' S CENTER	0. 000000	0		o o	0	
76. 03   03330   ENDOSCOPY	0. 000000	0		ol ol	0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		o o	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		ol ol	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	3, 036		0 0	0	90.00
90. 01   09001   OUTPATI ENT	0. 000000	17, 681		o o	0	90. 01
90. 02 09002 NEUROPSYCHOLOGY	0. 000000	0		o o	0	90.02
91. 00   09100   EMERGENCY	0. 000000	43, 205		0 408	0	91.00
91. 01   09101   SHORT STAY	0. 000000	0		o o	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
05 00 100500 1110111 11105 050111 050						95.00
95.00   09500   AMBULANCE SERVICES 200.00   Total (lines 50 through 199)		6, 373, 425	3, 06	6 408		200.00

Cost Center Description			ooportorre		10 12/01/2020	5/29/2024 9: 5	4 am
Cost Center Description			Title	: XVIII	Subprovi der -	PPS	
Cost Center Description					I RF		
Charge Ratio   From   Worksheet   Part I   col.   Part I   c				Charges		Costs	
Services   Services   Services   Subject To   Ded. & Coins.   Services   Services   Services   Subject To   Ded. & Coins.   Services	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
Worksheet C, Part I, col.   Subject To Ded. & Coln.   Ded. & Col		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
Part I		From	Services (see	Servi ces	Services Not		
ANCILLARY SERVICE COST CENTERS		Worksheet C,	inst.)	Subject To	Subject To		
ANCILLARY SERVICE COST CENTERS		Part I, col.		Ded. & Coins	. Ded. & Coins.		
ANCI LLARY SERVICE COST CENTERS							
SOLID     DOSOO    DELPATTING ROOM   DOSOON		1. 00	2.00	3. 00	4. 00	5. 00	
S2 00   05200   05200   DELIVERY ROOM & LABOR ROOM   0 0 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0							
54. 00   05400   RADI OLOGY-DI ARONSTIC   0. 324641   0   0   0   0   55. 00   05500   RADI OLOGY-DI ARONSTIC   0. 210840   0   0   0   0   55. 00   05500   RADI OLOGY-THERAPEUTI C   0. 210840   0   0   0   0   55. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   057. 00   058.00   MRI   0. 066685   0   0   0   0   0   0   0   0   0	50.00   05000   OPERATING ROOM	0. 136255	0		0	0	50.00
55.00   05500   RADIOLOGY-THERAPEUTIC   0.210840   0   0   0   0   55.00	52.00   05200   DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
57.00   05700   05700   050000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   0500000   050000   0500000   05000000   0500000   0500000   05000000   05000000	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 324641	0		0	0	54.00
57. 01   03630   LITRA SOUND	55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 210840	0		0	0	55.00
SB.00   05900   MR    0.06685  0   0   0   0   58.00	57.00 05700 CT SCAN	0. 033777	0		0 0	0	57.00
59.00   05900   05900   05900   05900   0   0   0   0   59.00	57. 01   03630   ULTRA SOUND	0. 071924	0		0 0	0	57. 01
60.00   06000   LABORATORY	58. 00   05800   MRI	0. 066685	0		0 0	0	58.00
60.00   06000   LABORATORY   0.000000   0   0   0   0   0   0   0	59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 059298	0		0 0	0	59.00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0		0. 194782	0		0 0	0	60.00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0	60. 01 06001 BL00D LABORATORY	0. 000000	0		0 0	l o	60. 01
64.00   06400   INTRAVENOUS THERAPY   0.000000   0   0   0   0   64.00   65.00   06500   RESPI RATORY THERAPY   0.285852   0   0   0   0   0   65.00   66.00   06600   PHYSI CAL THERAPY   0.285852   0   0   0   0   0   0   66.00   67.00   06700   OCCUPATI ONAL THERAPY   0.000000   0   0   0   0   0   0   67.00   68.00   06800   SPEECH PATHOLOGY   0.000000   0   0   0   0   0   0   68.00   69.00   06900   ELECTROCARDI OLLOGY   0.150380   0   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0.217176   0   0   0   0   0   0   72.00   07200   IMPLE DEV. CHARGED TO PATIENTS   0.433276   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0.298009   0   0   987   0   73.00   74.00   07400   RENAL DIALYSI S   0.546756   0   0   0   0   74.00   76.00   03020   OTHER NACI LLARY   0.000000   0   0   0   0   76.00   76.01   03140   CARDI AC REHAB   0.138325   0   0   0   0   0   76.00   76.03   03330   EMDOSCOPY   0.000000   0   0   0   0   76.03   77.00   07700   ALLGGENEIC STEM CELL ACQUISITION   0.000000   0   0   0   0   0   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0.000000   0   0   0   0   90.01   09000   CLINIC   0.134281   0   0   0   0   0   90.02   09002   NEUROPSYCHOLOGY   0.243975   0   0   0   0   0   90.02   09002   NEUROPSYCHOLOGY   0.243975   0   0   0   0   0   90.01   09001   UTPATIENT STAY   0.000000   0   0   0   0   90.02   09002   NEUROPSYCHOLOGY   0.243975   0   0   0   0   0   91.01   09101   SHORT STAY   0.000000   0   0   0   0   0   92.00   09000   OSERVATION BEDS (NON-DISTINCT PART   0.848298   0   0   0   0   0   90.01   07100   NONOTHER REMEDIAL COST CENTERS   0.000000   0   0   0   0   90.02   09000   OSERVATION BEDS (NON-DISTINCT PART   0.848298   0   0   0   0   0   90.01   07100   CARDI ACCENTAL CARDI ACC			0		0 0	0	1
65.00   06500   RESPIRATORY THERAPY   0.308141   0   0   0   0   0   65.00   66.00   06600   PHYSI CAL THERAPY   0.285852   0   0   0   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0.000000   0   0   0   0   67.00   68.00   06800   SPEECH PATHOLOGY   0.000000   0   0   0   0   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0.150380   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.217176   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.433276   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0.298009   0   0   987   0   73.00   74.00   07400   RENAL DI ALYSI S   0.546756   0   0   0   0   74.00   76.01   03140   CARDI AC REHAB   0.138325   0   0   0   0   0   76.01   76.01   03140   CARDI AC REHAB   0.138325   0   0   0   0   0   76.01   76.02   03070   WOMEN'S CENTER   0.194762   0   0   0   0   76.02   77.00   07700   ALLOGENEI C STEM CELL ACQUISITION   0.000000   0   0   0   0   0   0   78.00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   0   78.00   07900   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   0   90.01   09000   LINIC   0.243975   0   0   0   0   0   90.02   09002   NEUROPSYCHOLOGY   0.243975   0   0   0   0   0   91.01   09101   SHORTE STEMY CE COST CENTERS   0.000000   0   0   0   0   91.01   09101   SHORTE STAY   0.000000   0   0   0   0   0   92.00   09000   DEBRENATI ON BEDS (NON-DISTINCT PART   0.848298   0   0   0   0   0   90.01   09000   Subtotal (see instructions)   0.000000   0   0   0   0   001   OND	·	1	0		0 0	0	64.00
66. 00 06600 PHYSICAL THERAPY		1		•	-		
07.00   0.0700   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000		1	0		0	0	
68. 00			-		-	-	
69. 00   06900   ELECTROCARDIOLOGY   0. 150380   0   0   0   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0. 217176   0   0   0   0   0   0   71. 00   72. 00   07200   IMPLD DEV. CHARGED TO PATIENTS   0. 433276   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 298009   0   0   987   0   73. 00   74. 00   07400   RENAL DI ALYSIS   0. 546756   0   0   0   0   0   74. 00   76. 00   03020   OTHER ANCILLARY   0. 0000000   0   0   0   0   0   76. 01   03140   CARDIAC REHAB   0. 138325   0   0   0   0   0   76. 02   03070   WOMEN'S CENTER   0. 194762   0   0   0   0   0   77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 0000000   0   0   0   0   77. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 0000000   0   0   0   0   77. 00   079000   CLINIC   0. 000000   0   0   0   0   78. 00   09000   OUTPATIENT SERVICE COST CENTERS   79. 00   09001   UITPATIENT   0. 243975   0   0   0   0   0   79. 01   09001   UITPATIENT   0. 243975   0   0   0   0   79. 02   09020   DIERROENSYCHOLOGY   0. 210820   0   0   0   0   79. 00   09000   DIERROENSYCHOLOGY   0. 210820   0   0   0   0   79. 00   09000   DIERREENCY   0. 262856   408   0   0   0   0   79. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 848298   0   0   0   0   79. 00   09500   AMBULANCE SERVICES   79. 00   09500   AMBULANCE SERVICES   0. 000000   0   0   70   0010   CLESS PBP CLINIC CENTERS   0. 000000   0   70   0010   CLESS PBP CLINIC CENTERS   0. 000000   0   70   0010   CLESS PBP CLINIC CENTERS   0. 000000   0   70   0010   CLESS PBP CLINIC CENTERS   0. 000000   0   70   0010   0010   0010   0010   0010   0010   0010   70   0010   0010   0010   0010   0010   0010   0010   70   0010   0010   0010   0010   0010   0010   0010   70   0010   0010   0010   0010   0010   0010   0010   0010   70   0010					-	-	
71. 00							1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 433276   0   0   0   0   0   72. 00   73. 00   73.00   DRUGS CHARGED TO PATIENTS   0. 298009   0   0   0   987   0   73. 00   74. 00   07400   RENAL DIALYSIS   0. 546756   0   0   0   0   0   0   0   74. 00   76. 00   03020   OTHER ANCI LLARY   0. 000000   0   0   0   0   0   0   0		1	-		-	-	1
73. 00		1	-		-		
74. 00   07400   RENAL DIALYSIS   0.546756   0   0   0   0   74. 00   76. 00   03020   OTHER ANCILLARY   0.000000   0   0   0   0   76. 00   76. 01   03140   CARDIAC REHAB   0.138325   0   0   0   0   0   76. 02   03070   WOMEN'S CENTER   0.194762   0   0   0   0   0   76. 02   030330   ENDOSCOPY   0.000000   0   0   0   0   0   77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0.000000   0   0   0   0   0   78. 00   07800   CAR T-CELL   IMMUNTHERAPY   0.000000   0   0   0   0   78. 00   09000   CLI NIC   COST CENTERS    90. 00   09000   CLI NIC   0.134281   0   0   0   0   90. 01   09001   OUTPATIENT   0.243975   0   0   0   0   90. 02   09002   NEUROPSYCHOLOGY   0.210820   0   0   0   91. 01   09101   SHORT STAY   0.000000   0   0   0   91. 01   09101   SHORT STAY   0.000000   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.848298   0   0   0   0   00   OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   0.000000   0   00   OTHER REIMBURSABLE COST CENTERS   0.0000000   0   00   OTHER REIMBURSABLE COST CENTERS   0.0000		1	-				
76. 00   03020   OTHER ANCI LLARY   0.000000   0   0   0   0   76. 00   76. 00   76. 01   03140   CARDI AC REHAB   0.138325   0   0   0   0   0   76. 01   76. 02   76. 02   03070   WOMEN'S CENTER   0.194762   0   0   0   0   0   76. 02   76. 03   03330   ENDOSCOPY   0.000000   0   0   0   0   0   76. 03   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   0   0   77. 00   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   0   0   0			-				1
76. 01 03140 CARDIAC REHAB		1		•	-		
76. 02  03070  WOMEN'S CENTER		1	-		-	-	1
76. 03 03330 ENDOSCOPY		1	0				1
77. 00			0		-	ľ	
78. 00		1	ŭ		-	_	
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT   OUTPATIE		1					1
90. 00		0.000000	0		0 0	0	78.00
90. 01   09001   0UTPATI ENT   0. 243975   0   0   0   0   0   90. 01   90. 02   09002   NEUROPSYCHOLOGY   0. 210820   0   0   0   0   0   90. 02   91. 00   09100   EMERGENCY   0. 262856   408   0   0   107   91. 00   91. 01   09101   SHORT STAY   0. 000000   0   0   0   0   0   92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART   0. 848298   0   0   0   0   0   00000   09200   09500   AMBULANCE SERVI CES   0. 000000   95. 00   200. 00   Subtotal (see instructions)   408   0   987   107   200. 00   201. 00   Cless PBP Clinic Lab. Services-Program   0   0   0   0   001   0   0   0   0   0   00201   0   0   0   0   003   0   0   0   0   004   0   0   0   005   0   0   0   006   0   0   0   007   0   0   008   0   0   009   0   0   009   0   0   009   0   0   009		0.124201		1			00.00
90. 02		l l			-		
91. 00				•	-	-	
91. 01			-		-		
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0.848298   0   0   0   0   92.00		1			-		
OTHER REIMBURSABLE COST CENTERS   O   O   O   O   O   O   O   O   O		1					
95. 00		0. 848298	0		0 0	0	92.00
200.00       Subtotal (see instructions)       408       0       987       107 200.00         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0       0       201.00							1
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges		0. 000000					
Only Charges			408			107	
		ا ا			0		201.00
202.00   Net Charges (line 200 - line 201)   408  0  987  107 202.00							
	202.00   Net Charges (line 200 - line 201)		408		0 987	107	202.00

