This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-0186 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 10:37 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/26/2022 Time: 10:37 am use only ] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERSIDE MEDICAL CENTER (14-0186) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
	1 2 SI GNATURE STATEMENT				
1	Pa	tricia ViIt	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Patricia Vilt			2
3	Signatory Title	SENIOR VP & CHIEF ACCOUNTING OFFI			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	408, 499	-106, 762	0	0	1. 00
2.00 Subprovider - IPF	0	33, 657	0		0	2. 00
3.00 Subprovider - IRF	0	17, 162	0		0	3. 00
4. 00 SUBPROVI DER 1						4. 00
5.00 Swing Bed - SNF	0	0	0		0	5. 00
6.00 Swing Bed - NF	0				0	6. 00
9.00 HOME HEALTH AGENCY I	0	0	-1		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		9, 645		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200. 00 Total	0	459, 318	-97, 118	0	0	200. 00

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

Health Financial Systems RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0186 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 10:37 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 350 NORTH WALL STREET 1.00 PO Box: 1.00 2.00 City: KANKAKEE State: IL Zip Code: 60901 County: USA 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal RIVERSIDE MEDICAL 140186 28100 01/01/1966 Ν Р 0 3.00 1 CENTER RIVERSIDE MEDICAL Р 4.00 Subprovider - IPF 14S186 28100 01/01/2015 0 4 Ν 4.00 CENTER - PSY 5.00 Subprovider - IRF RIVERSIDE MEDICAL 14T186 28100 01/01/1984 Ν Ρ 0 5.00 CENTER - RHB 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10 00 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA RIVERSIDE MEDICAL 147400 28100 01/01/1984 Р Ν 12.00 12.00 Ν CENTER - HHA 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC PEMBROKE RURAL HEALTH 143976 28100 01/01/1987 N 0 N 15.00 CLINIC Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 20.00 12/31/2021 21.00 Type of Control (see instructions) 21.00 2 3.00 1.00 2. 00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N 22. 00 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to N Ν N 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ГА	Provi der C	CN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/26/2022 10:	pared
			NAHE 413.89 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3.00	
.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (se umn 1. R) NAHE mn 2.	ee If column 1 MA payment	Y	Υ		60. (
.01    If line 60 is yes, complete columns 2 and 3 for each instructions)	y/N	IME	Direct GME	23. 00	Direct GME	60. (
	.,		31.00t ome		511 001 0m2	
	1.00	2. 00	3. 00	4.00	5.00	
.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61. (
.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. (
.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.
.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
.06 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	Pro	gram Name	Program Cod		Unweighted Direct GME FTE Count	
		1.00	2. 00	3.00	4.00	
.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0.00	0.00	61.
FTE unweighted count.  20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0. 00	61.
the direct GME FTE unweighted count.					1.00	
ACA Provisions Affecting the Health Resources and Ser				ariad for which		(2)
<ul><li>.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction.</li><li>.01 Enter the number of FTE residents that rotated from a</li></ul>	tions)					62. 62.
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ram. (se	<u>ee instructio</u>				

Health Financial Systems	RI VERSI	DE MEDICAL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CC		eriod: rom 01/01/2021	Worksheet S-2 Part I Date/Time Prep 5/26/2022 10:3	pared:
			Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2.00	3.00	
Section 5504 of the ACA Base Yea	ar FTE Residents in No	onprovider Settings				
period that begins on or after s 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to re settings. Enter in column 2 the resident FTEs that trained in ye of (column 1 divided by (column	July 1, 2009 and before yes, or your facilit haber of unweighted nor brattions occurring in the number of unweighted our hospital. Enter in	re June 30, 2010.  ry trained residents  -primary care all nonprovider inon-primary care column 3 the ratio	0.00			64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
	-	- C	FTEs Nonprovi der Si te	FTES in Hospital	(col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col. 1/	65. 00
			Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Current		n Nonprovider Settings	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of		ny aona maaidant	0.00	. 41	0. 000000	<i>((</i> 00
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divid	occurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	6. 41	0.00000	66.00
	Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
			Si te		.,,	
	1.00	2.00	3. 00	4. 00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	INTERNAL MEDICINE		0.00	14. 92	2. 0.000000	67. 00

	applif cable column.			I
	If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00 Y	0. 00 Y	97. 00 98. 00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	Y	Y	98.00
	column 1 for title V, and in column 2 for title XIX.			
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	Υ	Y	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for			
	title XIX.			
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	Υ	Y	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1			
	for title V, and in column 2 for title XIX.			
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N	N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1			
	for title V, and in column 2 for title XIX.			
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and			
	in column 2 for title XIX.			
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	Υ	Υ	98. 05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
	column 2 for title XIX.			
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Υ	Y	98. 06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
	column 2 for title XIX.			
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105. 00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		106. 00
	for outpatient services? (see instructions)			
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R	N		107. 00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)			
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an			
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?			
	Enter "Y" for yes or "N" for no in column 2. (see instructions)			

	Provi der C		eri od:	Worksheet S-	2
			rom 01/01/2021 o 12/31/2021	Part I Date/Time Pr	
			V	5/26/2022 10 XI X	: 37 a
			1. 00	2.00	1
08.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N		108.
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2.00	3.00	4.00	1
19.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109
				1.00	+
0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. It	f yes,	N	110
			1 00	2.00	4
1.00  f this facility qualifies as a CAH, did it participate in t	he Frontier (	Community	1. 00 N	2.00	111
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dumn 1 is Y, ticipating ir	period? Enter enter the column 2.	·		
		1. 00	2. 00	3.00	+
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	peri od? 5 "Y", enter ne	N			112
Miscellaneous Cost Reporting Information		N.			
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 3" percent includes	N			0115
5.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116
7.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no. 3.00 Is the malpractice insurance a claims-made or occurrence pol		N			117
if the policy is claim-made. Enter 2 if the policy is occurr		Premi ums	Losses	Insurance	
		T T Gill Ullis	203363	Trisui ance	
		1. 00	2.00	3. 00	4
3.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118
3.01 List amounts of malpractice premiums and paid losses:			0		0118
	center other	(			
3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.		than the	1.00		118
Administrative and General? If yes, submit supporting sched and amounts contained therein.  OOD NOT USE THIS LINE  OOS 3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quelid Hold Harmless provision in ACA §3121 and applicable amendments?	lule listing of Harmless pro n column 1, "Y nalifies for t	than the cost centers ovision in ACA for yes or the Outpatient	1.00		118
Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  O OD NOT USE THIS LINE  O OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Column 2, "Y" for yes or "N" for no.	lule listing of Harmless pro n column 1, "Y Halifies for t tts? (see inst	than the post centers  wision in ACA for yes or the Outpatient ructions)	1. 00 N	2.00	118
Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  OOD NOT USE THIS LINE  OOD IS this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that question Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.  OD Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.  OD Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	lule listing of the listing of the list of	than the cost centers  vision in ACA "for yes or he Outpatient ructions) es charged to  (w) (3) of the	1. 00 N	2.00	118 119 120
Administrative and General? If yes, submit supporting sched and amounts contained therein.  ODD NOT USE THIS LINE  OD Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold §3121 and applicable amendments. The interior of the interior o	lule listing of Harmless produced in column 1, "Yealifies for this? (see instantable deviced in §1903 is "Y", enter	than the post centers  wision in ACA for yes or the Outpatient pructions)  es charged to  f(w)(3) of the prin column 2	0 0 0 N N N Y	2.00	118 119 120 121
Administrative and General? If yes, submit supporting sched and amounts contained therein.  O ODD NOT USE THIS LINE  O OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that queried Hold Harmless provision in ACA §3121 and applicable amendments.  O OD Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.  O OD Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  O OD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	Harmless produced in the column 1, "Yell if its? (see instantable deviced in \$1903 is "Y", enter the certi	than the cost centers  vision in ACA "for yes or he Outpatient ructions) es charged to  s(w)(3) of the er in column 2	0 0 0 N N N N N N N N N N N N N N N N N	2.00	118 119 120 122 122
Administrative and General? If yes, submit supporting sched and amounts contained therein.  O OD NOT USE THIS LINE  O OOI Sthis a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questioned Hold Harmless provision in ACA §3121 and applicable amendments. There in column 2, "Y" for yes or "N" for no.  O OD Id this facility incur and report costs for high cost implations. On the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no.  O OD Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  O OD Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	Harmless produced in the column 1, "Y halifies for the column 1, "Y halifies for the column 1, "Y halifies for the column 1, "Y", enter the certical in the ce	than the cost centers  ovision in ACA "for yes or the Outpatient ructions) es charged to see in column 2  for no. If	0 0 0 N N N N N N N N N N N N N N N N N	2.00	118 119 120 122 125 126
Administrative and General? If yes, submit supporting sched and amounts contained therein.  O OD NOT USE THIS LINE  O OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questioned Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no.  O Did this facility incur and report costs for high cost implational patients? Enter "Y" for yes or "N" for no.  O Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  O Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  O O If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2	Harmless produced in column 1, "Y ladifies for this? (see instantable deviced in §1903 is "Y", enter the certificant in the cer	than the cost centers  wision in ACA for yes or the Outpatient ructions)  es charged to  for no. If  fication date	0 0 0 N N N N N N N N N N N N N N N N N	2.00	118 119 120 121 122 128 126
and amounts contained therein.  9.00 DO NOT USE THIS LINE  0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.  1.00 Did this facility incur and report costs for high cost implationable apatients? Enter "Y" for yes or "N" for no.  2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2.  7.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2.  8.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2.	Harmless produced in column 1, "Yell if its? (see instantable deviced in \$1903 is "Y", enterproved and "N" or yes and "N" of the certification in the certif	than the cost centers  vision in ACA "for yes or he Outpatient ructions) es charged to s(w)(3) of the er in column 2  for no. If fication date fication date	N N N	2.00	118 118 120 121 122 126 127 128
8. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9. 00 DO NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 no oll f this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 no oll f this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 no oll f this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 no oll f this is a Medicare certified liver transplant center, entin column 2 no oll f this is a Medicare certified liver transplant center, entin column 2 no oll f this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 no oll f this is a Medicare certified liver transplant center, entin column 2 no determination date, if applicable, in column 2 no oll f this is a Medicare certified liver transplant center, entin column 2 no determination date, if applicable, in column 2 no determination date, if applicable no oll manual center no oll manu	Harmless produced in column 1, "Y halifies for the sering of the certificer the certification of the certificat	than the post centers  Avision in ACA Toryes or he Outpatient ructions) The Scharged to second of the post of the	N N N	2.00	118 119 120 121 122 122 120 121

alth Financial Systems  SPITAL AND HOSPITAL HEALTH CARE COMPLE:	RIVERSIDE ME X IDENTIFICATION DATA	Provider CC	N: 14-0186	Peri od:		worksheet S-2	
				From O	1/01/2021 2/31/2021	Part I Date/Time Pro 5/26/2022 10:	
					1. 00	2.00	-
1.00 If this is a Medicare certified in			rti fi cati or		1.00	2.00	131.
date in column 1 and termination d 2.00 If this is a Medicare certified is in column 1 and termination date,	let transplant center, e	nter the certifi	cation date	e			132.
3.00 Removed and reserved 4.00 If this is an organ procurement or	ganization (OPO), enter		n column 1				133. 134.
and termination date, if applicabl All Providers							
0.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home	office cost	ts	N		140.
1.00	2.	00		nome and	3.00	of the	
If this facility is part of a chai home office and enter the home off				name and	address	or the	
1. 00 Name:	Contractor's Name:		Contrac	ctor's Nu	mber:		141.
2. 00 Street: 3. 00 Ci ty:	PO Box: State:		Zi p Coo	le:			142. 143.
						1.00	-
4.00 Are provider based physicians' cos	ts included in Worksheet	A?				Y	144.
					1. 00	2.00	+
5.00 olf costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility incomperiod? Enter "Y" for yes or "N"	for yes or "N" for no i Lude Medicare utilization	n column 1. If c	olumn 1 is		1. 00	2.00	145.
o.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the previ- column 1. (See CMS Pub.			f	N		146
						1.00	
7.00 Was there a change in the statisti 3.00 Was there a change in the order of						N N	147. 148.
9.00 Was there a change to the simplifi				or no.		N	149.
		Part A 1.00	Part B 2.00		itle V 3.00	Title XIX 4.00	4
Does this facility contain a provi		n exemption from	n the appli	cation of	the low	er of costs	
or charges? Enter "Y" for yes or " 5.00Hospital	N" Tor no Tor each compo	N N	and Part B	. (See 42	V CFR 9413 N	3. 13) N	 155.
5. 00 Subprovi der – IPF		N	N		N	N	156
7.00 Subprovider - IRF 3.00 SUBPROVIDER		N	N		N	N	157 158
2. 00 SNF		N	N		N	N	159.
D. OO HOME HEALTH AGENCY		N	N		N	N	160.
1. 00 CMHC 1. 10 CORF			N N		N N	N N	161 161
						1.00	-
Multicampus  5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has o	ne or more campu	ises in diff	erent CB	SAs?	N	165.
	Name O	County		Zip Code	CBSA	FTE/Campus	
5.00 If line 165 is yes, for each	U	1. 00	2. 00	3. 00	4. 00	5.00	0 166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	
Health Information Technology (HIT	under §1886(n)? Enter	"Y" for yes or "	N" for no.			Y	167.
3.00  f this provider is a CAH (line 10  reasonable cost incurred for the H	IT assets (see instructi	ons)					168. 168.
		oo +bio ! !	and terro				
3.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)? 0.00 If this provider is a meaningful u	'Enter "Y" for yes or "N	" for no. (see i	nstructions	s)	•		9169