Health Financial Systems	RI VERVI EW	HOSPI TAI		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der C	CN: 15-0059 CCN: 15-T059	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V	pared:
		Title	: XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost Rei mbursed	Cost Reimbursed				

					IRF		
		Cos	sts				
	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.)				
		6. 00	7. 00	1			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.	. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.	. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0			54.	. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0			55.	. 00
57.00	05700 CT SCAN	0	0			57.	. 00
57. 01	03630 ULTRA SOUND	0	0				. 01
58. 00	05800 MRI	0	0				. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1				. 00
60. 00	06000 LABORATORY	0	0				. 00
60. 01	06001 BLOOD LABORATORY	0	١				. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	ĺ				. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	1			. 00
65. 00	06500 RESPIRATORY THERAPY		0				. 00
66. 00	06600 PHYSI CAL THERAPY			1			. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0					. 00
68. 00	· ·	0					
69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0		1			. 00 . 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					. 00
		0		1			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		1			. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	294	1			. 00
74.00		0	0	1			. 00
76.00	03020 OTHER ANCI LLARY	0	0	•			. 00
76. 01	03140 CARDI AC REHAB	0	0	•			. 01
76. 02	03070 WOMEN'S CENTER	0	0				. 02
76. 03	03330 ENDOSCOPY	0	0	1			. 03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1			. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			78.	. 00
00.05	OUTPATIENT SERVICE COST CENTERS	-	-	ı			0.0
90.00	09000 CLI NI C	0	1	1			. 00
90. 01	09001 OUTPATI ENT	0	0				. 01
90. 02	09002 NEUROPSYCHOLOGY	0	0	ł			. 02
91. 00	09100 EMERGENCY	0	0	1			. 00
91. 01	09101 SHORT STAY	0	0	•			. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.	. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		0					. 00
200.00		0	294			200.	
201.00		0				201.	. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	0	294			202.	. 00

Health Financial Systems	RIVERVIEW HOSPITAL	In Lie	u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0		Worksheet D-1			
		From 01/01/2023 To 12/31/2023				
	Title XVIII	Hospi tal	PPS			
Cost Center Description						
			1. 00			
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private room of	On Inpatient days (including private room days and swing-bed days, excluding newborn) 15,54					
2.00 Inpatient days (including private room of						

	Cost Center Description	113	
	DADT I ALL DDAW DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15, 544	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15, 544	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	11, 885	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5. 00
	reporting period		,
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 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	_	
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	2, 885	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 XLX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT	Ü	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	35, 224, 626	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line $5 \times 1$ ) x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $7 \times 1$ ) x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 35, 224, 626	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	33, 224, 020	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Pri vate room charges (excluding swing-bed charges)	0	
30. 00 31. 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
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)	0.00	35. 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 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 266. 12	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	6, 537, 756	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	6, 537, 756	41.00

JIVII O I	Financial Systems ATION OF INPATIENT OPERATING COST	RI VERVI EW H	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	
	Cost Center Description	Total	-	XVIII	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	(col. 3 x	
		1.00	2. 00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
2. 00	NURSERY (title V & XIX only)	0	0				42
	Intensive Care Type Inpatient Hospital Units		2 507	2 47/ 6	7 (10	1 510 402	1,
3. 00 4. 00	INTENSIVE CARE UNIT	6, 207, 504	2, 507	2, 476. C	610	1, 510, 403	43
. 00	BURN INTENSIVE CARE UNIT					I	45
. 00	SURGICAL INTENSIVE CARE UNIT					I	46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	Line 200)			1. 00 7, 252, 921	48
. 01	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	0	48
. 00	Total Program inpatient costs (sum of lines				,	15, 301, 080	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inp	atient routine :	servi ces (froi	n Wkst. D, su	n of Parts I and	1, 702, 790	50
. 00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	619, 300	51
20	and IV)	•	, 000 (11			3.7,500	
2. 00	Total Program excludable cost (sum of lines					2, 322, 090	
3. 00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anest	netist, and	12, 978, 990	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program discharges					0	54
. 00	Target amount per discharge					0.00	55
. 01	Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor					0. 00 0	
. 00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
. 00	Bonus payment (see instructions)	ring cost and tai	get amount (	THE 50 IIITHUS	11116 33)	0	
00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	
	updated and compounded by the market basket)					1	
0. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	n prior year (	cost report,	updated by the	0. 00	60
. 00	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 tl	he amount by	which operati	ng costs (line	0	61
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost report	ing period (See	0	64
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	er 31 of the o	cost reportin	a period (See	0	65
). OO	instructions)(title XVIII only)	tts arter becomb		2031 Tepor trii	g perrou (see	ı	
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line (	65)(title XVI	ll only); for	0	66
	CAH, see instructions		D	. 6. 11			
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	or the cost r	aporting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)						
0. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service c				<i>'</i>	I	7
. 00	Program routine service cost (line 9 x line	71)		ŕ		I	72
. 00	Medically necessary private room cost applic	•	•			l	73
. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column	1	74
. 50	26, line 45)	. Juli ne Bei vi ce	50313 (110III I	TO ROTICE L D,	art II, COLUMIII	I	'`
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				I	76
. 00	Program capital-related costs (line 9 x line					I	77
. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi don rocca	de)		I	78
. 00	Total Program routine service costs for comp				nus line 79)	I	80
. 00	Inpatient routine service costs for comp			. (		I	81
. 00	Inpatient routine service cost limitation (I		)			I	82
	Reasonable inpatient routine service costs (		s)			I	83
	Program inpatient ancillary services (see in		ne)			I	84
1.00						i e e e e e e e e e e e e e e e e e e e	1 0.
. 00 5. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•	,				
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS	of lines 83 th	,				86

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 01/01/2023 To 12/31/2023		pared: 4 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				8, 291, 733	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	7, 737, 826	35, 224, 626	0. 21967	1 8, 291, 733	1, 821, 453	90.00
91.00 Nursing Program cost	0	35, 224, 626	0.00000	0 8, 291, 733	0	91.00
92.00 Allied health cost	o	35, 224, 626	0.00000	0 8, 291, 733	0	92.00
93.00 All other Medical Education	o	35, 224, 626	0. 00000	0 8, 291, 733	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
	Component CCN: 15-T059	From 01/01/2023 To 12/31/2023	
	Title XVIII	Subprovi der -	PPS
		IRF	

		IRF		
	Cost Center Description		1 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	I NPATI ENT DAYS			
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3, 870	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3, 870	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pri	ivate room days,	0	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		3, 870	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 3	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	of the cost	U	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			
8.00	Total swing-bed NF type inpatient days (including private room days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excluding	swing-bed and	2, 200	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	Join days)	O	10.00
11. 00		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
12.00		e room days)	0	12.00
40.00	through December 31 of the cost reporting period			40.00
13. 00			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line Medically necessary private room days applicable to the Program (excluding swing-bed of		0	14. 00
15. 00		uays)	0	15.00
	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of	f the cost	0. 00	17.00
	reporting period			
18. 00		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	the cost	0.00	19.00
20.00		ne cost	0. 00	20. 00
	reporting period			
21.00			5, 857, 963	
22. 00		ing period (line	0	22. 00
22.00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting	a norted (line	0	22.00
23. 00	x line 18)	g period (iille d	U	23. 00
24. 00		na period (line	0	24. 00
	7 x line 19)	(	_	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting	period (line 8	0	25.00
	x line 20)		_	
26.00	j ,		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		5, 857, 963	27.00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)	g,	0	29. 00
30.00			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00			0. 00	32.00
33.00			0.00	33.00
34.00		u ons)	0.00	34.00
35. 00 36. 00			0.00	35. 00 36. 00
37.00	· · · · · · · · · · · · · · · · · · ·	fferential (line	-	37.00
37.00	27 minus line 36)		5, 507, 705	57.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00			1, 513. 69	
39.00			3, 330, 118	
	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 3, 330, 118	40.00
41.00	Trotal Trogram general Tripatrent routine Service Cost (Title 39 + Title 40)	I	3, 330, 118	41.00

COMPUTAT	inancial Systems TON OF INPATIENT OPERATING COST		HOSPITAL Provider C	CN: 15-0059	Peri od:	u of Form CMS-2 Worksheet D-1	
			Component	CCN: 15-T059	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	
			Title	xVIII	Subprovi der -	PPS	14 alli
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	oust defited bescription	Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)	0 3	(col. 3 x col. 4)	
42.00 N	HIDGEDY (+; +I - V 0 VIVI .)	1.00	2.00	3.00	4.00	5. 00	42.0
	URSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units	0	С	0.0	00 0	0	42.0
	NTENSIVE CARE UNIT	0	C	0.0	00 0	0	43.0
	ORONARY CARE UNIT						44.0
	URN INTENSIVE CARE UNIT						45.0
	URGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY)			•			46. 0 47. 0
.,, 66   6	Cost Center Description						17.0
40.00   D	rogram inpatient ancillary service cost (Wk	o+ D 2 ool	2 Line 200)			1.00	40.0
48. 00   P 48. 01   P	rogram inpatient anciliary service cost (wk rogram inpatient cellular therapy acquisiti	SI. D-3, COI. on cost (Works	3, TINE 200) heet D-6 Part	III line 10	column 1)	1, 643, 924 0	
	otal Program inpatient costs (sum of lines				, corumn r)	4, 974, 042	
	ASS THROUGH COST ADJUSTMENTS						
	ass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	717, 838	50.0
	II) ass through costs applicable to Program inp	atient ancilla	rv services (f	rom Wkst D	sum of Parts II	91. 988	51.0
а	nd IV)		. ,			,,,,,,	" "
	otal Program excludable cost (sum of lines				hard and	809, 826	
	otal Program inpatient operating cost exclu edical education costs (line 49 minus line		erated, non-ph	ysıcıan anest	netist, and	4, 164, 216	53.0
	ARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00 P	rogram di scharges					0	
	arget amount per discharge					0.00	
	ermanent adjustment amount per discharge djustment amount per discharge (contractor	use only)				0. 00 0. 00	
	arget amount (line 54 x sum of lines 55, 55		)			0.00	1
1	ifference between adjusted inpatient operat	ing cost and t	arget amount (	line 56 minus	line 53)	0	
	onus payment (see instructions)	I FF 6			100/	0	
	rended costs (lesser of line 53 ÷ line 54, pdated and compounded by the market basket)	or line 55 Tro	m tne cost rep	orting period	enaing 1996,	0. 00	59.0
	xpected costs (lesser of line 53 ÷ line 54,	or line 55 fr	om prior year	cost report,	updated by the	0.00	60.0
	arket basket)					_	
5 5	ontinuous improvement bonus payment (if lin 5.01, or line 59, or line 60, enter the les 3) are less than expected costs (lines 54 x	ser of 50% of	the amount by	which operati	ng costs (line	0	61.0
	nter zero. (see instructions) elief payment (see instructions)					0	62.0
	llowable Inpatient cost plus incentive paym	ent (see instr	uctions)			Ö	
	ROGRAM INPATIENT ROUTINE SWING BED COST						
	edicare swing-bed SNF inpatient routine cos nstructions)(title XVIII only)	ts through Dec	ember 31 of th	e cost report	ing period (See	0	64.0
	edicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reportin	g period (See	0	65.0
1	nstructions)(title XVIII only)						
I .	otal Medicare swing-bed SNF inpatient routi AH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66.0
	itle V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost r	eporting period	0	67.0
(	line 12 x line 19)	_					
	itle 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
	otal title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lin	e 68)		0	69.0
P/	ART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILIT	Y, AND ICF/IID	ONLY			
	killed nursing facility/other nursing facil				)		70.0
	djusted general inpatient routine service c rogram routine service cost (line 9 x line		iine /U = IINe	۷)			71. C
- 1	edically necessary private room cost applic	,	m (line 14 x l	i ne 35)			73.0
1	otal Program general inpatient routine serv	•		,			74.0
	apital-related cost allocated to inpatient 6, line 45)	routine servic	e costs (from	worksheet B,	Part II, column		75.0
1	er diem capital-related costs (line 75 ÷ li						76.0
	rogram capital-related costs (line 9 x line						77.
1	npatient routine service cost (line 74 minu ggregate charges to beneficiaries for exces		provider recon	ds)			78.0
	otal Program routine service costs for comp				nus line 79)		80.
31. 00 I	npatient routine service cost per diem limi	tati on					81.
1	npatient routine service cost limitation (I						82.0
1	easonable inpatient routine service costs ( rogram inpatient ancillary services (see in		115)				83.0
1	tilization review - physician compensation		ons)				85.0
	otal Program inpatient operating costs (sum	of lines 83 t					86.0
	ART IV - COMPUTATION OF OBSERVATION BED PASS						

Health Financial Systems	RI VERVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component	CCN: 15-T059	From 01/01/2023 To 12/31/2023		pared: 4 am
		Title	XVIII	Subprovi der  - I RF	PPS	
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, 262, 747	5, 857, 963	0. 21556	0	0	90.00
91.00 Nursing Program cost	0	5, 857, 963	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	5, 857, 963	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 857, 963	0. 00000	00	0	93.00

Heal th	n Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPU	TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od:	Worksheet D-1	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	pared: 4 am
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days a	nd swing-bed days, excluding newborn)		15, 544	1.00
2.00	Inpatient days (including private room days,	excluding swing-bed and newborn days)		15, 544	2.00
3. 00	Private room days (excluding swing-bed and ob do not complete this line.	servation bed days). If you have only p	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed a	nd observation bed days)		11, 885	4.00
5 00	Total swing-bed SNE type inpatient days (incl.	uding private room days) through Decemb	er 31 of the cost	0	5 00

Next   F. ALL PROVIDER COMPONENTS		Cost Center Description	1.00	
MATERIAL DAYS		DADT I ALL DROW DED COMPONENTS	1. 00	
1.00 Inpatient days (including private room days and saing-bed days. excluding newborn) 15,544 2.00 1.00 Inpatient days (including private room days, actual ding saing-bed and newborn days) 15,544 2.00 2.00 Inpatient days (including private room days, actual ding saing-bed and newborn days) 15,544 2.00 2.00 Inpatient days (including private room days) 17,00 New only private room days 2.00 No not complete this 11 including and gaing saing-bed days) 17,00 New only private room days 2.00 No not complete this 11 including and gaing saing-bed days) 17,00 New only private room days 2.00 New only private room days 3.00 New 2.00 New				
1. Injustient days (including private room days, excluding saing-bed and newborn days)   15,544   2.00	1. 00	· · · · · · · · · · · · · · · · · · ·	15, 544	1.00
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this time.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  1.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  1.00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and neaborn days) (see instructions) which is a private room days) after one days).  1.00 Swing-bed SWF type inpatient days applicable to title xVIII and (y (including private room days) after observed SWF type inpatient days applicable to title xVIII and (y (including private room days) after otherwise of the cost reporting period (it calendary year, enter 0 on this line).  1.00 Swing-bed SWF type inpatient days applicable to title xVIII and (y (including private room days) after otherwise period (it calendary year, enter 0 on this line).  1.00 Swing-bed SWF type inpatient days applicable to title xVIII and (y (including private room days) after otherwise year of the cost reporting period (it calendary year, enter 0 on this line).  1.00 Swing-bed SWF type inpatient days applicable to title xVIII and (y (including private room days).  1.00 Swing-bed SWF type inpatient days applicable to title xVIII and (y (including private room days).  1.00 Swing-bed December 31 of the cost reporting period (it calendary year, enter 0 on this line).  1.00 Swing-bed December 31 of the cost				2.00
do not complete this line.  4. 00 Semi-private room days (excluding swing-bed and observation bed days)  5. 00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost operating period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total sing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SWF type inpatient days applicable to title EWILL only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11. 00 Swing-bed SWF type inpatient days applicable to title EWILL only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SWF type inpatient days applicable to title EWILL only (including private room days)  13. 00 Total increase and the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medical (ly necessary private room days applicable to title EWILL only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Medical (ly necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  16. 00 Medical (ly necessary private room days applicable to services after December 31 of the cost reporting period (line of the private year)  17. 00 Medicare rate for swing-bed SWF services applicable to services afte				3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period (if calendary year, enter 0 on this line)   Cost of the cost reporting period   Cost of the cost period   Cost of the cost reporting period   Cost of the cos		do not complete this line.		
reporting period (if calendar year, enter 0 on this line)  7.00 Total samp-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Total samp-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and new private room days) after December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after SNIII only (including private room days) after December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to december 31 of the cost reporting period (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to december 31 of the cost reporting period (see instructions)  10.00 Swing-bed NF type inpatient days applicable to december 31 of the cost reporting period (see instructions)  10.00 Swing-bed NF type inpatient days applicable to december 31 of the cost reporting period (see instructions)  10.00 Microsoft NF type inpatient days applicable to title SV or XIX only (including private room days)  10.10 Microsoft NF type inpatient days applicable to the Program (excluding swing-bed days)  10.10 Microsoft NF type inpatient days applicable to services after December 31 of the cost reporting period (see instructions)  10.10 Microsoft NF type inpatient days applicable to services after December 31 of the cost reporting period (see instructions)  10.10 Microsoft NF type inpatient days applicable to services after December 31 of the cost reporting period (see instructions)  10.10 Microsoft NF type inpatient routine services after December 31 of the co	4.00	Semi-private room days (excluding swing-bed and observation bed days)	11, 885	4. 00
10.00   Total swingh-edd SNF type inpatient days (including private room days) after December 31 of the cost operating period (in calendar year, enter 0 on this iline)   7.00   Total swingh-edd NF type inpatient days (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this iline)   7.00   Total swingh-edd NF type inpatient days (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this iline)   7.00	5.00		0	5.00
reporting period (if calendar year, enter 0 on this line)  7. 00  8. 00  8. 00  8. 00  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00  Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10. 00  Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00  Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00  Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00  8. 00  Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  9. 01  8. 00  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  9. 01  8. 00			_	
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (it calendar year, enter 0 on this line) 10 total inpatient days including private room days) after December 31 of the cost proporting period (it calendar year, enter 0 on this line) 10 total inpatient days including private room days applicable to the Program (excluding swing-bed and 311 on the cost publicable in the program (excluding swing-bed and 311 on the cost including private room days) 11 to 10 total inpatient days applicable to the Program (excluding swing-bed and 311 on the cost reporting period (see Instructions) 11 to 10 total inpatient days applicable to the Program (excluding private room days) 12 to 12 to 13 to 14 to 25 to 14 t	6.00		0	6.00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 08 ing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (incleded year, enter 0 on this line)  13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (incleded year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Total pursery days (it it V or XIX only)  16. 00 Misser days (it it V or XIX only)  17. 00 Medical rursery days (it it V or XIX only)  18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line or XIII applicable to SNF type services after December 31 of the cost reporting period (line or XIII applicable to SNF type services after December 31 of the cost reporting period (line or XIII applicable to SNF type services after December 31 of the cost re	7 00		0	7.00
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)   10.00	7.00		U	7.00
reporting period (if calendar year, énter 0 on this line) 10.00 10.00 Swing-bed SW Type invate room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10.00 Swing-bed SW Type Inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see Instructions) 11.00 Swing-bed SW Type Inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed MF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed MF type inpatient days applicable to title X or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Narsery days (title V or XIX only) 17.00 Narsery days (title V or XIX only) 18.00 Swing-Beb DolluSTNNN 19.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period (line or reporting period or reporting period or reporting period (see instructions) 19.00 Medical drate for swing-bed SWF services applicable to services after December 31 of the cost reporting period (line or reporting period well of the period of the cost reporting period (line or reporting period swing-bed SWF services applicable to services after December 31 of the cost reporting period (line or reporting period (see instructions) 19.00 Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line or x line 18) 22.00 Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line or x line 18) 23.00 Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line or x line 18) 24.00 General inpatient routine service cost (see instructions) 19.00 General inpatient	8. 00		0	8. 00
newborn days) (see instructions)   0   10.00			_	
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through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to ItilE XVIII only (including private room days) after  12.00 Swing-bed Net Type inpatient days applicable to ItilE XV or XIX only (including private room days)  13.00 Swing-bed Net Type inpatient days applicable to ItilE XV or XIX only (including private room days)  14.00 Swing-bed Net Type inpatient days applicable to ItilE XV or XIX only (including private room days)  15.00 Swing-bed Net Type inpatient days applicable to ItilE XV or XIX only (including private room days)  16.00 Medically necessary private room days applicable to ItilE XV or XIX only (including private room days)  17.00 Medical room days applicable to ItilE XV or XIX only (including private room days)  18.00 New ItilE XV or XIX only)  19.00 New ItilE XV or XIX only)  19.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  19.00 Medical or rate for swing-bed SNF services applicable to services after December 31 of the cost one preporting period (including private room days)  19.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost one preporting period (including applicable to SNF type services after December 31 of the cost one preporting period (including applicable to SNF type services after December 31 of the cost reporting period (line one preporting period (lin				
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December 31 of the cost reporting period (if calendar year, enter 0 on this line)   1.2	44.00			44.00
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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) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 Total nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 16.00 0 Nursery days (title V or XIX only) 0 16.00 0 Nursery days (title V or XIX only) 0 17.00 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicader rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicald rate for swing-bed NF services after December 31 of the cost reporting period (line 5 X ine 12) 19.00 Medicald rate for swing-bed sort (see instructions) 19.00 Medicald rate for swing-bed sort (see instructions) 19.00 Medicald rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 X ine 12) 19.00 Medicald rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 X ine 12) 19.00 Medicald rate for swing-bed cost (see instructions) 19.00 Medicald rate for swing-bed cost (see instructions) 19.00 Medicald rate for swing-bed cost (see instructions) 19.00 Medicald rate for swing-bed co	12 00		0	12.00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 SWING BED ADJUSTNENT  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of some period of the cost reporting period (line of some period of the cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 18)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 19)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 19)  25.00 Swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed cost (line 27 minus line 26)  29.00 Pirvate room charges (excluding swing-bed cost (line 32 minus	12.00		U	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 SWing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line sine 18)  23.00 SWing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line sine 18)  24.00 SWing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 19)  25.00 SWing-bed cost applicable to NF type services after December 31 of the cost reporting period (line sine 20)  26.00 Total swing-bed cost sepilicable to NF type services after December 31 of the cost reporting period (line sine 20)  27.00 Cercard inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room cost differential (line 30 + 11 minus line 26)  29.00 Private room cost differential (line 30 + 11 minus line 30)  39.00 Average peri diem private room charge (line 30 + 11 minus line 31)  39.00 Private room cost differential (line 30 + 11 minus line 31)  39.00 Private room cost differential (line 30 + 11 minus line 31)  39.00 Program general inpatient routine service cost to to the Program (line 14 x line 31)	13. 00		0	13.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00			_	
16.00 Nursery days (title V or XIX only)  With BED ADUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period will dedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting period will dedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period will dedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period will dedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period systems will be services after December 31 of the cost reporting period will dedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line period systems) will be services after December 31 of the cost reporting period (line period systems) will be supplied be to SNF type services after December 31 of the cost reporting period (line period systems) will be supplied be to SNF type services after December 31 of the cost reporting period (line period systems) will be supplied be supplied by the service after December 31 of the cost reporting period (line period systems) will be supplied by the service after December 31 of the cost reporting period (line period systems) will be supplied by the service after December 31 of the cost reporting period (line period systems) will be supplied by the service after December 31 of the cost reporting period (line period systems) will be supplied by the service after December 31 of the cost reporting period (line period systems) will be supplied by the service after December 31 of the cost reporting period (line period systems) will be supplied by the service after December 31 of the cost reporting period (line period systems) will be supplied by the service after December 31 of the cost reporting period (line period systems) w	14.00		0	14.00
SWING BED ADJUSTMENT  1.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period re	15.00	Total nursery days (title V or XIX only)	0	15.00
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost perporting period ore period period	16.00		0	16. 00
reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Total swing-bed cost (see instructions)  29. 00 Total swing-bed cost (see instructions)  29. 00 Semi-private room charges (excluding swing-bed charges)  29. 00 O Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Average per diem private room cost differential (line 27 + line 28)  30. 00 Average per diem private room cost differential (line 3 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 General inpatient routine service cost per dem (see instructions)  30. 00 General inpatient routine service cost per dem (see instructions)  30. 00 General inpatient routine service cost per dem (see instructions)  30. 00 General inpatient routine service cost per dem (see instructions)  30. 00 General inpatient routine service cost				
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reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost or reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Total swing-bed cost (see instructions)  29.00 Total swing-bed cost (see instructions)  29	10 00		0.00	10.00
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20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10tal general inpatient routine service cost (see instructions) 35, 224, 626 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 13.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 18.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 18.00 Swing-bed cost (see instructions) 19.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 19.00 Swing-bed cost (see instructions) 19.00 Swing-bed swing-bed cost (see instructions) 19.00 Swing-bed swing-bed cost (see instructions) 19.00 Swing-bed swing-bed swing-bed cost (see instructions) 19.00 Swing-bed swi	17.00		0.00	17.00
reporting period Total general inpatient routine service cost (see instructions) 35, 224, 626 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 3.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type service safter December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type service cost fermore period (line 20 time 20	20.00		0. 00	20.00
22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   0 26.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   35,224,626   28.00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0 29.00   29.00   Private room charges (excluding swing-bed charges)   0 29.00   30.00   Semi-private room charges (excluding swing-bed charges)   0 30.00   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0.000000   32.00   Average perivate room per diem charge (line 29 + line 3)   0.00   33.00   Average per diem private room cost differential (line 32 minus line 33) (see instructions)   0.00   34.00   Average per diem private room cost differential (line 34 x line 31)   0.00   35.00   Average per diem private room cost differential (line 34 x line 31)   0.00   37.00   Private room cost differential dijustment (line 3 x line 35)   0 36.00   37.00   Private room cost differential adjustment (line 3 x line 35)   0 35.00   38.00   Average per diem private room cost differential (line 3 x line 35)   0 36.00   37.00   Program general inpatient routine service cost per diem (see instructions)   2.266.12   38.00   Adjusted general inpatient routine service cost per diem (see instructions)   0.00   38.00   Program general inpatient routine service cost per diem (see instructions)   0.00   38.00   Program general inpatient routine service cost per diem (see instructions)   0.00   38.00   Program general inpatient routine service cost per		reporting period		
5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O Semi-private room charges (excluding swing-bed charges) O Semi-private room charges (line 29 ÷ line 3) O Semi-private room charge (line 29 ÷ line 3) O Semi-private room cost differential (line 30 ÷ line 4) O Semi-private room cost differential (line 30 ÷ line 4) O Semi-private room cost differential (line 30 ÷ line 4) O Semi-private room cost differential (line 30 ÷ line 4) O Semi-private room cost differential (line 30 ÷ line 31) O Semi-private room cost differential (line 30 ÷ line 31) O Semi-private room cost differential (line 30 ÷ line 31) O Semi-private room cost differential (line 30 ÷ line 31) O Semi-private room cost differential (line 30 ÷ line 31) O Semi-private room cost differential (line 30 ÷ line 31) O Semi-private room cost differential (line 30 ÷ line 31) O Semi-private room cost differential (	21. 00	Total general inpatient routine service cost (see instructions)	35, 224, 626	21. 00
23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Private room Charges (excluding swing-bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room per diem charge (line 29 + line 3)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 32 minus line 33)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)  27 minus line 36)  28. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22. 00		0	22. 00
x line 18)  24.00  24.00  25.00  25.00  26.00  27.00  28.00  29.0			_	
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average perion the private room per diem charge (line 30 + line 4) 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 35, 224, 626) 38.00 Application of the cost reporting period (line 8	23. 00	] 3 11 31 1	0	23. 00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24.00		0	24.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 30 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626) 37.00 Private room cost differential cost net of swing-bed cost and private room cost differential (line 35, 224, 626) 38.00 Average per diem private room cost differential (line 37 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24.00		U	24.00
x line 20) Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 30 * line 4) Ceneral inpatient routine service cost/charge ratio (line 30 * line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x	25 00		0	25.00
26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  RRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  3.00 Semi-private room charges (excluding swing-bed charges)  3.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  3.00 Average private room per diem charge (line 29 ÷ line 3)  3.00 Average semi-private room per diem charge (line 30 ÷ line 4)  3.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  3.00 Average per diem private room cost differential (line 34 x line 31)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626)  3.00 Private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 Average per diem private room cost differential (line 3 x line 35)  3.00 A	23.00		O	23.00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average private room per diem charge (line 30 + line 4)  31. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  32. 00 Average per diem private room cost differential (line 34 x line 31)  33. 00 Average per diem private room cost differential (line 34 x line 31)  34. 00 Average per diem private room cost differential (line 3 x line 35)  35. 00 Average per diem private room cost differential (line 3 x line 35)  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 35, 224, 626)  37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	26.00	,	0	26. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  29.00  29.00  30.00  31.00  32.00  33.00  34.00  35.00  36.00  37.00  37.00  38.00  38.00  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	35, 224, 626	27. 00
29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 29 ÷ line 3)  4. 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 35, 224, 626)  40 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)  9 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 29. 00  30. 00  30. 00  30. 00  30. 00  30. 00  31. 00  32. 00  33. 00  40. 00  40. 00		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
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 35, 224, 626)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  0 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 Aoconomic private room cost differential (line 35, 224, 626)  2. 266. 12 38. 00 2. 30.00 Aoconomic private room cost applicable to the Program (line 14 x line 35)  30.00 Aoconomic private room cost differential (line 35)  0 30.00 Aoconomic private room cost differential (line 35, 224, 626)  31.00 Aoconomic private room cost differential (line 35, 224, 626)  32. 00 Aoconomic private room cost differential (line 35, 224, 626)  33. 00 Aoconomic private room cost differential (line 35, 224, 626)  34. 00 Aoconomic private room cost differential (line 36)  35. 00 Aoconomic private room cost differential (line 37, 224, 626)  36. 00 Aoconomic private room cost differential (line 37, 224, 626)  37. 00 Aoconomic private room cost differential (line 37, 224, 626)  37. 00 Aoconomic private room cost differential (line 37, 224, 626)  38. 00 Aoconomic private room cost differential (line 30, 224, 626)  38. 00 Aoconomic private room cost differential (line 32 minus line 33)  38. 00 Aoconomic private room cost differential (line 30, 224, 626)  39. 00 A				28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  9.00 Program general inpatient routine service cost (line 9 x line 38)  0.000 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.000 ONUM SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	29. 00		-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average 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 35, 224, 626)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35, 224, 626)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Average semi-private room charge differential (line 3 x line 31)  38.00 Average per diem private room cost differential (line 35, 224, 626)  37.00 27 minus line 36)  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)  40.00		, , , , , , , , , , , , , , , , , , ,		
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 35, 224, 626)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  35.00  37.00  37.00  38.00  39.00  40.00				
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 35, 224, 626 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
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 35, 224, 626 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 36.00 37				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 35, 224, 626 37.00 3		, , , , , , , , , , , , , , , , , , ,		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 266.12 38.00 Program general inpatient routine service cost (line 9 x line 38) 886,053 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 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)  2, 266.12 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  886,053 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	200	, , ,	,, 520	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2, 266. 12 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
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)  886,053 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00		·	
		, , , , , , , , , , , , , , , , , , , ,		
41.00   lotal Program general inpatient routine service cost (line 39 + line 40)   886,053   41.00				
	41.00	lotal Program general inpatient routine service cost (line 39 + line 40)	886, 053	41.00