Health Financial Systems	RIVERSIDE MEDICAL CENTER			eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN				Worksheet S-2	2
			From 01/01/202		
			To 12/31/202		epared:
				5/26/2022 10:	37 am
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in					171. 00
section 1876 Medicare cost plans reporte	d on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1.	lf column 1 is yes, er	nter the number of section	on		
1876 Medicare days in column 2. (see ins					

	Financial Systems RIVERSIDE MED AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Peri od:	wof Form CMS- Worksheet S-2	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	epared
				Y/N		: 37 ar
				1. 00		
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	sponses. Enter			
	mm/dd/yyyy format.		<u> </u>			
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.
,0	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)	IN		''
	reporting period. It yes, enter the date of the change in t	50. diii. 2. (555	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N			2.
	voluntary or "I" for involuntary.					
0	Is the provider involved in business transactions, includir	ng management	N			3
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other relationships? (see instructions)	er similar				
	Terationships: (see matractions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
0	Column 1: Were the financial statements prepared by a Cert		Υ	Α		4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	arrabre in				
0	Are the cost report total expenses and total revenues diffe	erent from	N			5
	those on the filed financial statements? If yes, submit red					
				Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column	2. If you is	the provider	N		6.
0	is the legal operator of the program?	z. II yes, Is	the provider	IN		0
0	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Υ		7.
0	Were nursing programs and/or allied health programs approve		ved during the	Υ	•	8
	cost reporting period? If yes, see instructions.					
0	Are costs claimed for Interns and Residents in an approved		cal education	Υ		9
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		ho current	Υ		10
00	cost reporting period? If yes, see instructions.	n renewed in t	.ne current	1		10
00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Dad Dabta				Date 2.00 the    V/I 3.00    Date 3.00    Legal Oper. 2.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	-i one		V	12
00	If line 12 is yes, did the provider's bad debt collection p			st reporting		13
00	period? If yes, submit copy.	or roy or ango o	idi ing tina aat	or ropor aring		
00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see inst	tructi ons.	N	14
	Bed Complement					
00	Did total beds available change from the prior cost reporti					15
		Y/N	t A Date	Y/N		_
		1.00	2.00	3. 00	Date 2.00 he  V/I 3.00  Legal Oper. 2.00  Y/N 1.00  Y N N N N N N N N N N N N N N N N N N	
	PS&R Data					
00	Was the cost report prepared using the PS&R Report only?	N		N		16
	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)					
00	Was the cost report prepared using the PS&R Report for	Y	04/19/2022	Υ	04/19/2022	17
50	totals and the provider's records for allocation? If		0171772022	•	0171772022	''
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)		1			
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18
00	Report data for additional claims that have been billed					
00	had an and the body and the DOAD Date of the City of the	1	I			
00	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.	N		N		19
00		N		N		19

Heal th	Financial Systems RIVERSIDE MED	DICAL CENTER		In Lie	u of Form CMS	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCI	N: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet Sapart II Date/Time Pi 5/26/2022 10	repared:
		Descrip	oti on	Y/N	Y/N	3. 37 dili
		0		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4. 00	21. 00
	records? If yes, see instructions.					200
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HO	SPI TALS)			
22.00	Capital Related Cost	a i notrupti ono				22. 00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		ls made dur	ing the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during t	his cost re	porting period?		24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ing period?	If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reportin	g period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporting	period? If	yes, submit		27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	ntered into duri	ng the cost	reporti ng		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		t Service R	eserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructions urity with new d	ebt? If yes	, see		30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new d	ebt? If yes	, see		31. 00
32. 00	Purchased Services  Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	uctions.	-			32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appno, see instructions.	olied pertaining	to competi	tive bidding? If		33. 00
24.00	Provi der-Based Physicians	anangamant with	nnovi don ho	Code lo loved a boo		24.00
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	· ·	•	. ,		34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		s with the			35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36 00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been pr	repared by the h	ome office?			37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office? I	f yes, see	N		40. 00
		1.0	0	2.	00	
41.00	Cost Report Preparer Contact Information					44.00
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.	RI CHARD		SCHI LTZ		41.00
42. 00	Enter the employer/company name of the cost report preparer.	RIVERSIDE MEDIC	AL CENTER			42. 00
43. 00		8159357256 X349	2	RPSCHI LTZ@RHC. I	NET	43. 00

Health Financial Systems	RIVERSIDE MED	DICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIM	BURSEMENT QUESTI ONNAI RE	Provi der CCN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/26/2022 10:	pared:
		3.00			
Cost Report Preparer Contact Inf	formation				
41.00 Enter the first name, last name held by the cost report preparer respectively.		DIRECTOR OF FINANCE			41. 00
42.00 Enter the employer/company name preparer.	of the cost report				42.00
43.00 Enter the telephone number and ereport preparer in columns 1 and					43. 00

Health Financial Systems RIVERSI
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: | Provider CCN: 14-0186

				'	0 12/31/2021	5/26/2022 10:3	
						I/P Days / 0/P	37 dili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	· · · · ·	Line Number		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	225	82, 125	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		225	82, 125	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	_				8. 00
9.00	CORONARY CARE UNIT	32. 00	13	4, 745	0.00	0	9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		256	93, 440	0.00		14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00				0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00				0	17. 00
18. 00	SUBPROVI DER	42. 00	0	C	)	0	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	404.00					21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE	20.00					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	00.40					25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		300				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0				31.00
32.00	Labor & delivery days (see instructions)		0		1		32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 00
33. 01	121011 of to floati air days and air sonai ges	I	ı	I	T.	1	55.01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: Provider CCN: 14-0186

				T	o 12/31/2021	Date/Time Pre 5/26/2022 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	37 dili	
	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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 544	3, 029	41, 729			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds)	7, 032	11 //2				2. 00
3. 00	HMO and other (see instructions) HMO IPF Subprovider	7,032	11, 663 0				3.00
4. 00	HMO IRF Subprovider	0	319				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	o <sub>l</sub>	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	12, 544	3, 029	Ĭ			7. 00
7.00	beds) (see instructions)	12, 011	0,027	11, ,2,			7.00
8.00	INTENSIVE CARE UNIT	1, 565	302	4, 159			8. 00
9.00	CORONARY CARE UNIT	0	0	0			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		132	1, 818			13.00
14.00	Total (see instructions)	14, 109	3, 463	47, 706	21. 33	1, 999. 57	14.00
15.00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF	1, 499	257	3, 118			16. 00
17. 00	SUBPROVI DER - I RF	6, 142	143	8, 505			
18. 00	SUBPROVI DER		0	0	0.00	0.00	
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE	44 400	4 000				21. 00
22. 00	HOME HEALTH AGENCY	11, 432	1, 299	19, 440	0.00	36. 31	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE			_			24. 00
24. 10 25. 00	HOSPICE (non-distinct part)			0			24. 10 25. 00
25. 00	CMHC - CMHC CMHC - CORF	0	0	0	0.00	0.00	
26. 00	RURAL HEALTH CLINIC	191	0	1, 834			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	171	0				
27. 00	Total (sum of lines 14-26)	S S	J		21. 33		27. 00
28. 00	Observation Bed Days		501	2, 609		2, 100. 77	28. 00
29. 00	Ambulance Trips	2, 816	00.	2,00,			29. 00
30. 00	Employee discount days (see instruction)	_, _,		0			30. 00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	194	329			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	О					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: Provider CCN: 14-0186

				To	12/31/2021	Date/Time Prep 5/26/2022 10:	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1 00		11. 00	12.00	13.00	14. 00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	3, 342	2, 280	9, 521	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)			1, 343	0		2. 00
3. 00	HMO IPF Subprovider			1, 343	0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				U		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	C	3, 342	2, 280	9, 521	14. 00
15. 00	CAH visits			, , , , ,	,	,	15. 00
16.00	SUBPROVI DER - I PF	0. 00	C	118	11	226	16. 00
17.00	SUBPROVI DER - I RF	0.00	C	537	40	753	17. 00
18.00	SUBPROVI DER	0. 00	C		0	0	18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			0			33. 00
	LTCH non-covered days LTCH site neutral days and discharges			0			33. 00
33.01	Lion of te fleutral days and discharges	1		١	ı		55.01

Provider CCN: 14-0186

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Pre

							5/26/2022 10:	pared: 37 am
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200. 00	168, 712, 246	3, 761, 592	172, 473, 838	4, 257, 382. 00	40. 51	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	С	0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	С	0.00	0. 00	3.00
4. 00	B Physician-Part A -		0	0	С	0.00	0. 00	4.00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0 440, 303	0	1	0. 00 1, 911. 00		
6. 00	Physician-Part B Non-physician-Part B for		66, 011	0				
	hospital-based RHC and FQHC services		·		·			
7. 00	Interns & residents (in an approved program)	21. 00	1, 739, 937	0	1, 739, 937	55, 246. 00	31. 49	7. 00
7. 01	Contracted interns and residents (in an approved		0	О	С	0.00	0.00	7. 01
8.00	programs) Home office and/or related		0	0	С	0.00	0. 00	8. 00
9.00	organization personnel SNF	44. 00	0	0	000 (74	0.00		
10. 00	Excluded area salaries (see instructions)		65, 550, 649	470, 025	66, 020, 674	1, 079, 264. 00	61. 17	10.00
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		1, 280, 667	0	1, 280, 667	13, 799. 00	92. 81	11. 00
12. 00	Contract Labor: Top Level		381, 216	0	381, 216	7, 616. 00	50. 05	12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	С	0.00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	0	С	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		0	0	C	0.00	0.00	14. 01
14. 02	Related organization salaries		0	Ō	C	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	_				
16. 00	Home office and Contract Physicians Part A - Teaching		0	_				16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	C	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	С	0.00	0. 00	16. 02
17. 00	Wage-related costs (core) (see instructions)		26, 502, 082	0	26, 502, 082			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		9, 175, 128	0	9, 175, 128			19. 00 20. 00
	A Non-physician anesthetist Part		0	0				21.00
	B Physician Part A -		0	0				22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	C			22. 01
23. 00	Physician Part B		16, 244					23. 00
	Interns & residents (in an		30, 075 469, 665	l e				24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	С			25. 50
25. 51	(core) Related organization		0	0	С			25. 51
25. 52			0	0	C			25. 52
	- Administrative -							

					Т	o 12/31/2021	Date/Time Prep 5/26/2022 10:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	,		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE		0.47.540		7// 100	04 700 00	05.03	
26. 00	Employee Benefits Department	4. 00	-347, 568					26. 00
27. 00	Administrative & General	5. 00	24, 739, 512					27. 00
28. 00	Administrative & General under contract (see inst.)		421, 966	0	421, 966	2, 417. 00	174. 58	28. 00
29. 00	Maintenance & Repairs	6. 00	1, 770, 109	31, 013	1, 801, 122	77, 409. 00	23. 27	29. 00
30. 00	Operation of Plant	7. 00	704, 097					30. 00
31. 00	Laundry & Linen Service	8. 00	568, 382					31. 00
32. 00	Housekeepi ng	9. 00	2, 139, 001	33, 879				32. 00
33.00	Housekeeping under contract		131, 124	0	131, 124			33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 453, 345	-749, 962	703, 383	39, 323. 00	17. 89	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	769, 238	769, 238	44, 216. 00		36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	2, 652, 009	-1, 998, 212	653, 797	26, 940. 00	24. 27	38.00
39.00	Central Services and Supply	14. 00	525, 650	16, 621	542, 271	28, 106. 00	19. 29	39.00
40.00	Pharmacy	15. 00	3, 350, 086	-3, 350, 086	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	1, 734, 059	41, 156	1, 775, 215	63, 582. 00	27. 92	41.00
	Records Library							
42.00	Social Service	17. 00	2, 506, 895	-976, 462	1, 530, 433			42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: | To 12/31/202 Provider CCN: 14-0186

					'	0 12/01/2021	5/26/2022 10: 3	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		167, 019, 085	3, 761, 592	170, 780, 677	4, 201, 664. 00	40. 65	1.00
	instructions)							
2.00	Excluded area salaries (see		65, 550, 649	470, 025	66, 020, 674	1, 079, 264. 00	61. 17	2.00
	instructions)							
3.00	Subtotal salaries (line 1		101, 468, 436	3, 291, 567	104, 760, 003	3, 122, 400. 00	33. 55	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 661, 883	0	1, 661, 883	21, 415. 00	77. 60	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 502, 082	0	26, 502, 082	0.00	25. 30	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		129, 632, 401	3, 291, 567	132, 923, 968	3, 143, 815. 00	42. 28	6. 00
7.00	Total overhead cost (see		42, 348, 667	-2, 250, 544	40, 098, 123	1, 308, 493. 00	30. 64	7.00
	instructions)							

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lieu of Form CMS-2552-10			
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 14-0186	Peri od:	Worksheet S-3		
		From 01/01/2021			
			Part IV		

	To 12/31/2021	Date/Time Prep 5/26/2022 10:3	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	5, 845, 011	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	17, 414, 397	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	194, 513	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	299, 148	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	625, 508	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	674, 369	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	10, 822, 784	
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	192, 000	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	125, 464	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	36, 193, 194	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0186	Peri od: Worksheet S-3 From 01/01/2021 Part V			

		To	12/31/2021	Date/Time Prep 5/26/2022 10:	
	Cost Center Description		Contract Labor		37 alli
	Social Social Priming		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		1, 280, 667	36, 193, 194	1. 00
2.00	Hospi tal		1, 280, 667	36, 193, 194	2. 00
3.00	Subprovi der - IPF		0	0	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	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12.00	Separately Certified ASC				12.00
	Hospi tal -Based Hospi ce				13. 00
14. 00	Hospital-Based Health Clinic RHC		0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC				16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
	Renal Dialysis				17. 00
18. 00	Other		0	0	18. 00

Heal th	Financial Systems	RIVERSIDE MED	OLCAL CENTER		In Lie	eu of Form CMS-:	2552-10
HOME H	HEALTH AGENCY STATISTICAL DATA		Provider C	CN: 14-0186	Period: From 01/01/2021	Worksheet S-4	
			Component	CCN: 14-7400	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
					Home Health Agency I	PPS	
						20	
0. 00	County				KANKAKEE	00	0. 00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00				•	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
		(	)	1. 00	2.00	3.00	
2.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						2.00
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0. 00	0. 0 0. 0		•	
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			11. 1 12. 8		1	
7. 00	Nursi ng Supervi sor			0.0			
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			9. 4		1	8. 00 9. 00
10.00	Occupational Therapy Service			1.5	0.00	1.50	10. 00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0		•	
13.00	Speech Pathology Supervisor			0.0	0.00	0.00	13. 00
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 5			1
16. 00	Home Health Aide			0. 7	0.00	0. 78	16. 00
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0.0		•	1
757.55	(	<u> </u>				CBSA Data	
	HOME HEALTH AGENCY CBSA CODES					1.00	
19. 00 20. 00	Enter in column 1 the number of CBSAs where List those CBSA code(s) in column 1 serviced					3 16984	19. 00 20. 00
	first code).	during this co	ost reporting p	Jerrou (Trile 2	o contains the		
20. 01 20. 02						28100 99914	20. 01 20. 02
			oisodes With Outliers	IIIPA Enisode	s PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
	PPS ACTIVITY DATA	1. 00	2.00	3.00	4. 00	5. 00	
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	4, 568 1, 291, 269					
23. 00	Physical Therapy Visits	3, 972		1	58 5	4, 788	1
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	1, 197, 671 353	225, 119 246		1, 460 3 0	1, 441, 712 602	
26. 00	Occupational Therapy Visit Charges	107, 364	72, 768	90		181, 035	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	14 4, 196	l e	1	0 0		27. 00 28. 00
29. 00	Medical Social Service Visits	13	1		0 0	14	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	3, 859 543			0 0 1	4, 151 761	30. 00 31. 00
32. 00	Home Health Aide Visit Charges	66, 224	26, 100	24	14 120	92, 688	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	9, 463	1, 711	23	21	11, 432	33. 00
34.00	Other Charges	0 470 500	460 100	1	0 0		1
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2, 670, 583					
36. 00	Total Number of Episodes (standard/non outlier)	1, 103		13	5	1, 245	36. 00
37. 00	Total Number of Outlier Episodes	10 /5/	86		0		1
38. 00	Total Non-Routine Medical Supply Charges	12, 656	762	98	85 44	14, 44/	38. 00

Heal th	Financial Systems	RIVERSIDE MED	OLCAL CENTER		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA	-	Provi der C	CN: 14-0186	Peri od:	Worksheet S-8	
			Component	CCN: 14-3976	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	
					RHC I	Cost	37 diii
					1.	00	
1 00	Clinic Address and Identification				3400 SOUTH MAI	N CT	1 1 00
1.00	Street		Ci	ty	State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		HOPKINS PARK			60944	2. 00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rura	d or "II" for i	ırhan		1.00	2 00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - EITE	ei k ioi iuia	11 01 0 101 0		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4. 00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS ACT)					6. 00 7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
				•			
					1. 00	2. 00	
10. 00	Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of c	other operation	s in column	N	C	10.00
	Tiour 5, 7	Sun	day	N	Monday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1) CLINIC		I	08: 30	17: 00	08: 30	11 00
11.00	I CELINI C			06. 30	17.00	06. 30	11. 00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section on 2 the	N N	C	12.00 13.00
				Prov	ider name	CCN number	
					1. 00	2.00	
14. 00	RHC/FQHC name, CCN number	N/ /N	I v	NO // 1 1	VIV	T	14. 00
		Y/N 1.00	V 2.00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				4.00	3.00	15. 00
				inty			
2.00	City Ctata 71D Cada C			00			0.65
2. 00	City, State, ZIP Code, County	Tuesday	KANKAKEE Wedn	esday	Thur	sday	2. 00
		to	from	to	from	to	
		6.00	7. 00	8. 00	9. 00	10.00	
	Facility hours of operations (1)						
11. 00	CLINIC	17: 00			08: 30	17: 00	11. 00

Health Financial Systems	RIVERSIDE MED	I CAL CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0186	Peri od:	Worksheet S-8	
				From 01/01/2021		
		Component	CCN: 14-3976	To 12/31/2021	Date/Time Pre	
					5/26/2022 10:	37 am_
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 30	17: 00				11. 00

Heal th	Financial Systems RIVERSIDE MEDICA	AL CENTER		In lie	u of Form CMS-2	2552-10			
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN:	14-0186	Peri od:	Worksheet S-10				
				From 01/01/2021 To 12/31/2021	Date/Time Pre				
					5/26/2022 10:				
					1. 00				
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line	202 column	8)	0. 202808	1. 00			
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid				44, 894, 407	2. 00			
3. 00	Did you receive DSH or supplemental payments from Medicaid?				44, 694, 407 Y	3. 00			
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	ntal payments i	from Medica	i d?	Ϋ́	4. 00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments t	from Medicaid			0	5. 00			
6.00	Medicaid charges				230, 047, 187	6. 00			
7.00	Medicaid cost (line 1 times line 6)	(line 7 minus	oum of lin	oo O and E. i.f.	46, 655, 410				
8. 00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(Time / minus	Sulli 01 1111	es z and 5; ii	1, 761, 003	8. 00			
	Children's Health Insurance Program (CHIP) (see instructions for each line)								
9.00	Net revenue from stand-alone CHIP				0	9. 00			
10.00	Stand-al one CHIP charges				0	10.00			
11. 00	Stand-alone CHIP cost (line 1 times line 10)	(line 11 minus	alina O. i	F . zono +bon	0				
12. 00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(Tine II minus	STITLE 9; T	i < zero then	U	12. 00			
	Other state or local government indigent care program (see ins	structions for	each line)						
13.00	Net revenue from state or local indigent care program (Not in	cluded on lines	s 2, 5 or 9		0	13. 00			
14. 00	Charges for patients covered under state or local indigent can	re program (No	t included	in lines 6 or	0	14. 00			
15. 00	10)  State or local indigent care program cost (line 1 times line 1	1.4.)			0	15. 00			
16. 00	Difference between net revenue and costs for state or local in		rogram (lin	e 15 minus line	0	16. 00			
	13; if < zero then enter zero)	g p.	9 (		_				
	Grants, donations and total unreimbursed cost for Medicaid, Chinstructions for each line)	HIP and state/I	local indig	ent care program	ns (see				
17. 00	Private grants, donations, or endowment income restricted to 1				0	17. 00			
18. 00	Government grants, appropriations or transfers for support of				0	18. 00			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	al indigent car	re programs	(sum of lines	1, 761, 003	19. 00			
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
			1. 00	2. 00	3. 00				
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	acility	11, 286, 64	2 4, 454, 582	15, 741, 224	20. 00			
20.00	(see instructions)	derrity	11, 200, 04	2 4, 454, 502	15, 741, 224	20.00			
21. 00	Cost of patients approved for charity care and uninsured disco	ounts (see	2, 289, 02	1 4, 454, 582	6, 743, 603	21. 00			
22.00	instructions)	66				22.00			
22. 00	Payments received from patients for amounts previously written charity care	n off as		0	0	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)		2, 289, 02	1 4, 454, 582	6, 743, 603	23. 00			
					4 00				
24. 00	Does the amount on line 20 column 2, include charges for patie	ant days hoven	d a Longth	of stay limit	1. 00 N	24. 00			
24.00	imposed on patients covered by Medicaid or other indigent care		u a rengtii	or stay iriii t	IN	24.00			
25. 00	If line 24 is yes, enter the charges for patient days beyond stay limit		are program	s length of	0	25. 00			
26. 00	Total bad debt expense for the entire hospital complex (see in	nstructions)			17, 754, 158	26. 00			
27. 00	Medicare reimbursable bad debts for the entire hospital comple		ctions)		1, 181, 416				
27. 01	Medicare allowable bad debts for the entire hospital complex	(see instructio	ons)		1, 817, 563				
28. 00	Non-Medicare bad debt expense (see instructions)				15, 936, 595				
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex Cost of uncompensated care (line 23 column 3 plus line 29)	xpense (see ins	structions)		3, 868, 216 10, 611, 819				
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			12, 372, 822				
2	,	/			, 5, _, 522				