	Financial Systems	RI VERVI EW				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0059	Peri od: From 01/01/2023	Worksheet D-1	
					To 12/31/2023	Date/Time Pre	
			Ti tl	e XIX	Hospi tal	5/29/2024 9:5 Cost	04 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		I npati ent	Inpatient	Diem (col.	1	(col. 3 x	
		Cost 1.00	<u>Days</u> 2.00	÷ col . 2) 3.00	4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	0	C				42.00
	Intensive Care Type Inpatient Hospital Units					_	
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	6, 207, 504	2, 507	2, 476. (	0	0	43.00
45.00	BURN INTENSIVE CARE UNIT					I	45.00
46.00	SURGICAL INTENSIVE CARE UNIT					I	46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			471, 375	48. 00
48. 01	Program inpatient cellular therapy acquisiti				, column 1)	0	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.(	01)(see instru	ctions)		1, 357, 428	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
			·				
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	55. 00
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55		<b>\</b>			0. 00 0	1
57.00	Difference between adjusted inpatient operat			line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	0			ŕ	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	m the cost rep	orting period	endi ng 1996,	0. 00	59.00
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior vear	cost report.	updated by the	0.00	60.00
	market basket)		p		.,	1	
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61.00
	53) are less than expected costs (lines 54 x					I	
	enter zero. (see instructions)		S	·		I	
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instri	ictions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstr	actions)			0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	oor 21 of the	cost roportin	a ported (Soc		65.00
03.00	instructions)(title XVIII only)	ts after beceilik	bei 31 of the	cost reportin	g perrou (see	l	05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21	of the cost r	oporting ported	0	67.00
67.00	(line 12 x line 19)	e costs through	i beceiiber 31	or the cost r	eporting perrou	l	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after [	December 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 : lin	e 68)		0	69.00
J 7. UU	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY		0	J 07. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service	cost (line 37	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)		I	71.00
73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		m (line 14 x l	ine 35)		I	73.00
74. 00	Total Program general inpatient routine serv					I	74.00
75. 00	Capital -related cost allocated to inpatient	routine service	e costs (from	Worksheet B,	Part II, column	I	75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				I	76.00
77. 00	Program capital -related costs (line 9 x line					I	77.00
78.00	Inpatient routine service cost (line 74 minu			-1->		I	78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)	I	79. 00 80. 00
81. 00	Inpatient routine service costs for comp		SSS TIME COLLO	(11110 70 1111		I	81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 8°				I	82.00
83. 00 84. 00	Reasonable inpatient routine service costs (		ns)			I	83.00
04. UU	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)			I	85.00
85.00						I	86.00
85. 00 86. 00	Total Program inpatient operating costs (sum		ir dugir do)				-
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions	S THROUGH COST	n ought ooy			3, 659	

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 01/01/2023 To 12/31/2023		
		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	)			8, 291, 733	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	7, 737, 826	35, 224, 626	0. 21967	1 8, 291, 733	1, 821, 453	90.00
91.00 Nursing Program cost	0	35, 224, 626	0.00000	0 8, 291, 733	0	91.00
92.00 Allied health cost	0	35, 224, 626	0.00000	0 8, 291, 733	0	92.00
93.00 All other Medical Education	0	35, 224, 626	0.00000	0 8, 291, 733	0	93. 00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0059	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T059		
	Title XIX	Subprovi der -	Cost
		I RF	

		IRF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	)	3, 870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days		3, 870	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	y private room days,	0	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		3, 870	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Dece	ember 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December.	ner 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	oci oi tiic cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through Decer	mber 31 of the cost	0	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room days) after December	er 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)		7	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding behavior and the program (excluding private room days) (see instructions)	arng swrng-bed and	7	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including privations)	te room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)			
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including priva-	te 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 pri	vate room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including pri	vato room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this		U	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-		0	14.00
15.00		,	0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17. 00		31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31	of the cost	0.00	18. 00
10.00	reporting period	of the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 3	1 of the cost	0.00	19. 00
	reporting period			
20.00		of the cost	0.00	20.00
21 00	reporting period		E 0E7 0/0	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost rep	porting ported (line	5, 857, 963 0	21. 00 22. 00
22.00	5 x line 17)	on tring period (irine	U	22.00
23.00		rting period (line 6	0	23. 00
	x line 18)			
24. 00		orting period (line	0	24.00
05.00	7 x line 19)		0	05.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost report x line 20)	ting period (line 8	0	25. 00
26. 00			0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 2	26)	5, 857, 963	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	,		
	General inpatient routine service charges (excluding swing-bed and observation bed	d charges)	0	28. 00
	Private room charges (excluding swing-bed charges)		0	
30.00	Semi-pri vate room charges (excluding swing-bed charges)		0	
31. 00 32. 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	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see ins	tructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	,	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cos	t differential (line	5, 857, 963	37. 00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)	T	1, 513. 69	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		1, 513. 69	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	5)	0, 370	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)		10, 596	
		·		

	TION OF INPATIENT OPERATING COST	RI VERVI EW	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023		epared:
			Ti tl	e XIX	Subprovi der -	Cost	94 aiii
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1		Program Cost (col. 3 x	
		1. 00	Days 2.00	÷ col . 2) 3.00	4.00	col . 4) 5. 00	
	NURSERY (title V & XIX only)	0	(	0.0	00 0	0	42. 00
	ntensive Care Type Inpatient Hospital Units	0		0.0	00 0	0	43.00
4	CORONARY CARE UNIT	0	,	7		l	44.00
4	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00 I	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			2, 448	48.00
	Program inpatient cellular therapy acquisiti				, column 1)	0	
	Total Program inpatient costs (sum of lines	41 through 48.	01)(see instru	ctions)		13, 044	49. 0
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D su	m of Parts I and	0	50.00
	III)	atront routino	301 11 003 (11 0	iii iii(St. B, Sui	ii or rai to r and	ĺ	00.0
	Pass through costs applicable to Program inp and IV)		ry services (f	rom Wkst. D,	sum of Parts II	0	
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		olated non	weleler ans-+	hotist and	0	
	medical education costs (line 49 minus line		erated, non-pr	ysician anesti	netist, and	l	53.0
	FARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program di scharges					0	
	Target amount per discharge					0. 00 0. 00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0.00	
	Target amount (line 54 x sum of lines 55, 55		)			0.00	1
57. 00 I	Difference between adjusted inpatient operat	ing cost and t	arget amount (	line 56 minus	line 53)	0	57. C
	Bonus payment (see instructions)					0	
	Trended costs (lesser of line 53 ÷ line 54,		m the cost rep	orting period	endi ng 1996,	0.00	59.0
60.00 I	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)		om prior year	cost report,	updated by the	0.00	60.0
61. 00	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 operati	ng costs (line	0	61.0
	enter zero. (see instructions) Relief payment (see instructions)					0	62. 0
	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			Ö	
	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 instructions)(title XVIII only)	its after Decem	ber 31 of the	cost reporting	g period (See	1	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66. 0
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost r	eporting period	0	67.0
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir (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 XIX swing-bed NF inpatient PART III – SKILLED NURSING FACILITY, OTHER N					0	69. 0
	Skilled nursing facility/other nursing facil				)		70.0
71.00	Adjusted general inpatient routine service c	ost per diem (					71.0
	Program routine service cost (line 9 x line	,	m (lina 14!	ino 25)			72.0
	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•		•	Part II, column		75. 0
76. 00 I	Per diem capital-related costs (line 75 ÷ li						76.0
	Program capital-related costs (line 9 x line						77.0
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi den recon	·ds)			78. 0 79. 0
	Total Program routine service costs for comp				nus line 79)		80.0
1	Inpatient routine service cost per diem limi			:	<i>´</i>		81.0
00 00	Inpatient routine service cost limitation (I						82.0
1	Reasonable inpatient routine service costs (		ns)			l	83.0
83. 00 I	Decare innetient!!!						
83. 00 I 84. 00 I	Program inpatient ancillary services (see in		ons)		ŀ		84.0
83. 00   1 84. 00   1 85. 00	Program inpatient ancillary services (see ir Utilization review - physician compensation Total Program inpatient operating costs (sum	(see instructi					84. 0 85. 0 86. 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 CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-T059	From 01/01/2023 To 12/31/2023		pared: 4 am
		Ti tl	e XIX	Subprovi der -	Cost	
				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	e instructions)	)			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
· ·		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		,		(from line	(col. 3 x	
				89)	col. 4) (see	
				,	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 262, 747	5, 857, 963	0. 21556	0	0	90.00
91.00 Nursing Program cost	o	5, 857, 963	0. 00000	00	0	91.00
92.00 Allied health cost	ol	5, 857, 963	0.00000	00	0	92.00
93.00 All other Medical Education	o	5, 857, 963		00	0	93. 00
·	. '	•	•	•		•