Heal th	n Financial Systems	RIVERSIDE MEDICA	L CENTER		In Lie	u of Form CMS-2	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	)F EXPENSES	Provi der CO		Peri od:	Worksheet A	
					From 01/01/2021 Fo 12/31/2021	Date/Time Pre	narod:
					10 12/31/2021	5/26/2022 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
	OFNEDAL CEDILLOS COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT		20 227 420	20, 336, 43	E42 10E	20 070 (22	1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT		20, 336, 438 9, 447, 747	9, 447, 74			1
3.00	00300 OTHER CAP REL COSTS		7, 447, 747 O		0	9, 001, 030	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-347, 568	39, 506, 623	39, 159, 05	-	37, 354, 593	
5. 01	01160 COMMUNI CATI ONS	0	0	01, 101, 10	942, 765	942, 765	
5.02	00550 DATA PROCESSING	3, 672, 905	7, 037, 994	10, 710, 89 <sup>e</sup>	133, 367	10, 844, 266	
5.03	00591 PURCHASI NG	959, 243	1, 553, 526	2, 512, 76	-562, 388	1, 950, 381	5. 03
5.05	00590 BUSI NESS OFFI CE	6, 150, 408	1, 443, 792	7, 594, 20	88, 083	7, 682, 283	
5.06	00592 OTHER ADMIN & GENERAL	13, 956, 956	38, 597, 424	52, 554, 38			1
6. 00	00600 MAI NTENANCE & REPAI RS	1, 770, 109	8, 740, 638				
7.00	00700 OPERATION OF PLANT	704, 097	82, 717	786, 81		828, 091	
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	568, 382 2, 139, 001	44, 013	612, 39			
10.00	01000 DI ETARY	1, 453, 345	925, 180 2, 215, 537	3, 064, 18 3, 668, 88			•
11. 00	01100 CAFETERI A	1, 433, 343	2, 213, 337		1, 941, 892		•
13. 00	01300 NURSING ADMINISTRATION	2, 652, 009	195, 469	2, 847, 47		849, 266	
14.00		525, 650	528, 577	1, 054, 22		1, 070, 848	
15.00	01500 PHARMACY	3, 350, 086	7, 263, 942	10, 614, 02	-9, 613, 881	1, 000, 147	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 734, 059	984, 033	2, 718, 09	2 -575, 485	2, 142, 607	16. 00
17. 00		2, 506, 895	136, 386			1, 666, 819	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	1, 739, 937	0	1, 739, 93		1, 739, 937	
22. 00	l l	371, 447	615, 565				
23. 00		247, 539	6, 104	253, 64	3 14, 422	268, 065	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS	14, 039, 386	2, 248, 228	16, 287, 61	75, 918	16, 363, 532	30.00
31. 00		3, 145, 380	859, 953	4, 005, 33			
32. 00	1	3, 143, 300	037, 733		0 2, 134	4, 007, 407	
40. 00	04000 SUBPROVI DER - I PF	1, 413, 354	77, 441	1, 490, 79	-		
41. 00	04100 SUBPROVI DER – I RF	2, 452, 315	1, 148, 288	3, 600, 60		3, 663, 309	
42.00	04200 SUBPROVI DER	0	0		0	0	42. 00
43.00	04300 NURSERY	963, 305	207, 412	1, 170, 71	7 66, 866	1, 237, 583	43. 00
	ANCILLARY SERVICE COST CENTERS						4
50.00	1 1	3, 688, 217	7, 034, 424	10, 722, 64			
51.00		2, 978, 761	234, 205	3, 212, 96			
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 609, 135	152, 059	1, 761, 19	4 78, 513 0 0	1, 839, 707 0	
54. 00	05400 RADI OLOGY – DI AGNOSTI C	5, 051, 191	5, 329, 902	10, 381, 09	-	6, 841, 651	
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	225, 138	319, 628	544, 76		550, 816	
54. 02	1 1	887, 284	132, 633	1, 019, 91		1, 047, 223	
55.00	l l	1, 853, 493	12, 070, 376			3, 271, 808	•
57.00	05700 CT SCAN	818, 801	382, 559	1, 201, 36	23, 121	1, 224, 481	57.00
58. 00	05800 MRI	318, 354	131, 882	450, 23	12, 386		
59. 00		1, 674, 654	6, 522, 200				
60.00		2, 752, 504	7, 414, 606				
60. 01	06001 BLOOD LABORATORY	0	0		0		
62.00	1 1	100.051	00 214		0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	199, 851 1, 632, 219	80, 214 615, 561	280, 06 2, 247, 78			
66. 00	1 1	4, 801, 417	1, 000, 444	5, 801, 86			
69. 00		1, 305, 537	474, 457	1, 779, 99			
71. 00	1 1	0	0		870, 680		
72. 00	1	0	12, 008, 592	12, 008, 59			
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		30, 806, 670		
75. 01	03955 RENAL DIALYSIS (IP)	0	892, 437	892, 43			75. 01
76. 00		359, 486	19, 948				
76. 01	1 1	948, 368	23, 879				•
76. 02		1, 315, 903	310, 042				
76. 03	+ I	0	0		0	0	
76. 04 76. 05	03952	1, 479, 596	296, 536		0 2 -98, 078	1 (70 054	
	07698 HYPERBARI C OXYGEN THERAPY	641, 568	247, 417				
, 0. 70	OUTPATIENT SERVICE COST CENTERS	041, 000	241,411	000, 70	J, /14	072, 079	, 0. 70
88. 00		209, 345	60, 442	269, 78	7 -6, 737	263, 050	88. 00
89. 00		0	0		0,707	0	1
91.00	1 1	4, 728, 964	1, 080, 928	5, 809, 89	38, 532		•
92.00							92.00
	09202 OBSERVATION BEDS (DISTINCT PART)	0	0		0	0	1
92. 01	04951 I NFUSI ON	441, 794	7, 333, 061	7, 774, 85	5 -7, 110, 775	664, 080	93. 00
93. 00					_		
	04950 COMMUNITY HEALTH CENTERS	1, 184, 985	81, 034		-1, 128, 385	137, 634	93. 01
93. 00 93. 01				1, 266, 01			

Health Financial Systems	RIVERSIDE MEDI	CAL CENTER		In Lie	eu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der CC		Peri od:	Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/26/2022 10:37 am
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	
			+ col . 2)	ons (See A-6)	Trial Balance
					(col. 3 +-
	1. 00	2. 00	3. 00	4. 00	col . 4) 5.00
99. 10 09910 CORF	1.00	2.00	3.00	4.00	0 99.10
101.00 10100 HOME HEALTH AGENCY	2, 975, 966	351, 291	3, 327, 25	43, 706	
SPECIAL PURPOSE COST CENTERS	2/ // 0/ /00	001,7271	0,027,20	10,700	3, 3, 3, 7, 7, 3
109. 00 10900 PANCREAS ACQUISITION	0	0	(	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	О	0	(	o	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	(	0	0 111.00
113.00 11300 INTEREST EXPENSE		5, 894, 591			4, 129, 558 113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	114, 987, 463	215, 354, 344	330, 341, 807	-51, 219	330, 290, 588 118. 00
NONREI MBURSABLE COST CENTERS				T	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	0 190. 00
191. 00 19100 RESEARCH	0	0	(	0	0 191.00
191. 01 19101  SENI OR ADVAN 191. 02 19102  CARE-A-VAN	4 057	0	4 05-	7	0 191. 01 4, 957 191. 02
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	4, 957 53, 719, 826	10, 117, 477	4, 957 63, 837, 303		
192. 01 19201 REFERENCE LAB	33, 717, 020	10, 117, 477	03, 037, 303	0 0 0	0192.01
192. 02 19202 MEALS ON WHEELS	0	0	ì		0 192. 02
193. 00 19300 NONPALD WORKERS		Ö	ĺ	ol o	0 193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	168, 712, 246	225, 471, 821	394, 184, 06	7 0	394, 184, 067 200. 00

Health FinancialSystemsRIVERSIDERECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0186

Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/26/2022 10:37 am

				5/26/2022 10:	<u>37 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS	T			
1.00	00100 CAP REL COSTS-BLDG & FIXT	0		1	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	0			2.00
3.00	00300 OTHER CAP REL COSTS	0			3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-152, 074			4.00
5. 01	01160 COMMUNI CATI ONS	0			5. 01
5.02	00550 DATA PROCESSI NG	0		1	5. 02
5.03	00591 PURCHASI NG	0			5. 03
5.05	00590 BUSI NESS OFFI CE	0			5. 05
5.06	00592 OTHER ADMIN & GENERAL	-17, 225, 161			5. 06
6.00	00600 MAI NTENANCE & REPAI RS	0	1,,		6. 00
7. 00	00700 OPERATION OF PLANT	0			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0			9. 00
10. 00	01000 DI ETARY	-741			10. 00
11. 00	01100 CAFETERI A	-1, 690, 236		1	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	179		•	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0			14. 00
15. 00	01500 PHARMACY	0		l .	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-26, 100			16. 00
17. 00	01700 SOCI AL SERVI CE	-2, 810			17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0		7	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	-8, 884	1, 018, 079		22. 00
23. 00	02301 PARAMED EDUCATION PROGRAM	0	268, 065	5	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-74, 226	16, 289, 306		30.00
31.00	03100 INTENSIVE CARE UNIT	0	4, 007, 487	7	31.00
32.00	03200 CORONARY CARE UNIT	0	0		32.00
40.00	04000 SUBPROVI DER - I PF	0	1, 506, 655	5	40.00
41.00	04100 SUBPROVI DER - I RF	0	3, 663, 309		41.00
42. 00	04200 SUBPROVI DER	0			42. 00
43. 00	04300 NURSERY	0	l control of the cont	3	43. 00
10.00	ANCILLARY SERVICE COST CENTERS		1,207,000		10.00
50.00	05000 OPERATI NG ROOM	-4, 728, 784	10, 829, 962		50.00
51. 00	05100 RECOVERY ROOM	0		l .	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM				52.00
53. 00	05300 ANESTHESI OLOGY		0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-2, 636	1	1	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	-2,030			54. 01
54. 02	05404 ULTRASOUND				54. 02
	05500 RADI OLOGY-THERAPEUTI C			l .	1
55. 00		1			55. 00
57. 00	05700 CT SCAN	0			57. 00
58. 00	05800 MRI	0		•	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			59.00
60.00	06000 LABORATORY	0		l .	60.00
60. 01	06001 BLOOD LABORATORY	0	-	)	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	l .		62. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	2, 002, 379		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	2, 283, 740		65.00
66. 00	06600 PHYSI CAL THERAPY	0			66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 842, 994	1	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	870, 680		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 008, 592	2	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-674	30, 805, 996	b	73. 00
75. 01	03955 RENAL DIALYSIS (IP)	0	892, 437	7	75. 01
76.00	03956 CARDI AC REHAB	0	385, 038	3	76. 00
76. 01	03950 OP PSY/CDU	-66, 979	915, 101		76. 01
76. 02	03957 RI MMS	-704, 647	836, 561		76. 02
76. 03	03951 GENETIC/OAK PLAZA CLINICS	0			76. 03
76. 04	03952 PAIN CLINIC	0			76. 04
76. 05	03953 DI ABETES	-227, 062	1, 450, 992		76. 05
	07698 HYPERBARI C OXYGEN THERAPY	0	l .		76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS		, 0,2,0,7	4	70.70
88. 00	08800 RURAL HEALTH CLINIC	-107, 489	155, 561		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	107,107	n .55,561		89. 00
91. 00	09100 EMERGENCY	-23, 979	5, 824, 445		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	23, 7/7	3, 024, 440		92.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93. 00	04951 I NFUSION		664, 080		93. 00
93. 00		24 220		•	
73. UI	04950 COMMUNITY HEALTH CENTERS	-26, 338	111, 296	7	93. 01
0F 00	OTHER REIMBURSABLE COST CENTERS	205 502	E 200 740		05.00
95. 00	09500 AMBULANCE SERVI CES 09910 CORF	-385, 583			95. 00 99. 10
	10100 HOME HEALTH AGENCY				101.00
101.00	PITOTOO TOURE HEALTH AGENCT	1 0	y 3,370, <del>9</del> 03	y	1101.00

Health FinancialSystemsRIVERSIDERECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 14-0186

Peri od: Worksheet A From 01/01/2021 To 12/31/2021 Date/Time Prepared:

			5/26/2022 10:37 a	am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION	0	0	109.	. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	110.	. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	111.	. 00
113.00 11300 INTEREST EXPENSE	-4, 129, 558	0	113.	. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-29, 583, 782	300, 706, 806	118.	. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.	. 00
191. 00 19100 RESEARCH	O	0	191.	. 00
191. 01 19101 SENI OR ADVAN	O	0	191.	. 01
191. 02 19102 CARE-A-VAN	o	4, 957	191.	. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	63, 888, 522	192.	. 00
192. 01 19201 REFERENCE LAB	o	0	192.	. 01
192.02 19202 MEALS ON WHEELS	o	o	192.	. 02
193. 00 19300 NONPALD WORKERS	o	o	193.	. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-29, 583, 782	364, 600, 285	200.	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0186

| Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: | 5/26/2022 10: 37 am

					5/26/20	22 10:37 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
4 00	A - PROFESSIONAL FEES	50.00		4 700 704		1.00
1.00	OPERATING ROOM	50.00		4, 728, 784		1.00
2.00	EMERGENCY	91.00		22, 693		2.00
3. 00	I NFUSI ON	93.00		35, 475		3. 00
	B - BONUSES AND VACATION ACCE	DIIAI	U	4, 786, 952		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11, 767	0		1.00
2. 00	DATA PROCESSING	5. 02	133, 367	0		2.00
3.00	PURCHASI NG	5. 03	28, 962	0		3. 00
4. 00	BUSINESS OFFICE	5. 05	89, 485	0		4. 00
5.00	OTHER ADMIN & GENERAL	5. 06	1, 495, 795	0		5. 00
6. 00	MAINTENANCE & REPAIRS	6.00	31, 013	0		6. 00
7. 00	OPERATION OF PLANT	7. 00	41, 277	0		7. 00
8. 00	LAUNDRY & LINEN SERVICE	8.00	8, 559	0		8. 00
9. 00	HOUSEKEEPI NG	9.00	33, 879	0		9. 00
10.00	DI ETARY	10.00	19, 276	0		10.00
11. 00	NURSING ADMINISTRATION	13. 00	22, 756	0		11. 00
12. 00	CENTRAL SERVICES & SUPPLY	14.00	6, 405	0		12. 00
13. 00	MEDICAL RECORDS & LIBRARY	16.00	41, 156	0		13. 00
14.00	SOCIAL SERVICE	17.00	46, 597	0		14. 00
15.00	I&R SERVICES-OTHER PRGM	22.00	39, 951	0		15. 00
	COSTS APPRV		·			
16.00	PARAMED EDUCATION PROGRAM	23. 00	14, 422	0		16. 00
17.00	ADULTS & PEDIATRICS	30.00	191, 299	0		17. 00
18.00	INTENSIVE CARE UNIT	31.00	45, 388	0		18. 00
19.00	SUBPROVI DER - I PF	40.00	18, 444	0		19. 00
20.00	SUBPROVI DER - I RF	41.00	37, 697	0		20. 00
21.00	NURSERY	43.00	18, 091	0		21. 00
22.00	OPERATING ROOM	50.00	60, 288	0		22. 00
23.00	RECOVERY ROOM	51.00	53, 760	0		23. 00
24.00	RADI OLOGY-DI AGNOSTI C	54.00	65, 283	0		24. 00
25. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	3, 656	0		25. 00
26. 00	ULTRASOUND	54. 02	17, 842	0		26. 00
27. 00	RADI OLOGY-THERAPEUTI C	55. 00	29, 851	0		27. 00
28. 00	CT SCAN	57. 00	15, 414	0		28. 00
29. 00	MRI	58. 00	8, 894	0		29. 00
30. 00	CARDIAC CATHETERIZATION	59. 00	19, 608	0		30. 00
31. 00	LABORATORY	60.00	52, 423	0		31. 00
32. 00	I NTRAVENOUS THERAPY	64.00	4, 626	0		32. 00
33. 00	RESPI RATORY THERAPY	65.00	24, 278	0		33. 00
34. 00	PHYSI CAL THERAPY	66.00	66, 631	0		34.00
35. 00	ELECTROCARDI OLOGY	69.00	70, 883	0		35. 00
36. 00	DRUGS CHARGED TO PATIENTS	73.00	73, 107	0		36.00
37. 00	CARDI AC REHAB	76.00	5, 604	0		37.00
38. 00	OP PSY/CDU	76. 01	9, 853	0		38. 00
39. 00	RIMMS	76. 02	11, 633	0		39. 00
40.00	DI ABETES	76.05	9, 122	0		40.00
41. 00	HYPERBARI C OXYGEN THERAPY	76. 98	9, 599	0		41. 00
42.00	RURAL HEALTH CLINIC	88.00	1, 785	0		42.00
43.00	EMERGENCY	91.00	77, 662	0		43. 00
44. 00	INFUSION COMMUNITY HEALTH CENTERS	93.00	10, 421	0		44. 00
45. 00 46. 00	AMBULANCE SERVICES	93. 01 95. 00	111, 516 53, 945	0		45. 00 46. 00
46. 00 47. 00		l I		0		47. 00
	HOME HEALTH AGENCY	101.00	58, 564	-		
48. 00	PHYSICIANS' PRIVATE OFFICES	192.00	459, 758 3, 761, 592	<u>0</u>		48. 00
	C - CAFETERIA		3, 701, 592	U		
1.00	CAFETERIA CAFETERIA	11.00	769, 238	1, 172, 654		1. 00
1.00	0	<u> </u>	769, 238	1, 172, 654		1.00
	D - NURSING ADMINISTRATION		, 57, 250	1, 1, 2, 007		
1.00	CENTRAL SERVICES & SUPPLY	14.00	10, 216	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	13, 971	Ö		2. 00
3. 00	ADULTS & PEDIATRICS	30.00	19, 889	Ö		3. 00
4. 00	ADULTS & PEDIATRICS	30.00	25, 582	0		4. 00
5. 00	ADULTS & PEDIATRICS	30.00	32, 714	ñ		5. 00
6. 00	ADULTS & PEDIATRICS	30.00	36, 226	Ö		6. 00
7. 00	INTENSIVE CARE UNIT	31.00	50, 220	ñ		7. 00
8. 00	INTENSIVE CARE UNIT	31.00	31, 819	Ö		8. 00
9. 00	SUBPROVI DER - I RF	41. 00	40, 952	ő		9. 00
10.00	NURSERY	43.00	48, 798	ő		10.00
11. 00	OPERATING ROOM	50.00	57, 047	Ö		11. 00
12. 00	OPERATING ROOM	50.00	14, 634	Ö		12. 00
13. 00	RECOVERY ROOM	51.00	33, 440	Ö		13. 00
14. 00	RECOVERY ROOM	51.00	15, 611	Ö		14. 00
	I .		- * - 1	-1		

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 10:37 am Provider CCN: 14-0186

					5/26/2022	10:37 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
15.00	RECOVERY ROOM	51.00	8, 841	0		15. 00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	81, 514 13, 782	0		16.00
17. 00 18. 00	RADI OLOGY DI AGNOSTI C	54. 00 54. 00	2, 928	0		17. 00 18. 00
19. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-DI AGNOSTI C	54.00	2, 928 16, 414	0		19. 00
20. 00	RADI OLOGY-DI AGNOSTI C	54.00	3, 575	0		20. 00
21. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	2, 476	0		21. 00
22. 00	ULTRASOUND	54. 02	9, 759	0		22. 00
23. 00	CT SCAN	57.00	9, 006	o		23. 00
24. 00	MRI	58.00	3, 501	0		24. 00
25. 00	CARDIAC CATHETERIZATION	59.00	32, 547	Ö		25. 00
26. 00	RESPI RATORY THERAPY	65.00	13, 021	0		26. 00
27. 00	PHYSI CAL THERAPY	66.00	31, 442	0		27. 00
28.00	PHYSI CAL THERAPY	66.00	48, 739	0		28. 00
29.00	EMERGENCY	91.00	3, 514	0		29. 00
30.00	AMBULANCE SERVICES	95.00	154, 940	0		30.00
	0		816, 903	0		
	E - COST OF GOODS SOLD					
1.00	INTRAVENOUS THERAPY	64.00	0	1, 018, 322		1. 00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	870, 680		2. 00
	PATI ENT		_			
3. 00	DRUGS CHARGED TO PATIENTS	7300		<u>5, 251, 622</u>		3. 00
	U LITTLE ZATLON DEVICEN		0	7, 140, 624		
1 00	F - UTILIZATION REVIEW OTHER ADMIN & GENERAL	E 0/	1 022 050			1 00
1. 00	OTHER ADMIN & GENERAL		1, 023, 059 1, 023, 059	0		1. 00
	G - RECOVERY ROOM		1, 023, 059	U		
1. 00	RECOVERY ROOM	51.00	254, 061	O		1.00
1.00	O RECOVERT ROOM		254, 061	0		1.00
	H - IV THERAPY		254, 001	<u> </u>		
1.00	INTRAVENOUS THERAPY	64. 00	699, 479	0		1.00
1.00	0		699, 479	0		1.00
	I - INSURANCE		37,7,17,7	<u> </u>		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	865, 819		1. 00
				865, 819		
	J - INTEREST		<u> </u>			
1.00	OTHER ADMIN & GENERAL	5. 06	0	1, 765, 033		1. 00
	0 — — — — —			1, 765, 033		
	K - RADI OLOGY					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	423, 703	0		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00	L	0.00	0	0		6. 00
	0		423, 703	0		
4 00	L - ESTABLISH OTHER CRC	2 00		(0/ 100		1.00
1. 00	OTHER CAP REL COSTS	3.00	0	696, 488		1. 00
	O   N - RX SALARIES		0	696, 488		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	3, 350, 086	O		1.00
1.00	n FATTENTS		3, 350, 086	0		1.00
	O - FLOAT NURSING		3, 330, 000	- σ <sub>l</sub>		
1. 00	ADULTS & PEDIATRICS	30.00	1, 204, 065	Λ		1.00
	0		1, 204, 065	0		1.00
	P - CHC DI RECTORS		., == ., ===	-,		
1.00	RURAL HEALTH CLINIC	88.00	4, 501	477		1. 00
2.00	PHYSICIANS' PRIVATE OFFICES	192. 00	1, 155, 006	79, 917		2. 00
	0		1, 159, 507	80, 394		
	Q - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	22, 131, 855		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	O	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	U	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
17.00	I .	0.00	<u> </u>	U		1 14.00

Provider CCN: 14-0186

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 10:37 am

					5/26/2022 10: 37	<u>am</u>
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
15. 00		0.00	0	0	1	15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
			0	-		
19.00		0.00	U	0		19. 00
20.00		0. 00	O	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	2	23. 00
24.00		0.00	0	0	2	24. 00
25.00		0.00	o	0	2	25. 00
26.00		0.00	ol	0	2	26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
29.00		<u> </u>	— — <del> </del>			19.00
	U AND CONTRACT LABOR		U	22, 131, 855		
	R - A&G CONTRACT LABOR	= 0.1	اه	4 400 004		
1.00	OTHER ADMIN & GENERAL	5. 06	0	1, 403, 381		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
	0		0	1, 403, 381		
	S - UTILITIES					
1.00	MAINTENANCE & REPAIRS	6.00	0	636, 716		1.00
2.00		0.00	o	. 0		2.00
3. 00		0.00	0	0		3. 00
4. 00		0.00	o o	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	0	0	1	6. 00
			U	U	1	
7.00		0.00	0	0		7. 00
8.00		0. 00	O	0		8. 00
9.00		000	0	0		9. 00
	0		0	636, 716		
	T - POSTAGE					
1.00	PURCHASI NG	5. 03	0	287, 954		1.00
				287, 954		
	V - COMMUNICATIONS	•	•			
1.00	COMMUNI CATI ONS	5. 01	0	942, 765		1.00
	0	— — <del></del> +	— — <del>ŏ</del>	942, 765	1	
	W - PHYSICIAN COMPENSATION	1	<u> </u>	, 12, 100		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 100, 000	Δ		1. 00
1.00	TOTALS	— <del></del>	1, 100, 000	— — <u> </u>	i	1.00
F00 00						20.00
500.00	Grand Total: Increases		14, 561, 693	41, 910, 635	50	00.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 10:37 am Provider CCN: 14-0186

					·	/26/2022 10:37 am
	Coot Contor	Decreases	Calami	0+bas	What A 7 Dof	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - PROFESSIONAL FEES	7.00	0.00	7. 00	10.00	
1.00	OTHER ADMIN & GENERAL	5. 06	0	4, 786, 952	0	1. 00
2.00		0.00	0	0		2. 00
3. 00		0.00	0	0	9	3. 00
	B - BONUSES AND VACATION ACCR	PHAL	U <sub>I</sub>	4, 786, 952		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 761, 592	0	1. 00
2.00		0.00	O	0		2. 00
3.00		0.00	0	0	l .	3.00
4. 00 5. 00		0. 00 0. 00	0	0	l .	4. 00 5. 00
6. 00		0.00	0	0		6.00
7.00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11.00
12. 00		0.00	Ö	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	0	0	l .	22.00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
27. 00		0.00	o	0		27. 00
28. 00		0.00	O	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00 31. 00		0. 00 0. 00	0	0		30.00
31.00		0.00	0	0		31. 00 32. 00
33. 00		0.00	Ö	0		33. 00
34.00		0.00	0	0		34.00
35. 00		0.00	0	0		35. 00
36. 00 37. 00		0. 00 0. 00	0	0		36. 00 37. 00
38. 00		0.00	Ö	0		38. 00
39. 00		0.00	0	0		39. 00
40.00		0.00	0	0		40.00
41. 00 42. 00		0. 00 0. 00	0	0		41. 00 42. 00
43. 00		0.00	0	0	- 1	43. 00
44.00		0.00	0	0	O	44. 00
45. 00		0.00	0	0	- 1	45. 00
46. 00 47. 00		0. 00 0. 00	0	0		46. 00 47. 00
48. 00		0.00	0	0	o	48. 00
	0 — — — — —			3, 761, 592		
	C - CAFETERI A					
1. 00	DI ETARY	1000	76 <u>9, 2</u> 38 769, 238	<u>1, 172, 654</u> 1, 172, 654		1.00
	D - NURSING ADMINISTRATION		707, 230	1, 172, 034		
1.00	NURSING ADMINISTRATION	13. 00	816, 903	0		1.00
2.00		0.00	0	0		2.00
3.00		0. 00 0. 00	0	0	l	3.00
4. 00 5. 00		0.00	0	0	l 1	4. 00 5. 00
6. 00		0.00	o	0	1	6. 00
7. 00		0.00	o	0	l .	7. 00
8. 00		0.00	0	0	l .	8. 00
9. 00 10. 00		0. 00 0. 00	0	0	l .	9. 00 10. 00
11. 00		0.00	0	0	- 1	11. 00
12.00		0.00	o	0	o	12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00
13.00		0.00	U	U	l O	15. 00