Health Financial Systems	RI VERVI EW HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/29/2024 9:5	pared:
	Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT 41. 00   04100   SUBPROVI DER -   RF			6, 041, 512 2, 395, 359 411, 066		30. 00 31. 00 41. 00
		1	,		1

	cost center bescription	To Charges	Program	Program Costs	
		To charges	Charges	(col. 1 x	
			orial ges	col . 2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		6, 041, 512		30.00
31. 00	03100 INTENSIVE CARE UNIT		2, 395, 359		31.00
41.00			411, 066		41.00
43.00	04300 NURSERY		·		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 136255	5, 129, 214	698, 881	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 324641	633, 059	205, 517	54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	0. 210840	2, 295	484	55. 00
57.00	05700 CT SCAN	0. 033777	1, 178, 816	39, 817	57.00
57. 01	03630 ULTRA SOUND	0. 071924	286, 712	20, 621	57. 01
58.00	05800 MRI	0. 066685	159, 456	10, 633	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 059298	3, 072, 342	182, 184	59.00
60.00	06000 LABORATORY	0. 194782	4, 608, 672	897, 686	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 432778	200, 095	86, 597	63.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 308141	1, 867, 771	575, 537	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 285852	894, 012	255, 555	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		0. 150380	778, 210	117, 027	69.00
71. 00		0. 217176	4, 056, 722	881, 023	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 433276	2, 051, 656	888, 933	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 298009	4, 244, 864	1, 265, 008	
74. 00	07400 RENAL DI ALYSI S	0. 546756	306, 257	167, 448	74.00
76.00	03020 OTHER ANCI LLARY	0. 000000	000, 207	0	76.00
76. 01	03140 CARDI AC REHAB	0. 138325	170, 344	23, 563	76. 01
76. 02	03070 WOMEN'S CENTER	0. 194762	170,011	20,000	76. 02
76. 03	03330 ENDOSCOPY	0. 000000	0	0	76.03
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	77.00
78. 00		0. 000000	0	0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000		0	70.00
90.00		0. 134281	25, 025	3, 360	90.00
90. 01	09001 OUTPATI ENT	0. 243975	60, 636	14, 794	90.01
	09002 NEUROPSYCHOLOGY	0. 210820	00, 000	0	90.02
91.00		0. 262856	1, 672, 367	439, 592	91.00
91. 01		0. 000000	1, 072, 307	437, 372	91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 848298	564, 260	478, 661	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0.040270	507, 200	470,001	72.00
95 00	09500 AMBULANCE SERVICES				95.00
200. 0			31, 962, 785	7, 252, 921	
201. 0			51, 702, 705 N		201.00
202. 0			31, 962, 785		202.00
202.0	7 1.00 3.6. 933 (11110 200 million 11110 201)	1	31, 732, 703		-32.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0059	Peri od:	Worksheet D-3	;
	Component	CCN: 15-T059	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	
	Title	· XVIII	Subprovi der - I RF	PPS	1 011
Cost Center Description	<u> </u>	Ratio of Cos		I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS					30
.00 03100 INTENSIVE CARE UNIT					31
. 00   04100   SUBPROVI DER - I RF			3, 538, 829		41
. 00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS					4
. 00   05000   OPERATING ROOM		0. 13625		66, 467	
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	
. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 32464		19, 371	
. 00   05500   RADI OLOGY-THERAPEUTI C		0. 21084	10 0	0	55
. 00  05700   CT SCAN		0. 03377		2, 113	
. 01  03630 ULTRA SOUND		0. 07192		1, 921	
. 00   05800   MRI		0. 06668		1, 090	
. 00   05900   CARDI AC CATHETERI ZATI ON		0. 05929		11, 152	
. 00   06000   LABORATORY		0. 19478		117, 107	
. 01  06001 BLOOD LABORATORY		0. 00000		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 43277		12, 211	
. 00   06400   I NTRAVENOUS THERAPY		0. 00000		0	
. 00   06500   RESPI RATORY THERAPY		0. 30814		93, 566	
. 00   06600   PHYSI CAL THERAPY		0. 28585		782, 933	
. 00   06700   OCCUPATI ONAL THERAPY		0. 00000		0	
. 00   06800   SPEECH PATHOLOGY		0. 00000		0	
. 00   06900   ELECTROCARDI OLOGY		0. 15038		3, 852	
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21717		161, 707	
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 43327		118, 654	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29800		204, 752	
. 00   07400   RENAL DI ALYSI S		0. 54675		29, 360	
. 00   03020 OTHER ANCI LLARY		0. 00000		0	
. 01   03140   CARDI AC REHAB		0. 13832		1, 589	
. 02   03070   WOMEN' S CENTER		0. 19476		0	
. 03   03330   ENDOSCOPY		0. 00000		0	
.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000		0	
.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00	0	78
OUTPATIENT SERVICE COST CENTERS					4
. 00   09000   CLI NI C		0. 13428		408	
. 01   09001   OUTPATI ENT		0. 24397		4, 314	
. 02 09002 NEUROPSYCHOLOGY		0. 21082		0	
. 00   09100   EMERGENCY		0. 26285		11, 357	
. 01   09101   SHORT STAY		0.00000		0	
. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 84829	98 0	0	92
OTHER REIMBURSABLE COST CENTERS		1			١.
. 00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through			6, 373, 425	1, 643, 924	
1.00 Less PBP Clinic Laboratory Services-Program onl	y charges (line 61)		0		201
2.00 Net charges (line 200 minus line 201)		1	6, 373, 425		202

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2023	
		To 12/31/2023	Date/Time Prepared:

INFAII	ENT ANGILLARI SERVICE COST AFFORTIONWENT	Frovider C	CN. 13-0039	From 01/01/2023 To 12/31/2023		pared: 4 am
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			1, 278, 615		30.00
31.00	03100 INTENSIVE CARE UNIT			143, 290		31.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY			0		43.00
	ANCILLARY SERVICE COST CENTERS			540.000	10.544	
50.00	05000 OPERATING ROOM		0. 1362			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
54. 00 55. 00	05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-THERAPEUTI C		0. 32464 0. 21084		8, 269 0	1
55.00	05700 CT SCAN		0. 21084		_	
57. 00	03630 ULTRA SOUND		0. 0337	· ·		
58. 00	05800 MRI		0.06668			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 05929			
60.00	06000 LABORATORY		0. 19478	· ·		
60. 01	06001 BLOOD LABORATORY		0. 00000		0	60.01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 4327		-	
64. 00	06400 I NTRAVENOUS THERAPY		0.00000		0	
65.00	06500 RESPIRATORY THERAPY		0. 30814		16, 803	
66.00	06600 PHYSI CAL THERAPY		0. 2858			
67.00	06700 OCCUPATI ONAL THERAPY		0. 00000		0	67.00
68.00	06800 SPEECH PATHOLOGY		0. 00000	00	0	68.00
69.00	06900 ELECTROCARDI OLOGY		0. 15038	31, 647	4, 759	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2171	76 333, 689	72, 469	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4332			
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 29800			
74. 00	07400 RENAL DIALYSIS		0. 5467			74. 00
76.00	03020 OTHER ANCI LLARY		0.00000		0	
76. 01	03140 CARDI AC REHAB		0. 13832			1
76. 02	03070 WOMEN' S CENTER		0. 19476		-	
76. 03	03330 ENDOSCOPY		0.00000			
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000			77.00
78. 00	O7800   CAR T-CELL   IMMUNOTHERAPY   OUTPATIENT SERVICE COST CENTERS		0.00000	0	0	78. 00
90.00	09000 CLINIC		0. 13428	31 0	0	90.00
90.00	09001 OUTPATI ENT		0. 13426			
90. 01	09002 NEUROPSYCHOLOGY		0. 21082		0,704	90.01
91.00	09100 EMERGENCY		0. 2628		19, 935	
91. 01	09101 SHORT STAY		0. 00000		0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 84829		4, 412	
	OTHER REIMBURSABLE COST CENTERS			2, 201	, ., .	1
95.00	09500 AMBULANCE SERVI CES					95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			2, 192, 806	471, 375	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00				2, 192, 806		202. 00

Health Financial Systems RIVE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	RVIEW HOSPITAL Provider C	CN: 15-0059	Peri od:	u of Form CMS-2552- Worksheet D-3	
	Component (	CCN: 15-T059	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	
	Ti tl	e XIX	Subprovi der -	Cost	4 dili
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS					30.00
31. 00   03100   INTENSIVE CARE UNIT					31.00
41. 00   04100   SUBPROVI DER - I RF			94, 755		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 13625	55 0	0	50. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM		0. 13625		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 32464		0	
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 21084		0	
57. 00   05700 CT   SCAN		0. 03377		0	
57. 01   03630   ULTRA   SOUND		0. 07192		0	
58. 00   05800   MRI		0. 06668	35 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05929	98 0	0	59.00
60. 00   06000   LABORATORY		0. 19478	32 540	105	60.00
60. 01   06001   BLOOD LABORATORY		0. 00000		0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 43277		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 30814		0	
66. 00   06600 PHYSI CAL THERAPY 67. 00   06700 OCCUPATI ONAL THERAPY		0. 28585 0. 00000	·	305 0	66. 00 67. 00
68. 00   06800  SPEECH PATHOLOGY		0.00000		0	
69. 00   06900   ELECTROCARDI OLOGY		0. 15038		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21717		2, 038	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 43327		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29800	0	0	73.00
74.00 07400 RENAL DIALYSIS		0. 54675	56 0	0	74.00
76. 00   03020   OTHER ANCI LLARY		0. 00000		0	76.00
76. 01   03140   CARDI AC REHAB		0. 13832		0	
76. 02   03070   WOMEN' S CENTER		0. 19476		0	76. 02
76. 03   03330   ENDOSCOPY		0. 00000		0	76. 03
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000		0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00 0	0	78.00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC		0. 13428	31 0	0	90.00
90. 01   09001   0UTPATI ENT		0. 24397	-	0	
90. 02   09002   NEUROPSYCHOLOGY		0. 21082		0	
91. 00 09100 EMERGENCY		0. 26285		0	
91. 01   09101   SHORT STAY		0. 00000		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 84829	98 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 throug			10, 992		200.00
201.00 Less PBP Clinic Laboratory Services-Program onli	y charges (line 61)		0		201.00

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)

95. 00 2, 448 200. 00 201. 00

202.00

10, 992

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 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 9:54 am