Provider CCN: 14-0186

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 10:37 am

		Decreases			<u> </u>	5/26/2022 10:	3/ am
	Cost Center	Li ne #	Sal ary	Other W	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		
16. 00		0.00	0	0	0		16. 00
17.00		0.00	o	0	O		17. 00
18.00		0.00	0	0	0		18. 00
19. 00		0.00	0	0	0		19. 00
20.00		0.00	0	0	0		20.00
21. 00		0.00	0	0	0		21. 00
22. 00 23. 00		0. 00 0. 00	0	0	0		22. 00 23. 00
24. 00		0.00	0	0	0		24. 00
25. 00		0.00	Ö	0	o		25. 00
26. 00		0.00	ō	O	o		26. 00
27.00		0.00	О	0	0		27. 00
28. 00		0.00	0	0	0		28. 00
29. 00		0.00	0	0	0		29. 00
30. 00		0.00	0	•	0		30. 00
	0		816, 903	0			-
1. 00	E - COST OF GOODS SOLD PURCHASING	5. 03	0	879, 304	0		1.00
2.00	PHARMACY	15. 00	0	6, 261, 320	0		2.00
3.00	TARWACT	0.00	0	0, 201, 320	o		3. 00
0.00	0 — — — — —		— — <del> </del>	7, 140, 624			0.00
	F - UTILIZATION REVIEW		· · ·				1
1.00	SOCIAL SERVICE	17. 00	1, 023, 059	0	0		1. 00
	0		1, 023, 059	0			
	G - RECOVERY ROOM						
1.00	ADULTS & PEDIATRICS	30.00	<u>254, 061</u>	0	0		1. 00
	U LV THEDADY		254, 061	0			-
1.00	H - IV THERAPY ADULTS & PEDIATRICS	30.00	699, 479	0	0		1.00
1.00	n FEDIATRICS	30.00	699, 479		— — — 4		1.00
	I - INSURANCE		377, 177	<u> </u>			1
1.00	OTHER ADMIN & GENERAL	5. 06	0	865, 819	0		1. 00
	0			865, 819			
	J - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1, 765, 033	0		1. 00
	0		0	1, 765, 033			
1 00	K - RADIOLOGY PHYSICIANS' PRIVATE OFFICES	192.00	119, 719	O	0		1.00
1. 00 2. 00	PHYSICIANS' PRIVATE OFFICES	192.00	86, 323	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	141, 290	0	0		3. 00
4. 00	PHYSICIANS' PRIVATE OFFICES	192.00	75, 893	Ö	ő		4. 00
5. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	119	Ō	0		5. 00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	359	0	0		6. 00
	0		423, 703	0			]
	L - ESTABLISH OTHER CRC						
1. 00	OTHER ADMIN & GENERAL	5.06	0	696, 488	0		1. 00
	O N. DV CALADIEC		0	696, 488			-
1 00	N - RX SALARIES	15 00	3, 350, 086	0	0		1 00
1. 00	PHARMACY		3, 350, 086		0		1.00
	0 - FLOAT NURSING		3, 330, 000	<u> </u>			
1.00	NURSING ADMINISTRATION	13.00	1, 204, 065	0	0		1. 00
	0 — — — — — —		1, 204, 065				
	P - CHC DI RECTORS						
1.00	COMMUNITY HEALTH CENTERS	93. 01	1, 159, 507	80, 394	0		1. 00
2.00		0.00	0	0	0		2. 00
	O DILLARIE DRUCE		1, 159, 507	80, 394			-
1.00	Q - BILLABLE DRUGS BUSINESS OFFICE	5. 05	0	1, 402	0		1.00
2.00	OTHER ADMIN & GENERAL	5. 06	0	50, 498	0		2. 00
3.00	PHARMACY	15.00	Ö	2, 475	ő		3. 00
4. 00	ADULTS & PEDIATRICS	30.00	ō	113, 072	o		4. 00
5.00	INTENSIVE CARE UNIT	31.00	o	75, 058	0		5. 00
6.00	SUBPROVIDER - IPF	40.00	0	2, 584	0		6. 00
7.00	SUBPROVI DER - I RF	41.00	0	15, 943	0		7. 00
8.00	NURSERY	43.00	0	23	0		8. 00
9.00	OPERATING ROOM	50.00	0	24, 648	0		9.00
10. 00 11. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51. 00 52. 00	0	5, 625 3, 001	0		10. 00 11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	3, 756, 871	0		12.00
13. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	o	3, 730, 071	o		13. 00
14. 00	ULTRASOUND	54. 02	Ö	295	o		14. 00
15. 00	RADI OLOGY-THERAPEUTI C	55.00	О	10, 598, 057	0		15. 00
16. 00	CT SCAN	57.00	0	1, 299	0		16. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Period: From 01/01/2021 To 12/31/2021 Worksheet A-6 Date/Time Prepared: 5/26/2022 10:37 am Provider CCN: 14-0186

						5/26/2022 10:	:37 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
17. 00	MRI	58. 00	0	9	0		17. 00
18.00	CARDIAC CATHETERIZATION	59.00	0	33, 810	0		18. 00
19.00	LABORATORY	60.00	0	13, 234	0		19. 00
20.00	INTRAVENOUS THERAPY	64.00	O	113	o		20.00
21.00	RESPIRATORY THERAPY	65.00	o	1, 339	o		21.00
22. 00	PHYSI CAL THERAPY	66.00	0	817			22. 00
23. 00	ELECTROCARDI OLOGY	69. 00	0	7, 883			23. 00
24. 00	OP PSY/CDU	76. 01	0	20			24. 00
25. 00	RI MMS	76. 02	0	88, 845			25. 00
26. 00	DI ABETES	76. 05	Ö	107, 200			26. 00
27. 00	HYPERBARI C OXYGEN THERAPY	76. 98	0	5, 644			27. 00
28. 00	EMERGENCY	91.00	0	65, 337			28. 00
29. 00	I NFUSI ON	93. 00	0	7, 156, 671	0		29. 00
29.00			— — <del> </del>	22, 131, 855	— — <sup>ч</sup>		29.00
	R - A&G CONTRACT LABOR		U	22, 131, 600			1
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ما	20, 456	0		1. 00
			0				
2.00	DI ETARY	10.00	0	385, 068			2.00
3.00	MEDICAL RECORDS & LIBRARY	16. 00	0	616, 641	0		3.00
4.00	ADULTS & PEDI ATRI CS	3000		381, 216	0		4. 00
	0		0	1, 403, 381			-
4 00	S - UTILITIES	0.00	ما	04 500			4 00
1.00	HOUSEKEEPI NG	9. 00	0	81, 528			1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	308, 256			2. 00
3.00	RADI OLOGY-THERAPEUTI C	55. 00	0	83, 855			3. 00
4.00	RI MMS	76. 02	0	7, 525	0		4. 00
5.00	HYPERBARI C OXYGEN THERAPY	76. 98	0	241	0		5. 00
6.00	RURAL HEALTH CLINIC	88. 00	0	13, 500	0		6. 00
7.00	AMBULANCE SERVICES	95.00	0	7, 194	0		7. 00
8.00	HOME HEALTH AGENCY	101.00	0	14, 858	0		8. 00
9.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	11 <u>9, 7</u> 59	0		9. 00
	0		0	636, 716			
	T - POSTAGE						
1.00	OTHER ADMIN & GENERAL	5. 06	0	287, 954	0		1. 00
				287, 954			1
	V - COMMUNICATIONS		•				1
1.00	MAINTENANCE & REPAIRS	6. 00	0	942, 765	0		1.00
				942, 765			
	W - PHYSICIAN COMPENSATION		-				1
1. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	1, 100, 000	0	0		1.00
	TOTALS		1, 100, 000	— — <u> </u>			55
500 00	Grand Total: Decreases		10, 800, 101	45, 672, 227			500.00
300.00	jo. a.i.a. rotar. Boor cases	1	10,000,101	10, 0, 2, 221			1 500. 00

| Period: | Worksheet A-7 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:

				1	o 12/31/2021	Date/Time Prep 5/26/2022 10:3	
				Acqui si ti ons		3/26/2022 10.	37 dili
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances	. a. c.iaccc	501.41.01.		Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
-	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	7, 974, 131	129, 241	(	129, 241	0	1. 00
2.00	Land Improvements	348, 835	6, 917, 179	C	6, 917, 179	0	2.00
3.00	Buildings and Fixtures	132, 388, 115	165, 476, 762	C	165, 476, 762	0	3.00
4.00	Building Improvements	8, 484, 575	79, 170, 529	C	79, 170, 529	0	4. 00
5.00	Fi xed Equipment	465, 399	1, 503, 485	C	1, 503, 485	0	5. 00
6.00	Movable Equipment	9, 865, 542	103, 833, 134	C	103, 833, 134	0	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	159, 526, 597	357, 030, 330	C	357, 030, 330	0	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	159, 526, 597	357, 030, 330	C	357, 030, 330	0	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	8, 103, 372	0				1. 00
2.00	Land Improvements	7, 266, 014	0				2. 00
3.00	Buildings and Fixtures	297, 864, 877	0				3. 00
4.00	Building Improvements	87, 655, 104	0				4. 00
5.00	Fi xed Equipment	1, 968, 884	0				5. 00
6.00	Movable Equipment	113, 698, 676	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	516, 556, 927	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	516, 556, 927	0				10. 00

Provider CCN: 14-0186   Period: From 01/01/2021   To 12/31/2021   To 12/31/2021   To 12/31/2021   Date/Time Prepared: 5/26/2022 10: 37 am
Cost Center Description   Depreciation   Lease   Interest   Insurance (see instructions)   Instructions   Insurance (see instructions)
SUMMARY OF CAPITAL   Summaria   Summa
Depreciation   Lease   Interest   Insurance (see instructions)
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2
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 & FIXT 20, 336, 438 0 0 0 0 0 0 1.00  2.00 CAP REL COSTS-MVBLE EQUIP 9, 447, 747 0 0 0 0 0 0 2.00  3.00 Total (sum of lines 1-2) 29, 784, 185 0 0 0 0 0 3.00  SUMMARY OF CAPITAL  Cost Center Description Other Capital -Relate d Costs (see through 14)
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2
1.00 CAP REL COSTS-BLDG & FIXT 20,336,438 0 0 0 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 9,447,747 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 29,784,185 0 0 0 0 3.00 SUMMARY OF CAPITAL  Cost Center Description Other Capital -Relate of cols. 9 through 14)
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)  Cost Center Description  Cost Center Description  Other Capital -Relate of cols. 9 through 14)
3.00 Total (sum of lines 1-2)  29,784,185  0  0  0  0  0  3.00  SUMMARY OF CAPITAL  Cost Center Description  Other Capital -Relate of cols. 9 through 14)
SUMMARY OF CAPITAL  Cost Center Description  Other Total (1) (sum Capital-Relate of cols. 9 d Costs (see through 14)
Cost Center Description  Other Total (1) (sum Capital-Relate of cols. 9 d Costs (see through 14)
Capi tal -Rel ate of cols. 9 d Costs (see through 14)
d Costs (see   through 14)
instructions
[TIISTI UCTI OHS)
14.00 15.00
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2
1. 00 CAP REL COSTS-BLDG & FIXT 0 20, 336, 438 1. 00
2.00 CAP REL COSTS-MVBLE EQUIP 0 9,447,747 2.00
3.00 Total (sum of lines 1-2) 0 29,784,185 3.00

Heal th	Financial Systems	RIVERSIDE MED	OLCAL CENTER		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/26/2022 10:3	pared:
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				2)	•		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FLXT	402, 858, 251		102,000,20		543, 185	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	113, 698, 676		1 10,0,0,0,			2. 00
3.00	Total (sum of lines 1-2)	516, 556, 927		516, 556, 92			3. 00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CE			F 40 40	5 00 007 400	0	4 00
1.00	CAP REL COSTS-BLDG & FIXT	0		0.0,.0		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1	153, 30		0	2.00
3.00	Total (sum of lines 1-2)	0		696, 48		0	3. 00
			St	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE			1			
1.00	CAP REL COSTS-BLDG & FIXT	0			0	20, 879, 623	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0	9, 601, 050	
3.00	Total (sum of lines 1-2)	0	696, 488	1	0	30, 480, 673	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 14-0186 

					0 12/31/2021	Date/lime Prep 5/26/2022 10:3	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2. 00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00 0	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		J	CALL REE GOOTO BEBG & TIAT	1.00	Ĭ	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
3.00	(chapter 2)		O		0.00		3.00
4.00	Trade, quantity, and time		0		0.00	o	4. 00
Г 00	di scounts (chapter 8)		0		0.00		Г 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by		0		0.00	О	6. 00
	suppliers (chapter 8)		_			_	
7. 00	Telephone services (pay stations excluded) (chapter		O		0.00	0	7. 00
	21)						
8.00	Television and radio service		0		0.00	0	8. 00
0.00	(chapter 21)		0		0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-5, 192, 186		0. 00	0	9. 00 10. 00
10.00	adjustment	A 0 2	3, 172, 100			Ĭ	10.00
11. 00	Sale of scrap, waste, etc.	В	-2, 636	RADI OLOGY-DI AGNOSTI C	54.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
12.00	transactions (chapter 10)	A-0-1	U			١	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14. 00	Cafeteria-employees and guests		-1, 403, 999	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		O		0. 00	0	15. 00
16. 00	Sale of medical and surgical	В	0	MEDICAL SUPPLIES CHARGED TO	71. 00	0	16. 00
	supplies to other than			PATI ENT			
17 00	patients Sale of drugs to other than	l B	.74	DDUCS CHARCED TO DATIENTS	72.00	0	17 00
17. 00	patients	В	-0/4	DRUGS CHARGED TO PATIENTS	73. 00	٥	17. 00
18. 00	Sale of medical records and	В	-26, 100	MEDICAL RECORDS & LIBRARY	16. 00	О	18.00
40.00	abstracts						40.00
19. 00	Nursing and allied health education (tuition, fees,		O		0. 00	0	19. 00
	books, etc.)						
20. 00	Vendi ng machi nes	В	-741	DI ETARY	10.00	0	
21. 00	Income from imposition of		0		0. 00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	О	22. 00
	overpayments and borrowings to	·					
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	0	RESITION THERAIT	03.00		23.00
_	limitation (chapter 14)	]					
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
۷۵. ۵۷	COSTS-BLDG & FLXT		U	WEE GOOTS-DEDG & TIAT	1.00		20.00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	О	27. 00
20 00	COSTS-MVBLE EQUIP		0	*** Cost Contor Dalated ***	10.00		20 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00		30.00
	therapy costs in excess of						
30. 99	Hospice (non-distinct) (see		0	ADIII TS & DEDIATDICS	30 00		30. 99
30. 99	instructions)		U	ADULTS & PEDIATRICS	30. 00		30. 77
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
02.00	Depreciation and Interest		J		3.00		02.00
33. 00	GOURMET COFFEE	В	-286, 237	CAFETERI A	11. 00	o	33. 00