		10 12/31/2023	5/29/2024 9: 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 Octo	ber 1 (see	6, 041, 312	1. 01
4 00	instructions)		0 405 070	4.00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after 0	ctober 1 (see	2, 195, 072	1. 02
1. 03	Instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occ	urring prior to October	. 0	1. 03
1.03	1 (see instructions)	arring prior to october	O	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occ	urring 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		253, 734	2.03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instruction Managed Care Simulated Payments	ons)	152, 326 0	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see	instructions)	110. 63	4.00
4.00	Indirect Medical Education Adjustment	Tristi ucti oris)	110.03	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost rep	ortina period endina or	0.00	5.00
	or before 12/31/1996. (see instructions)	ar ar ng para an amar ng ar		
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see ins	tructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for a	n 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 windo	w 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		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 00	cost report straddles July 1, 2011 then see instructions.	: t-t:(-)	0.00	7 00
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE lile track programs with a rural track for Medicare GME affiliated programs in acco		0. 00	7. 02
	and 87 FR 49075 (August 10, 2022) (see instructions)	ruance with 413.75(b)		
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopat	hic programs for	0.00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64		0.00	0.00
	1998), and 67 FR 50069 (August 1, 2002).	1 K 200 10 (may 12,		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503	of 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	teaching hospital	0.00	8. 02
	under § 5506 of ACA. (see instructions)			
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of	the CAA 2021 (see	0. 00	8. 21
	instructions)			
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line		0. 00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instruct FTE count for allopathic and osteopathic programs in the current year from you		0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.	i records	0.00	
12. 00	Current year allowable FTE (see instructions)			12.00
13. 00	Total allowable FTE count for the prior year.		0.00	
14. 00	Total allowable FTE count for the penultimate year if that year ended on or af	ter September 30 1997	0.00	
00	otherwise enter zero.	te. deptember de,,	0.00	
15. 00			0.00	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		0.00	17.00
18.00	Adjusted rolling average FTE count		0. 00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 000000	
22. 00	IME payment adjustment (see instructions)		0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions)		0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	10.050.110.105		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots und	er 42 CFR 412.105	0. 00	23. 00
24. 00	<pre>(f)(1)(iv)(C ). IME FTE Resident Count Over Cap (see instructions)</pre>		0. 00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23	or line 24 (see	0.00	25.00
23.00	instructions)	of Title 24 (See	0.00	23.00
26. 00	Resident to bed ratio (divide line 25 by line 4)		0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)		0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)		0.00000	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)		0	29. 01
	Di sproporti onate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see	instructions)	1. 19	30. 00
31.00	Percentage of Medicaid patient days (see instructions)		19. 09	
32.00	Sum of lines 30 and 31		20. 28	
33. 00	Allowable disproportionate share percentage (see instructions)		5. 95	33. 00

	· · · · · · · · · · · · · · · · · · ·	/ HOSPI TAL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Period: From 01/01/2023 To 12/31/2023		
		Title XVIII	Hospi tal	5/29/2024 9: 5 PPS	4 am
				'	
34 00	Disproportionate share adjustment (see instructions)			1. 00 122, 517	34 00
01.00	propertionate share and astment (see this tractions)		Prior to 10/1		01.00
			1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		0	0	35. 00
35. 00	Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	Hospital UCP, including supplemental UCP (see instructions	,	1, 468, 768	1, 299, 466	35. 02
35. 03	Pro rata share of the hospital UCP, including supplementa		1, 098, 558	326, 642	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary	3) v discharges (Lines 40 thro	1, 425, 200		36.00
40. 00	Total Medicare discharges (see instructions)	y ar senar ges (Trines to trine	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 Divide line 41 by line 40 (if less than 10%, you do not q		0		41.01
42. 00 43. 00	Total Medicare ESRD inpatient days (see instructions)	uality for adjustment)	0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divis	ded by line 41 divided by 7	0. 000000		44.00
	days)				45.00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruct Total additional payment (line 45 times line 44 times line	•	0.00		45. 00 46. 00
47. 00	Subtotal (see instructions)	6 41.01)	10, 190, 161		47.00
48. 00	Hospital specific payments (to be completed by SCH and MD	H, small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				Amount 1.00	
49. 00	1 1 3 3			10, 190, 161	
50.00	Payment for inpatient program capital (from Wkst. L, Pt.			737, 629	
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Direct graduate medical education payment (from Wkst. E-4			0	51.00 52.00
53.00	Nursing and Allied Health Managed Care payment	,		54, 720	
54.00	Special add-on payments for new technologies			19, 567	1
54. 01 55. 00	Islet isolation add-on payment	no (0)		0	54. 01 55. 00
55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lill Cellular therapy acquisition cost (see instructions)	ne 09)		0	55.00
56. 00	Cost of physicians' services in a teaching hospital (see	intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, P		through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Total (sum of amounts on lines 49 through 58)	Pt. IV, col. 11 line 200)		18, 941 11, 021, 018	
60.00	Primary payer payments			10, 522	
61. 00	Total amount payable for program beneficiaries (line 59 m	inus line 60)		11, 010, 496	61.00
62.00	Deductibles billed to program beneficiaries			1, 020, 316	
63.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			9, 200 38, 624	
	Adjusted reimbursable bad debts (see instructions)			25, 106	
66.00		i nstructi ons)		23, 120	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	Secretary III and III MG BBO		10, 006, 086	1
68. 00 69. 00	Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and			0	68.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	70). (101 3011 366 Tristi detre	113)	0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Dem		e instructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instruction			0	70.75
70. 87 70. 88	Demonstration payment adjustment amount before sequestrat SCH or MDH volume decrease adjustment (contractor use only			0	70. 87 70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see			O	70.89
70. 90	HSP bonus payment HVBP adjustment amount (see instruction	s)		0	
70. 91	HSP bonus payment HRR adjustment amount (see instructions	)		0	70. 91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions)  HVBP payment adjustment amount (see instructions)			0 -16, 819	
70. 94	1			-81, 373	
	Recovery of accelerated depreciation			0	1

alth Financial Systems RIV	/ERVIEW HOSPITAL		In Lie	u of Form CMS-2	255:
LCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	F	Period: From 01/01/2023 To 12/31/2023		
	Title	XVIII	Hospi tal	PPS	
		FFY (	(уууу)	Amount	
			0	1. 00	
.96 Low volume adjustment for federal fiscal year (yyyy	(Enter in column 0		0	0	70
the corresponding federal year for the period prior 97 Low volume adjustment for federal fiscal year (yyyy			0	0	70
the corresponding federal year for the period ending				I	
.98 Low Volume Payment-3	,		0	0	70
.99 HAC adjustment amount (see instructions)				28, 959	1 70
.00 Amount due provider (line 67 minus lines 68 plus/mi	nus lines 69 & 70)			9, 878, 935	
.01 Sequestration adjustment (see instructions)	,			197, 579	7
.02 Demonstration payment adjustment amount after seque	stration			0	
.03 Sequestration adjustment-PARHM pass-throughs				I	7
.00 Interim payments				9, 227, 926	7:
.01   Interim payments-PARHM				1	7
.00 Tentative settlement (for contractor use only)				0	1 7
.01 Tentative settlement-PARHM (for contractor use only	)			I	7
.00 Balance due provider/program (line 71 minus lines 7				453, 430	1 7
73)				1	
.01 Balance due provider/program-PARHM (see instruction	s)			I	7
.00 Protested amounts (nonallowable cost report items)	in accordance with			267, 424	. 7
CMS Pub. 15-2, chapter 1, §115.2				1	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
.00 Operating outlier amount from Wkst. E, Pt. A, line	2, or sum of 2.03			0	9
plus 2.04 (see instructions)					_
00 Capital outlier from Wkst. L, Pt. I, line 2				0	1 '
OD Operating outlier reconciliation adjustment amount	,			0	1 '
00 Capital outlier reconciliation adjustment amount (s				0	1 .
The rate used to calculate the time value of money				0.00	
OO Time value of money for operating expenses (see ins	,			0	1 '
00 Time value of money for capital related expenses (s	ee Instructions)		D::: -:- +- 10 /1	0 / (45+ 10 / 1	9
			Prior to 10/1 1.00	2. 00	+
HSP Bonus Payment Amount			1.00	2.00	+
0.00 HSP bonus amount (see instructions)			O	0	10
HVBP Adjustment for HSP Bonus Payment			<u> </u>		1,0
1.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	110
2.00 HVBP adjustment amount for HSP bonus payment (see i	nstructions)		0.0000000000		10
HRR Adjustment for HSP Bonus Payment			9	-	1.0
3.00 HRR adjustment factor (see instructions)			0, 0000	0, 0000	110
4.00 HRR adjustment amount for HSP bonus payment (see in	structions)		0	0	10
Rural Community Hospital Demonstration Project (§41)		ustment	-1		1
0.00 Is this the first year of the current 5-year demons					200
Century Cures Act? Enter "Y" for yes or "N" for no.	•			I	
Cost Reimbursement					1
1.00 Medicare inpatient service costs (from Wkst. D-1, P	t. II, line 49)				20
2.00 Medicare discharges (see instructions)	•			I	20
3.00 Case-mix adjustment factor (see instructions)			<u> </u>		20
Computation of Demonstration Target Amount Limitation	(1) (1) (1)				a .

	Pri or to 10/1	<u> </u>	
	1. 00	2.00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100.00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 0000000000	0. 0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current	t 5-year demonst	rati on	
peri od)			
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00 Reserved for future use			210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)			

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 4 To 12/31/2023 Date/Time Prepared: Provi der CCN: 15-0059

					1	0 12/31/2023	Date/lime Pre 5/29/2024 9:5	
					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	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	10/01 4. 00	5. 00	
1. 00	DRG amounts other than outlier	1.00	0	2.00	3.00	4.00	0.00	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	6, 041, 312	0	6, 041, 312		6, 041, 312	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 195, 072	0		2, 195, 072	2, 195, 072	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	253, 734	0	253, 734		253, 734	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	152, 326	0		152, 326	152, 326	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adj	ıstment						
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
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions)							
7. 00	Indirect Medical Education Adjustment factor	ustment for the 27.00	0.000000	0.000000	0.000000	0.000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	О	0	0	9. 01
	8.01) Disproportionate Share Adjustmo	on+						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0595	0. 0595	0. 0595	0. 0595		10.00
11. 00	instructions) Disproportionate share	34. 00	122, 517	0	89, 865	32, 652	122, 517	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	1, 425, 200	0	1, 098, 558	326, 642	1, 425, 200	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	rcentage of ESI 46.00	RD beneficiary 0	di scharges 0	0	0	0	12.00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	10, 190, 161 0	0	7, 483, 469 0	2, 706, 692 0	10, 190, 161 0	13. 00 14. 00
15. 00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	10, 190, 161	0	7, 483, 469	2, 706, 692	10, 190, 161	15. 00

LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:5	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	737, 629	O	529, 60	9 208, 020	737, 629	16.00
17. 00	new technologies	54. 00	19, 567	O	19, 56	.7	19, 567	
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	
19.00	SUBTOTAL			0	8, 032, 64	5 2, 914, 712	10, 947, 357	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	625, 552 0	0	456, 12	13 169, 429 0 0	625, 552 0	20. 00 20. 01
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	85, 804 0	0	54, 32	9 31, 475 0 0	85, 804 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. 0420	0. 0420	0. 042	0. 0420		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	26, 273	0	19, 15	7, 116	26, 273	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	737, 629	0	529, 60	9 208, 020	737, 629	26. 00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0.000000	0	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume  adjustments to Wkst. E, Pt. A.		Y					100. 00

Heal th Financial Systems RIVERVIEW HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0059 Period: From 01/01/2023 To 12/31/2023 Part A Exhibit 5 Date/Time Prepared: 5/29/2024 9:54 am

Title XVIII Hospital PPS

Wkst. E, Pt. Amt. from Period to Period on Total (cols.

				10	) 12/31/2023	5/29/2024 9:5	
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	6, 041, 312	6, 041, 312		6, 041, 312	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 195, 072		2, 195, 072	2, 195, 072	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	O	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	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	253, 734	253, 734		253, 734	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)		152, 326		152, 326	152, 326	2.03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments Indirect Medical Education Adjustment	2. 01 3. 00	0	0	0	0	3. 00 4. 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0	0	0	0	6. 00 6. 01
	instructions)						
7. 00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	e Add-on for S 27.00	0. 000000	0.000000	0. 000000		7. 00
8. 00	<pre>instructions) IME adjustment (see instructions)</pre>	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 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	0	0	0	0	9. 00 9. 01
10.00	Disproportionate Share Adjustment	22.00	0.0505	0.0505	0.0505		10.00
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0595	0. 0595	0. 0595		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	122, 517	89, 865	32, 652	122, 517	11. 00
11. 01	Uncompensated care payments	36. 00	1, 425, 200	1, 098, 558	326, 642	1, 425, 200	11. 01
12 00	Additional payment for high percentage of ESI Total ESRD additional payment (see		di scharges	0	ما	0	12 00
12. 00	instructions)	46. 00	0	U	U	U	12. 00
13.00	Subtotal (see instructions)	47. 00	10, 190, 161	7, 483, 469	2, 706, 692	10, 190, 161	13.00
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	10, 190, 161	7, 483, 469	2, 706, 692	10, 190, 161	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	737, 629	529, 609	208, 020	737, 629	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	19, 567	19, 567	0	19, 567	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	0 022 (45	0	0	18.00
19. 00	SUBTOTAL			8, 032, 645	2, 914, 712	10, 947, 357	19.00

Health Financial Systems	RI VERVI EW HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) RED	DUCTION CALCULATION EXHIBIT 5	Provider Co	CN: 15-0059	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/29/2024 9:5	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				

					To 12/31/2023	Date/Time Pre 5/29/2024 9:5	
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2, 00	3, 00	4, 00	
20. 00	Capital DRG other than outlier	1. 00	625, 552	456, 12	3 169, 429	625, 552	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	85, 804	54, 32	9 31, 475	85, 804	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0420	0. 042	0. 0420		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	26, 273	19, 15	7, 116	26, 273	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	737, 629	529, 60	9 208, 020	737, 629	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		_	A)				
07.00	1	0	1. 00	2. 00	3. 00	4. 00	07.00
27. 00	law wallows adjustment and an to Oatabaa 1	70.0/					27. 00 28. 00
28. 00 29. 00	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1	70. 96 70. 97	0	'	0	0	28.00
30.00	HVBP payment adjustment (see instructions)	70. 97	-16, 819		0 -16, 819		
30. 00	HVBP payment adjustment for HSP bonus	70. 93 70. 90	-10,019		-10, 619	-10, 619	30.00
30.01	payment (see instructions)	70. 90	0	'		0	30.01
31. 00	HRR adjustment (see instructions)	70. 94	-81, 373	-79, 39	7 -1, 976	-81, 373	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0.,0,0	,,,,,,	0 .,,,,	0.,070	31. 01
	instructions)						
	· · · · · · · · · · · · · · · · · · ·					(Amt. to	
						Wkst. E, Pt.	
		_				A)	
20.00	THAT BUT I SHOW	0	1. 00	2. 00	3.00	4. 00	20.00
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 28, 959	28, 959	32.00
100 00	Transfer HAC Reduction Program adjustment to		Υ				100.00
100.00	Wkst. E, Pt. A.		'				130.00

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 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 9:54 am

			10 12/01/2020	5/29/2024 9: 5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 573	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	ctions)		21, 595, 962	2.00
3. 00	OPPS or REH payments			17, 977, 956	3.00
4.00	Outlier payment (see instructions)			106, 735	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	ictions)		0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8. 00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs including REH dire	ect graduate medical educ	cation costs from	122, 778	9.00
	Wkst. D, Pt. IV, col. 13, line 200			  -	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES			3, 573	11.00
	Reasonable charges				<u> </u>
12.00	Ancillary service charges			12, 658	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			12, 658	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for			0	15.00
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(		on a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18. 00	Total customary charges (see instructions)			12, 658	
19.00	Excess of customary charges over reasonable cost (complete or	ly if line 18 exceeds li	ne 11) (see	9, 085	
	instructions)			  -	
20. 00	Excess of reasonable cost over customary charges (complete or	ly if line 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)			2 572	21 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			3, 573 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		Ö	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			18, 207, 469	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	•		197	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on lin			3, 238, 444	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	14, 972, 401	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)	1116 00)		١	28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			14, 972, 401	30.00
31.00	Primary payer payments			1, 840	•
32. 00	Subtotal (line 30 minus line 31)	056)		14, 970, 561	32.00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	(ES)		0	33.00
34. 00	Allowable bad debts (see instructions)			194, 145	
	Adjusted reimbursable bad debts (see instructions)			126, 194	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		183, 787	36.00
37.00	Subtotal (see instructions)			15, 096, 755	•
38. 00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ne)		0	39.00
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instruction N95 respirator payment adjustment amount (see instructions)	15)		0	39. 50 39. 75
39. 75 39. 97	Demonstration payment adjustment amount (see instructions)			0	39.75
39. 98	Partial or full credits received from manufacturers for repla	iced devices (see instru	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	, i	0	39. 99
40.00	Subtotal (see instructions)			15, 096, 755	40.00
40. 01	Sequestration adjustment (see instructions)			301, 935	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			14, 678, 274	40. 03 41. 00
41. 00	Interim payments Interim payments-PARHM			14, 070, 274	41.00
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)			-    -	42. 01
43.00	Balance due provider/program (see instructions)			116, 546	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0. 00	
93.00	Time Value of Money (see instructions)			0	93.00

Health Financial Systems RIVERVIEW HOSPITAL In L		In Lieu	Lieu of Form CMS-2552		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0059	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/29/2024 9:5	<u>4 am</u>
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				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	Provi der CCN: 15-0059	From 01/01/2023	
	Component CCN: 15-T059	To 12/31/2023	Date/Time Prepared:   5/29/2024 9:54 am
	Title XVIII	Subprovi der -	PPS

	litle XVIII   Subprovider -   IRF	PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1. 00	
00	Medical and other services (see instructions)	294	1.0
00	Medical and other services reimbursed under OPPS (see instructions)	107	2.0
00	OPPS or REH payments Outlier payment (see instructions)	125 0	3. 0 4. 0
01	Outlier reconciliation amount (see instructions)	0	
00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	
00	Line 2 times line 5	0	
00	Sum of lines 3, 4, and 4.01, divided by line 6	0. 00 0	7. 0 8. 0
00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direct graduate medical education costs from		9.0
00	Wkst. D, Pt. IV, col. 13, line 200		/. 0
. 00	Organ acqui si ti ons	0	
. 00	Total cost (sum of lines 1 and 10) (see instructions)	294	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges		
.00	Anci II ary servi ce charges	987	12.0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.0
00	Total reasonable charges (sum of lines 12 and 13)	987	14.0
00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	   15. C
00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	
	had such payment been made in accordance with 42 CFR §413.13(e)	-	
00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	
	Total customary charges (see instructions)	987	18.0
00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	693	19. (
00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. (
	instructions)		
	Lesser of cost or charges (see instructions)	294	•
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22. 23.
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	125	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
	Deductibles and coinsurance amounts (for CAH, see instructions)	0	
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	
JU	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	419	27.0
00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. (
	REH facility payment amount (see instructions)		28.
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments	419 0	1
	Subtotal (line 30 minus line 31)	419	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	417	
		419	
	Composite rate ESRD (from Wkst. I-5, line 11)	0	32. 33.
00	Allowable bad debts (see instructions)	0	32. 33. 34.
00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	0 0	32. 33. 34. 35.
00 00 00	Allowable bad debts (see instructions)	0	32. 33. 34. 35. 36.
00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	0 0 0	32. 33. 34. 35. 36. 37.
00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 0 0 0 0 419	32. 33. 34. 35. 36. 37. 38. 39.
00 00 00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0 0 0 0 419 0	32. 33. 34. 35. 36. 37. 38. 39.
00 00 00 00 00 00 50	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)	0 0 0 0 419 0 0	32. 33. 34. 35. 36. 37. 38. 39. 39.
00 00 00 00 00 00 50 75	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration	0 0 0 0 419 0	32. 33. 34. 35. 36. 37. 38. 39. 39. 39.
00 00 00 00 00 50 75 97	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)	0 0 0 419 0 0	32. 33. 34. 35. 36. 37. 38. 39. 39. 39.
00 00 00 00 00 50 75 97 98 99	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	0 0 0 419 0 0 0	32. 33. 34. 35. 36. 37. 38. 39. 39. 39. 39. 39. 40.
00 00 00 00 00 00 50 75 97 98 99 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions)	0 0 0 419 0 0 0 0 0 419 8	32. 33. 34. 35. 36. 37. 38. 39. 39. 39. 39. 39. 40. 40.
00 00 00 00 00 00 50 75 97 98 99 00 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	0 0 0 419 0 0 0	32. 33. 34. 35. 36. 37. 38. 39. 39. 39. 39. 40. 40. 40.
00 00 00 00 00 00 50 75 97 98 99 00 01 02	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions)	0 0 0 419 0 0 0 0 0 419 8	32. 33. 34. 35. 36. 37. 38. 39. 39. 39. 39. 40. 40. 40. 40. 40. 40. 40. 40. 40. 40
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM	0 0 0 419 0 0 0 0 419 8 0	32.1 33.1 35.1 36.3 37.3 39.3 39.3 39.3 39.4 40.4 40.4 40.4 41.4
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only)	0 0 0 419 0 0 0 0 419 8 0	33. 34. 35. 36. 37. 38. 39. 39. 39. 40. 40. 40. 41. 41.
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0 0 0 419 0 0 0 0 419 8 0	32.1 33.1 35.3 36.3 37.1 39.3 39.3 39.3 40.1 40.1 41.4 41.4 42.4 42.4
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments Interim payments (for contractors use only) Tentative settlement (for contractor use only) Balance due provider/program (see instructions)	0 0 0 419 0 0 0 0 419 8 0	33. 34. 35. 36. 37. 38. 39. 39. 39. 40. 40. 40. 41. 41. 42. 42.
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0 0 0 419 0 0 0 0 419 8 0	33. (33. (33. (35. (35. (35. (35. (35. (
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Bal ance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2	0 0 0 419 0 0 0 419 8 0 529	33. 34. 35. 36. 37. 38. 39. 39. 39. 39. 40. 40. 40. 41. 41. 42. 43. 43. 43.
00 00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments Interim payments (for contractors use only) Tentative settlement (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR	0 0 0 419 0 0 0 0 419 8 0 529 0 -118	32.1 33.3 34.1 35.1 36.1 37.1 38.1 39.3 39.3 39.4 40.1 40.1 41.4 42.4 43.4 43.4 44.1
00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Bal ance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2	0 0 0 419 0 0 0 419 8 0 529	32.1 33.1 34.1 35.1 36.1 39.1 39.1 39.2 39.3 39.4 40.1 40.1 41.1 42.1 43.1 44.1

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Period: W			
		From 01/01/2023		
	Component CCN: 15-T059	To 12/31/2023	Date/lime Pre   5/29/2024 9:5	pared:
	Title XVIII	Cubaravi dan	5/29/2024 9: 5 PPS	4 alli
	TI LIE XVIII	Subprovi der -	PPS	
		I RF		
	<u> </u>		1. 00	
93.00 Time Value of Money (see instructions)			0	93.00
94.00 Total (sum of lines 91 and 93)			0	94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			-	200. 00

Health Financial Systems RANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/29/2024 9:54 am Provi der CCN: 15-0059

					5/29/2024 9: 54	4 am
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		9, 160, 35	3	14, 550, 454	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,				0	2.00
3. 00	write "NONE" or enter a zero 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					3. 00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2023	67, 56	8 12/31/2023	127, 820	3. 01
3. 02				O	0	3. 02
3. 03				O	0	3.03
3.04				O	0	3. 04
3.05			(	0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			O	0	3.50
3. 51				O	0	3. 51
3. 52				O	0	3. 52
3. 53				O	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		67, 56	8	127, 820	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		9, 227, 920	6	14, 678, 274	4.00
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR		I		1	F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			O	0	5. 01
5. 02	TERMINAL TO THOMBER			o O	l ol	5. 02
5. 03				0	l ol	5. 03
	Provider to Program			-		
5.50	TENTATIVE TO PROGRAM		(	O	0	5.50
5. 51				0	o	5. 51
5. 52				o O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(	ס	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		453, 430		116, 546	6. 01
6. 02	SETTLEMENT TO PROGRAM			o O	0	6. 02
7. 00	Total Medicare program liability (see instructions)		9, 681, 35	-	14, 794, 820	7. 00
	,		., 52., 66.	Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2.00	
	Name of Contractor					8. 00

Component CCN: 15-T059

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		4, 558, 06		529	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			0	0	3. 01
3. 02 3. 03				0	0 0	3. 02 3. 03
3. 04				0		3. 04
3. 05				0	O	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51 3. 52				0	0 0	3. 51 3. 52
3. 53				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, 558, 06	4	529	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		4, 556, 00	14	529	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T .	1	T	
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0 0	5. 02
5. 03	Provider to Program			U	0	5. 03
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		59, 06	2	118	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 499, 00		411	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems RIVERVIEW HO	SPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0059	Peri od:	Worksheet E-1	
			From 01/01/2023 To 12/31/2023		epared:
				5/29/2024 9:5	<u>4 am</u>
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 line	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 a	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 instruction	ns)		32.00

Health Financial Systems	RI VERVI EW HOSPI TAL	In Lieu	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2023	Worksheet E-3 Part III	
	Component CCN: 15-T059	To 12/31/2023	Date/Time Prep 5/29/2024 9:54	
	Title XVIII	Subprovi der -	PPS	
		I RF		

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	4, 287, 027	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0053	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	63, 448	3.00
4. 00	Outlier Payments	315, 326	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	10. 602740	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13. 00	Total PPS Payment (see instructions)	4, 665, 801	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)		15.00
16.00		0	16.00
17.00		4, 665, 801	17.00
18. 00 19. 00		0 4, 665, 801	18. 00 19. 00
20.00	, ,	73, 512	
21. 00		4, 592, 289	
22. 00	Coi nsurance	16, 800	
23. 00		4, 575, 489	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18, 866	
25.00		12, 263	1
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18, 866	26.00
27.00	Subtotal (sum of lines 23 and 25)	4, 587, 752	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	3, 066	•
30. 00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 98	Recovery of accelerated depreciation.	0	31. 98
31. 99 32. 00	Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions)	0 4, 590, 818	31. 99
32. 00	Sequestration adjustment (see instructions)	91, 816	
32. 02	Demonstration payment adjustment amount after sequestration	71, 010	32.02
33. 00		4, 558, 064	33.00
34. 00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-59, 062	35.00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	315, 326	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	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE COVID-19 PHE)		
99.00		0.000000	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

Health Financial Systems	RIVERVIEW HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0059	Peri od:	Worksheet E-3
		From 01/01/2023	