From 01/01/2021

				To	0 12/31/2021	Date/Time Pre 5/26/2022 10:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1. 00	2.00	3. 00	4. 00	5. 00	
33. 01	AMBULANCE REVENUE	В		AMBULANCE SERVICES	95.00	0	
33. 02	MI SCELLANEOUS I NCOME	В		OTHER ADMIN & GENERAL	5. 06		
33. 03	THA DUES	A	-40, 980	OTHER ADMIN & GENERAL	5. 06	0	33. 03
33.04	VOCATIONAL TRAINING	A	-62, 424	ADULTS & PEDIATRICS	30.00	0	33. 04
33. 05	VOCATIONAL TRAINING	A	-66, 979	OP PSY/CDU	76. 01	0	33. 05
33.06	NON-ALLOWABLE MARKETING	A	-387, 970	OTHER ADMIN & GENERAL	5. 06	0	33. 06
33.07	NON-ALLOWABLE ADMIN	A	-247, 132	OTHER ADMIN & GENERAL	5. 06	0	33. 07
33.08	CHARITY CARE	A	-5, 250	OTHER ADMIN & GENERAL	5. 06	0	33. 08
33.09	NON-ALLOWABLE INTEREST	A	-3, 995, 989	INTEREST EXPENSE	113.00	0	33. 09
33. 10	MEDICALD ASSESSMENT	l A	-15, 747, 018	OTHER ADMIN & GENERAL	5. 06	0	33. 10
33. 11	INTEREST INCOME	В		INTEREST EXPENSE	113.00	0	33. 11
33. 12	REAL ESTATE TAX	l A l	-578, 732	OTHER ADMIN & GENERAL	5. 06	0	33. 12
33. 13	NON OPERATING INC UNRESTRICT	В		OTHER ADMIN & GENERAL	5. 06	0	
	DONOR	_	,			_	
33. 14	NURSE PRACTITIONER PART B	l A l	-152, 074	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 14
	BENEFI TS		·				
33. 15	NURSE PRACTITIONER PART B	l A	-388, 598	RIMMS	76. 02	0	33. 15
	SALARI ES		·				
33. 16	NURSE PRACTITIONER PART B	A	-107, 489	RURAL HEALTH CLINIC	88. 00	0	33. 16
	SALARI ES						
33. 17	NURSE PRACTITIONER PART B	A	-26, 338	COMMUNITY HEALTH CENTERS	93. 01	0	33. 17
	SALARI ES						
33. 18	NURSE PRACTITIONER PART B	A	-11, 396	ADULTS & PEDIATRICS	30.00	0	33. 18
	SALARI ES						
33. 19	NURSE PRACTITIONER PART B	A	179	NURSING ADMINISTRATION	13. 00	0	33. 19
	SALARI ES						
33. 20	NURSE PRACTITIONER PART B	A	-1, 286	EMERGENCY	91. 00	0	33. 20
	SALARI ES						
33. 21	NURSE PRACTITIONER PART B	A	-2, 810	SOCIAL SERVICE	17. 00	0	33. 21
	SALARI ES						
33. 22	NURSE PRACTITIONER PART B	A	-111, 692	DI ABETES	76. 05	0	33. 22
	SALARI ES						
50.00	TOTAL (sum of lines 1 thru 49)		-29, 583, 782				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<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.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10

Provider CCN: 14-0186 Peri od: Worksheet A-8-2 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

							5/26/2022 10:	<u>37 am</u>
	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	17. 00	SOCIAL SERVICE	0	0	0	197, 500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	406	406	0	197, 500	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	197, 500	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	197, 500	0	4.00
5.00	50.00	OPERATING ROOM	4, 728, 784	4, 728, 784	0	246, 400	0	5.00
6.00	53. 00	ANESTHESI OLOGY	0	0	0	239, 400	0	6.00
7.00	55. 00	RADI OLOGY-THERAPEUTI C	0	0	0	239, 400	0	7. 00
8.00	60.00	LABORATORY	0	0	0	197, 500	0	8. 00
9.00	65. 00	RESPI RATORY THERAPY	0	0	0	260, 300	0	9. 00
10.00	69. 00	ELECTROCARDI OLOGY	0	0	0	197, 500	0	10.00
11.00	76. 01	OP PSY/CDU	0	0	0	197, 500	0	11.00
12.00	76. 02	RIMMS	316, 049	316, 049	0	197, 500	0	12.00
13.00	76. 05	DI ABETES	115, 370	115, 370	0	197, 500	l o	13.00
14.00	76. 98	HYPERBARIC OXYGEN THERAPY	0	0	0	197, 500	l o	14.00
15.00	91.00	EMERGENCY	22, 693	22, 693	0	197, 500	l o	15.00
16.00	93. 00	I NFUSI ON	0	0	0	197, 500	l o	16.00
17.00	22. 00	I&R SERVICES-OTHER PRGM	8, 884	8, 884	0	197, 500	l o	17.00
		COSTS APPRV						
18.00	59.00	CARDIAC CATHETERIZATION	0	0	0	197, 500	0	18.00
19.00	5. 06	OTHER ADMIN & GENERAL	0	0	0	197, 500	0	19.00
200.00			5, 192, 186	5, 192, 186	0		0	200.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10

Provider CCN: 14-0186 Peri od: Worksheet A-8-2 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

								5/26/2022 10:	37 am_
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent o	of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted R	RCE Me	emberships &	Component	of Malpractice	
				Limit			Share of col.	Insurance	
						Educati on	12		
	1. 00	2. 00	8. 00	9. 00		12. 00	13. 00	14. 00	
1.00	17. 00	SOCIAL SERVICE	0		0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0		0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0		0	0	0	0	3.00
4.00	41. 00	SUBPROVIDER - IRF	0		0	0	0	0	4. 00
5.00	50.00	OPERATING ROOM	0		0	0	0	0	5.00
6.00	53. 00	ANESTHESI OLOGY	0		0	o	0	o	6. 00
7.00	55. 00	RADI OLOGY-THERAPEUTI C	0		0	o	0	o	7. 00
8.00	60.00	LABORATORY	O		0	o	0	o	8. 00
9.00	65. 00	RESPI RATORY THERAPY	O		0	o	0	o	9. 00
10.00	69. 00	ELECTROCARDI OLOGY	0		0	o	0	0	10.00
11.00	76. 01	OP PSY/CDU	0		0	o	0	0	11.00
12.00	76. 02	RIMMS	0		0	o	0	0	12.00
13.00	76. 05	DI ABETES	0		0	o	0	0	13.00
14.00	76. 98	HYPERBARIC OXYGEN THERAPY	0		0	o	0	0	14.00
15.00	91.00	EMERGENCY	0		0	o	0	0	15.00
16.00	93. 00	I NFUSI ON	0		0	o	0	0	16.00
17.00	22. 00	I&R SERVICES-OTHER PRGM	0		0	o	0	0	17. 00
		COSTS APPRV							
18. 00		CARDI AC CATHETERI ZATI ON	О		0	o	0	lo	18. 00
19. 00		OTHER ADMIN & GENERAL	0		0	ol	0	o	19.00
200.00			0		0	ol	0	ol	200. 00
	1	I .	· -	ļi	- 1	-1		-1	

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 14-0186

					'	0 12/31/2021	5/26/2022 10:	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	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		SOCIAL SERVICE	0	0	0	0		1. 00
2.00		ADULTS & PEDIATRICS	0	0	0	406		2. 00
3.00		INTENSIVE CARE UNIT	0	0	0	0		3. 00
4.00	41. 00	SUBPROVIDER - IRF	0	0	0	0		4. 00
5.00	50.00	OPERATING ROOM	0	0	0	4, 728, 784		5. 00
6.00	53. 00	ANESTHESI OLOGY	0	0	0	0		6. 00
7.00	55. 00	RADI OLOGY-THERAPEUTI C	0	0	0	0		7. 00
8.00	60.00	LABORATORY	0	0	0	0		8. 00
9.00	65. 00	RESPI RATORY THERAPY	0	0	0	0		9. 00
10.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0		10.00
11. 00	76. 01	OP PSY/CDU	0	0	0	0		11. 00
12.00	76. 02	RIMMS	0	0	0	316, 049		12.00
13.00	76. 05	DI ABETES	0	0	0	115, 370		13.00
14.00	76. 98	HYPERBARIC OXYGEN THERAPY	0	0	0	0		14.00
15. 00	91. 00	EMERGENCY	0	0	0	22, 693		15. 00
16.00	93. 00	I NFUSI ON	0	0	0	0		16. 00
17.00	22. 00	I&R SERVICES-OTHER PRGM	0	0	0	8, 884		17. 00
		COSTS APPRV						
18. 00	59. 00	CARDIAC CATHETERIZATION	0	0	0	0		18. 00
19.00	5. 06	OTHER ADMIN & GENERAL	0	0	0	0		19. 00
200.00			0	0	0	5, 192, 186		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0186 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 10:37 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** COMMUNI CATI ONS for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 20, 879, 623 00100 CAP REL COSTS-BLDG & FLXT 20 879 623 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 601, 050 9, 601, 050 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 37, 202, 519 95, 817 37, 306, 088 4.00 7, 752 01160 COMMUNICATIONS 5 01 5, 712 948 477 5 01 942.765 C 5.02 00550 DATA PROCESSING 10, 844, 266 310, 198 979, 493 969, 491 66,038 5.02 635, 969 5.03 00591 PURCHASI NG 1, 950, 381 154, 667 342, 384 12, 382 5.03 5.05 00590 BUSINESS OFFICE 7, 682, 283 367, 083 29, 174 2, 014, 811 37, 972 5.05 00592 OTHER ADMIN & GENERAL 34, 328, 776 1, 731, 165 1, 193, 696 3, 360, 452 196, 464 5 06 5 06 6.00 00600 MAINTENANCE & REPAIRS 10, 235, 711 500, 676 617, 972 631, 714 32, 194 6.00 00700 OPERATION OF PLANT 828, 091 4, 500, 948 882, 326 309, 686 7.00 14,033 7.00 00800 LAUNDRY & LINEN SERVICE 620, 954 135, 701 14, 584 185, 736 8.00 825 8.00 00900 HOUSEKEEPI NG 82, 556 9 00 3.016.532 28.879 855, 103 6,604 9 00 10.00 01000 DI ETARY 1, 360, 457 347, 362 39, 391 192, 396 11, 557 10.00 01100 CAFETERI A 11.00 251, 656 317, 848 216, 172 11.00 01300 NURSING ADMINISTRATION 849.445 135, 496 93.885 13.00 13.00 13, 208 14.00 01400 CENTRAL SERVICES & SUPPLY 1,070,848 216, 659 26, 495 181, 221 3, 302 14 00 01500 PHARMACY 1,000,147 80, 448 275, 716 8, 255 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2, 116, 507 192, 960 2,717 515, 059 42, 100 16.00 01700 SOCIAL SERVICE 17.00 1.664.009 392, 780 17.00 18, 055 1, 334 7, 429 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 1, 739, 937 13, 443 0 21.00 8, 840 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 1, 018, 079 497, 932 825 22.00 7, 469 22.00 268, 065 <u>11, 8</u>33 51, 740 02301 PARAMED EDUCATION PROGRAM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 16, 289, 306 2, 168, 461 117, 044 3, 365, 157 135, 379 30.00 03100 INTENSIVE CARE UNIT 31.00 4,007,487 310, 334 131, 447 789, 988 15, 684 31.00 32.00 03200 CORONARY CARE UNIT C 0 32.00 C 04000 SUBPROVIDER - IPF 40.00 1, 506, 655 r 14.307 297, 208 0 40.00 04100 SUBPROVIDER - IRF 41.00 3, 663, 309 271, 980 20, 151 638, 242 11, 557 41.00 04200 SUBPROVI DER 42.00 Ω 42.00 04300 NURSERY 24, 892 43.00 1, 237, 583 58, 823 268, 120 3, 302 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 829, 962 547, 462 1, 753, 336 1, 079, 378 23, 113 50.00 05100 RECOVERY ROOM 3, 573, 054 302, 582 26, 794 860, 899 17, 335 51.00 51.00 32, 448 05200 DELIVERY ROOM & LABOR ROOM 485, 907 52.00 1, 839, 707 178, 951 4, 953 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 839, 015 338, 793 587, 329 1, 226, 765 13, 208 54.00 40, 935 05401 NUCLEAR MEDICINE-DIAGNOSTIC 1, 651 54 01 550 816 16, 661 13 448 54 01 54.02 05404 ULTRASOUND 1,047,223 15, 369 142, 274 204, 185 3, 302 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 271, 808 159, 454 442, 575 13, 208 55.00 57.00 05700 CT SCAN 1, 224, 481 19, 551 366, 323 170, 985 4, 953 57.00 05800 MRI 40, 530 66, 387 57, 310 4, 953 58 00 462, 622 58 00 59.00 05900 CARDIAC CATHETERIZATION 8, 215, 199 118, 156 323, 597 442, 652 4, 127 59.00 06000 LABORATORY 10, 206, 299 221, 385 239, 469 746, 198 60.00 27, 241 60.00 60.01 06001 BLOOD LABORATORY 60.01 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 Ω 0 62 00 64.00 06400 INTRAVENOUS THERAPY 2,002,379 6,032 198, 840 1, 651 64.00 06500 RESPIRATORY THERAPY 42, 570 389, 623 5, 778 65.00 2, 283, 740 99,660 65.00 23, 939 06600 PHYSI CAL THERAPY 5, 947, 856 623, 048 47, 190 1, 148, 864 66, 00 66, 00 06900 ELECTROCARDI OLOGY 1, 842, 994 69.00 94, 593 219, 205 317, 431 13, 208 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 870,680 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 12,008,592 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 30, 805, 996 708, 945 C 0 0 73 00 75. 01 03955 RENAL DIALYSIS (IP) 892, 437 0 75.01 03956 CARDI AC REHAB 62, 291 3, 302 76.00 385.038 26, 560 110, 337 76.00 03950 OP PSY/CDU 229, 668 76.01 915.101 398.840 1.924 0 76.01 03957 RI MMS 76.02 836, 561 134, 341 16, 607 324, 261 9.906 76.02 76.03 03951 GENETIC/OAK PLAZA CLINICS 0 76.03 03952 PAIN CLINIC 76 04 0 76.04 03953 DLABETES 1, 450, 992 16, 797 895 257, 086 76.05 3, 302 76.05 07698 HYPERBARIC OXYGEN THERAPY 76. 98 892, 699 51, 275 11, 348 178, 383 0 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 155, 561 197, 652 942 54, 744 3, 302 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 C 0 89.00 91.00 09100 EMERGENCY 5, 824, 445 295, 305 109, 240 1, 201, 784 43, 750 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 0 04951 | NEUSLON 664, 080 119 439 93.00 93 00 10, 761 Ω 93.01 04950 COMMUNITY HEALTH CENTERS 111, 296 1,005,398 696 10, 431 1, 651 93.01