			From 01/01/2023 To 12/31/2023		
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		1, 357, 428		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, 357, 428	0	4. 00
5. 00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		1, 357, 428	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		1 421 005		0.00
8. 00 9. 00	Routine service charges		1, 421, 905	0	8. 00 9. 00
10. 00	Ancillary service charges Organ acquisition charges, net of revenue		2, 192, 806	U	10.00
	Incentive from target amount computation				11.00
	Total reasonable charges (sum of lines 8 through 11)		3, 614, 711	0	1
12.00	CUSTOMARY CHARGES		0,011,711		12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for	payment for services o	0	0	14.00
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
	Total customary charges (see instructions)		3, 614, 711	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	2, 257, 283	0	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line		0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)			0	19. 00
	Cost of physicians' services in a teaching hospital (see instr	cuctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		1, 357, 428	0	1
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				21.00
22. 00	Other than outlier payments	35p. 3134 131 113 p. 311	0	0	22.00
	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 357, 428	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				00.00
	Excess of reasonable cost (from line 18)		1 257 420	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		1, 357, 428	0	31.00
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)			0	34.00
	Utilization review			O	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	1, 357, 428	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	
38. 00	Subtotal (line 36 ± line 37)		1, 357, 428	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		O		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1, 357, 428	0	40.00
41.00	Interim payments		1, 472, 383	0	
42.00	Balance due provider/program (line 40 minus line 41)		-114, 955	0	1
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		l

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 01/01/2023	Worksheet E-3
	Component CCN: 15-T059		
	Title XIX	Subprovi der -	Cost

	li li	tle XIX	Subprovi der -	Cost	
			I RF	Outpotiont	
			Inpati ent 1.00	Outpati ent	
	DADT VILL CALCULATION OF DELMDLIDSEMENT ALL OTHER HEALTH SERVICES FO	D TITLES V OD VI		2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR COMPUTATION OF NET COST OF COVERED SERVICES	K IIILES V UK AI	A SERVICES		-
1. 00	Inpatient hospital/SNF/NF services		13, 044		1.00
2. 00	Medical and other services		13, 044	0	
3. 00	Organ acquisition (certified transplant programs only)		0	O	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		13, 044	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)		13, 044	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		94, 755		8. 00
9.00	Ancillary service charges		10, 992	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	3 ,		105, 747	0	12.00
	CUSTOMARY CHARGES	<u> </u>			
13. 00	Amount actually collected from patients liable for payment for service	es on a charge	0	0	13. 00
14 00	basis	for condice 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 §4		0	0	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	13. 13(e)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		105, 747	0.000000	
17. 00	Excess of customary charges over reasonable cost (complete only if lin	e 16 exceeds	92, 703	0	
17.00	line 4) (see instructions)	ic to exceeds	72, 703	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if lin	e 4 exceeds line	ol	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		13, 044	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete	d 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			13, 044	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
	Excess of reasonable cost (from line 18)		12 044	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		13, 044	0	
	Coi nsurance			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)		13, 044	0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
38. 00	Subtotal (line 36 ± line 37)		13, 044	0	1
			0	Ü	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		13, 044	0	
	Interim payments		43, 356	0	1
42.00	Balance due provider/program (line 40 minus line 41)		-30, 312	0	42.00
43.00		CMS 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 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 9:54	oared:
		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)					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 instr	ructions)		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 instruc	ctions)		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 | Period: From 01/01/20: To 12/31/20

oni y)				1270172020	5/29/2024 9:5	4 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3. 00	4.00	
1.00	Cash on hand in banks	7, 774, 333	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vable	0	0	0	0	3.00
4. 00 E. 00	Accounts receivable	121, 853, 926	1	0	0	4.00
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	15, 059, 550 -81, 181, 875	1	0		
7. 00	Inventory	8, 054, 723	1	0	0	
8. 00	Prepaid expenses	4, 191, 860	1	0	Ö	
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	75, 752, 517	0	0	0	11. 00
12 00	FIXED ASSETS Land	16, 050, 414	0	0	0	12.00
12. 00 13. 00	Land improvements	3, 469, 338	1	0		
14. 00	Accumulated depreciation	-4, 342, 210		0	Ö	
15.00	Bui I di ngs	166, 960, 514	1	0	0	15.00
16.00	Accumulated depreciation	-92, 128, 227	0	0	0	16.00
17. 00	Leasehold improvements	36, 505, 309		0	0	17. 00
18.00	Accumulated depreciation	-9, 370, 141	1	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	63, 091, 129 -39, 390, 704	1	0	0	19. 00 20. 00
21. 00	Automobiles and trucks	-39, 390, 704	0	0		•
22. 00	Accumulated depreciation		Ö	0	Ö	22.00
23. 00	Maj or movable equipment	127, 818, 612	0	0	0	23.00
24.00	Accumulated depreciation	-107, 853, 414	0	0	0	24.00
25. 00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00 29. 00	Accumul ated depreciation Minor equipment-nondepreciable		0	0	0 0	28. 00 29. 00
30.00	Total fixed assets (sum of lines 12-29)	160, 810, 620		0		•
	OTHER ASSETS					
31.00	Investments	48, 658, 235	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	70.007	0	0	0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	79, 827 48, 738, 062	1	0	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	285, 301, 199	1	0		36.00
00.00	CURRENT LIABILITIES	200,001,177	<u> </u>	<u> </u>		00.00
37.00	Accounts payable	10, 537, 281	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	10, 756, 379	0	0	0	38.00
39. 00	Payroll taxes payable	0	0	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	21, 364, 063		0	0	40. 00 41. 00
42. 00	Accel erated payments			U	l	42.00
43. 00	Due to other funds	149, 303, 743	0	0	0	•
	Other current liabilities	4, 969, 189	1	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	196, 930, 655	0	0	0	45.00
	LONG TERM LIABILITIES	1	1			
46.00	Mortgage payable Notes payable	41 007 400	0	0	0	•
47. 00 48. 00	Unsecured Loans	41, 827, 629	0	0	0	48.00
49. 00	Other long term liabilities	18, 074, 605		0	Ö	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	59, 902, 234		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	256, 832, 889	0	0	0	51.00
	CAPITAL ACCOUNTS		1			
52.00	General fund balance	28, 468, 310	1			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - unrestricted		•	0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	20.4/0.010		_	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	28, 468, 310 285, 301, 199	1	0	0	59. 00 60. 00
00.00	[59]	200, 301, 199		U	l	00.00
	1 '	1		l		'

Provider CCN: 15-0059

| Period: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/29/2024 9:5	
		General	Fund	Special P	urpose Fund	Endowment	
						Fund	
1 00		1. 00	2.00	3. 00	4. 00	5. 00	1 00
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		52, 004, 289 -23, 535, 995		0		1.00
2. 00 3. 00	Total (sum of line 1 and line 2)		-23, 535, 995 28, 468, 294				3.00
4. 00	ROUNDING	16	20, 400, 274			0	
5. 00	ROUNDING	0				0	
6. 00					o l	0	
7. 00		l o			o	0	
8.00		O			o i	0	
9.00		o			O	0	9. 00
10.00	Total additions (sum of line 4-9)		16		0		10.00
11. 00	Subtotal (line 3 plus line 10)		28, 468, 310	•	0		11.00
12. 00	Deductions (debit adjustments) (specify)	0			)	0	
13.00		0			)	0	
14. 00 15. 00		0		1		0	
16. 00		0		1		0	
17. 00						0	
18. 00	Total deductions (sum of lines 12-17)		0	`		O	18.00
19. 00	Fund balance at end of period per balance		28, 468, 310		o		19.00
	sheet (line 11 minus line 18)		.,,				
		Endowment	PI ant	Fund			
		Fund			_		
		6. 00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	0		(	)		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			O		3.00
4.00	ROUNDI NG		0				4.00
5.00			0				5. 00 6. 00
6. 00 7. 00			0				7.00
8. 00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	o	J		o		10.00
11. 00	Subtotal (line 3 plus line 10)	o					11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15. 00			0				15.00
16.00			0				16.00
17.00	Tatal daduations (sum of lines 10 17)		0	]			17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0		1	0		18. 00 19. 00
19.00	sheet (line 11 minus line 18)	١					19.00
							1

| Peri od: | Worksheet G-2 | From 01/01/2023 | Parts | & II | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0059

			To 12/31/2023	Date/Time Pre 5/29/2024 9:5	
	Cost Center Description	I npati ent	Outpati ent	Total	
		1, 00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				1
1.00	Hospi tal	48, 085, 7	94	48, 085, 794	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	6, 848, 8	37	6, 848, 837	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY		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)	54, 934, 6	31	54, 934, 631	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	11, 946, 9	36	11, 946, 986	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of	lines 11,946,9	36	11, 946, 986	16. 00
47.00	11-15)				47.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	66, 881, 6		66, 881, 617	17.00
18.00	Ancillary services	107, 814, 8		548, 814, 457	18.00
19.00	Outpati ent servi ces	6, 958, 2			
20.00	RURAL HEALTH CLINIC		0 0	_	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23. 00	AMBULANCE SERVICES		0	0	23.00
24. 00	CMHC				24.00
25. 00 26. 00	AMBULATORY SURGI CAL CENTER (D. P. ) HOSPI CE				25. 00 26. 00
27. 00	PHYSI CI AN PRACTI CE		0 66, 374, 427	66, 374, 427	27.00
27. 00	PROF FEES		0 37, 510, 927	37, 510, 927	
27. 01	DSH REVENUE		0 37, 510, 927		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 181,654,7			28.00
20.00	G-3, line 1)	101, 054, 7	033, 744, 300	037, 377, 142	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		295, 078, 964		29.00
30.00	ADD (SPECIFY)		0		30.00
31. 00			0		31.00
32. 00			0	•	32.00
33. 00			0	•	33.00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38.00			0		38.00
39.00			0		39. 00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfer	295, 078, 964		43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0059	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023		
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I,			837, 599, 142	l
2.00	Less contractual allowances and discounts on pat	ients' accounts		586, 760, 992	ı
3. 00	Net patient revenues (line 1 minus line 2)			250, 838, 150	ł
4. 00	Less total operating expenses (from Wkst. G-2, P			295, 078, 964	ł
5. 00	Net income from service to patients (line 3 minu	s line 4)		-44, 240, 814	5.00
	OTHER I NCOME			_	
6. 00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			4, 884, 956	1
8. 00	Revenues from telephone and other miscellaneous	communication services		0	
9. 00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
16. 00	Revenue from sale of medical and surgical suppli-	es to other than patients		0	16.00
	Revenue from sale of drugs to other than patient			0	17. 00
18. 00	Revenue from sale of medical records and abstrac	ts		0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.	)		0	19.00
	Revenue from gifts, flowers, coffee shops, and c	anteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			15, 760, 978	24.00
24.01	OTHER OPERATING REVENUE			58, 885	24. 01
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (sum of lines 6-24)			20, 704, 819	25.00
26 00	Total (line E plus line 25)			22 525 005	1 24 00

-23, 535, 995 29. 00

-23, 535, 995

95 26.00 0 27.00 0 28.00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Health	Financial Systems	RI VERVI EW HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0059	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD		<u> </u>	1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			625, 552	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			85, 804	1
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00	Total inpatient days divided by number of days in	n the cost reporting period (see ins	tructi ons)	40. 13	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instru			0.00	1
6. 00	Indirect medical education adjustment (multiply 1.01)(see instructions)	,	•	0	6.00
7. 00	Percentage of SSI recipient patient days to Media 30) (see instructions)	care Part A patient days (Worksheet	E, part A line	1. 19	7. 00
8.00	Percentage of Medicaid patient days to total days	s (see instructions)		19. 09	8.00
9.00	Sum of lines 7 and 8			20. 28	
10.00	Allowable disproportionate share percentage (see				10.00
	Disproportionate share adjustment (see instruction			26, 273	ł
12. 00	Total prospective capital payments (see instruct	ons)		737, 629	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see insti	ructions)		0	1.00
2. 00	Program inpatient ancillary capital cost (see in:	,		Ö	2.00
3. 00	Total inpatient program capital cost (line 1 plus			0	
4.00	Capital cost payment factor (see instructions)	•		0	4.00
5.00	Total inpatient program capital cost (line 3 x li	ine 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	,		0	2.00
3.00	Net program inpatient capital costs (line 1 minus			0	3.00
4. 00	Applicable exception percentage (see instructions			0. 00	
5.00	Capital cost for comparison to payments (line 3			0	5.00
6. 00	Percentage adjustment for extraordinary circumsta	,		0.00	
7.00	Adjustment to capital minimum payment level for		x line 6)	0	
8. 00 9. 00	Capital minimum payment level (line 5 plus line			0	
9. 00 10. 00	Current year capital payments (from Part I, line Current year comparison of capital minimum paymen		loce line ()	0	
11. 00	Carryover of accumulated capital minimum payment			0	
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level	to capital payments (line 10 plus li	no 11)	0	12.00
	Current year exception payment (if line 12 is pos			0	
	Carryover of accumulated capital minimum payment			0	
13.00	poarryover or accumurated capital mirrillium payment		ion owing period	ı	14.00
14. 00	(if line 12 is negative enter the amount on this	s line)			
	(iffine 12 is negative, enter the amount on this			0	15.00
14. 00 15. 00	(if line 12 is negative, enter the amount on this Current year allowable operating and capital pays Current year operating and capital costs (see insection)	ment (see instructions)		0	