Health Financial Systems	RIVERSIDE MED	ICAI CENTED		ln lic	eu of Form CMS-2	2552 10
COST ALLOCATION - GENERAL SERVICE COSTS	KI VERSI DE MED	Provi der CCN: 14-0186		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/26/2022 10:	pared:
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
	0	1. 00	2. 00	4. 00	5. 01	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	5, 208, 769	206, 187	1		l	•
99. 10   09910   CORF	0	0		0	0	
101. 00 10100 HOME HEALTH AGENCY	3, 370, 963	96, 837	7, 31	8 736, 456	15, 684	101.00
SPECIAL PURPOSE COST CENTERS		0				400.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110. 00 11000   I NTESTI NAL ACQUI SI TI ON	0	0		0		110. 00 111. 00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE	U	U		J	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	300, 706, 806	17, 394, 002	9, 340, 87	8 29, 244, 346	865, 929	
NONREIMBURSABLE COST CENTERS	300, 700, 800	17, 394, 002	9, 340, 67	29, 244, 340	000, 929	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43, 658		n 0	0	190. 00
191. 00 19100 RESEARCH	0	43, 030 N				191.00
191. 01 19101 SENI OR ADVAN	0	0				191. 01
191. 02 19102 CARE-A-VAN	4, 957	0		860	<b>l</b>	191. 02
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	63, 888, 522	2, 192, 535	260, 17			
192. 01 19201 REFERENCE LAB	0	0	,	0		192. 01
192. 02 19202 MEALS ON WHEELS	o	0		0	0	192. 02
193. 00 19300 NONPALD WORKERS	0	1, 249, 428		0	42, 925	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	364, 600, 285	20, 879, 623	9, 601, 05	37, 306, 088	948, 477	202. 00

Provider CCN: 14-0186

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 10: 37 am

					5/26/2022 10:	37 am_
Cost Center Description	DATA	PURCHASI NG	BUSI NESS	Subtotal	OTHER ADMIN &	
	PROCESSI NG		OFFI CE		GENERAL	
	5. 02	5. 03	5. 05	5A. 05	5. 06	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00  00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01   01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSING	13, 169, 486					5. 02
5. 03 00591 PURCHASI NG	209, 705	3, 305, 488				5. 03
5. 05 00590 BUSINESS OFFICE	2, 027, 150	5, 388				5. 05
5. 06   00592   OTHER ADMIN & GENERAL	2, 055, 112	8, 643		42, 874, 308	42, 874, 308	5. 06
6. 00 00600 MAI NTENANCE & REPAI RS	293, 587	21, 053		12, 332, 907	1, 643, 520	6. 00
7. 00 00700 OPERATION OF PLANT	237, 666	635		6, 773, 385	902, 642	7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	237,000	14, 773		972, 573	129, 608	8.00
9. 00   00900   HOUSEKEEPI NG	83, 882	26, 428		·		1
		•		4, 099, 984	546, 376	9.00
10. 00   01000   DI ETARY	139, 803	15, 967		2, 106, 933	280, 776	1
11. 00 01100 CAFETERI A	450.704	0	_	785, 676	104, 702	11.00
13. 00 01300 NURSING ADMINISTRATION	153, 784	391	0	1, 246, 209		
14. 00   01400   CENTRAL SERVI CES & SUPPLY	69, 902	21, 054	0	1, 589, 481	211, 819	14. 00
15. 00   01500   PHARMACY	265, 627	78, 489		1, 708, 682	227, 704	
16.00 01600 MEDICAL RECORDS & LIBRARY	405, 430	113		3, 274, 886		
17. 00   01700   SOCIAL SERVICE	293, 587	380		2, 377, 574		
21.00   02100   1 & R SERVICES-SALARY & FRINGES APPRV	0	0	0	1, 753, 380	233, 661	21. 00
22.00   02200   I &R SERVICES-OTHER PRGM COSTS APPRV	0	1, 041	0	1, 534, 186	204, 450	22. 00
23.00   02301   PARAMED EDUCATION PROGRAM	0	37	0	331, 675	44, 200	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 356, 094	77, 271	563, 361	24, 072, 073	3, 207, 917	30.00
31.00 03100 INTENSIVE CARE UNIT	237, 666	37, 447		5, 602, 145	746, 559	1
32. 00 03200 CORONARY CARE UNIT	l ol	0	0	0	0	32. 00
40. 00   04000   SUBPROVI DER - 1 PF	ol	1, 945	35, 743	1, 855, 858	247, 317	40.00
41. 00   04100   SUBPROVI DER -   I RF	209, 705	10, 400		4, 895, 138		41. 00
42. 00   04200   SUBPROVI DER	2077,700		0,,,,,	0,070,100	0	42. 00
43. 00   04300   NURSERY	41, 941	7, 464	١	1, 656, 694		1
ANCI LLARY SERVI CE COST CENTERS	71, 771	7, 404	14, 507	1, 030, 074	220,770	75.00
50. 00 05000 OPERATING ROOM	349, 509	914, 651	1, 151, 754	16, 649, 165	2, 218, 718	50.00
51. 00   05100   RECOVERY   ROOM	195, 725	16, 931		5, 132, 308		1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	55, 921					1
	55, 921	10, 793	0, 720	2, 617, 406	346, 603	
	_	0	-	10 010 177		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	321, 548	42, 373		10, 210, 177	1, 360, 639	1
54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	13, 980	25, 064		741, 839	98, 860	54. 01
54. 02   05404   ULTRASOUND	83, 882	10, 439		1, 672, 660		1
55. 00 05500 RADI OLOGY-THERAPEUTI C	153, 784	19, 093		4, 477, 829	596, 729	55. 00
57. 00   05700   CT   SCAN	111, 843	25, 016		2, 782, 800	370, 844	
58. 00   05800   MRI	125, 823	10, 274		999, 609	133, 211	1
59. 00   05900   CARDI AC   CATHETERI ZATI ON	27, 961	1, 027, 780		10, 840, 882		
60. 00   06000   LABORATORY	866, 781	611, 587	1, 598, 864	14, 517, 824	1, 934, 689	
60. 01  06001 BL00D LABORATORY	0	0	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
64.00   06400   I NTRAVENOUS THERAPY	41, 941	6, 657	3, 463	2, 260, 963	301, 303	64. 00
65. 00 06500 RESPIRATORY THERAPY	111, 843	29, 850	196, 627	3, 159, 691	421, 070	65.00
66. 00 06600 PHYSI CAL THERAPY	866, 781	22, 099	431, 150	9, 110, 927	1, 214, 149	66.00
69. 00 06900 ELECTROCARDI OLOGY	167, 764	32, 956	287, 769	2, 975, 920	396, 580	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	107, 828	978, 508	130, 399	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	625, 373	12, 633, 965	1, 683, 640	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	2, 337, 400	33, 852, 341	4, 511, 265	1
75. 01   03955   RENAL DIALYSIS (IP)	O	73		905, 775	120, 706	1
76. 00   03956   CARDI AC   REHAB	97, 862	719	· ·	704, 180	93, 841	1
76. 01 03950 OP PSY/CDU	167, 764	563		1, 758, 103	234, 290	1
76. 02 03957 RI MMS	n .37,701	11, 496		1, 357, 454	180, 898	1
76.03 03951 GENETIC/OAK PLAZA CLINICS		, ., .	0	0	0	76. 03
76. 04   03952   PAIN CLINIC		0	١	0	0	76. 04
76. 05   03953 DI ABETES	69, 902	3, 503	24, 138	1, 826, 615	243, 420	76. 05
76. 98 07698 HYPERBARI C OXYGEN THERAPY	07, 702	19, 023		1, 196, 529	159, 453	
OUTPATIENT SERVICE COST CENTERS	<u> </u>	17, 023	43,001	1, 170, 327	137, 433	70.70
		E11	2 510	414 220	EE 140	00 00
88. 00   08800   RURAL HEALTH CLINIC	0	511	3, 518 0	416, 230	55, 468 0	88. 00 89. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	١	(F 222		0 440 747		
91. 00 09100 EMERGENCY	349, 509	65, 302	553, 412	8, 442, 747	1, 125, 106	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
92. 01   09202   OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
93. 00  04951  I NFUSI ON	0	8, 766		1, 101, 320		
93. 01 04950 COMMUNITY HEALTH CENTERS	0	240	85, 168	1, 214, 880	161, 899	93. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	97, 862	5, 079	93, 258	7, 298, 641	972, 639	
99. 10   09910   CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	489, 312	10, 097	41, 839	4, 768, 506	635, 465	101. 00
	·		·			

In Lieu of Form CMS-2552-10 Health Financial Systems RIVERSIDE MEDICAL CENTER COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0186 Peri od: Worksheet B

From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/26/2022 10:37 am Cost Center Description DATA PURCHASI NG **BUSI NESS** Subtotal OTHER ADMIN & PROCESSI NG OFFI CE GENERAL 5.03 5A. 05 5.02 5.05 5.06 SPECIAL PURPOSE COST CENTERS 0 0 109. 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 | SLET ACQUISITION o 0 ol 0 111.00 113.00 11300 I NTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 259, 854 32, 726, 094 118. 00 118.00 12, 847, 938 12, 163, 861 288, 449, 541 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 0 43, 658 5, 818 190. 00 0 0 191.00 0 0 0 0 191. 01 19101 SENI OR ADVAN 0 191. 01 191. 02 19102 CARE-A-VAN 0 0 5, 817 775 191. 02 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 9, 926, 548 192. 00 74, 487, 368 45, 634 192. 01 19201 REFERENCE LAB 0 0 192. 01 192.02 19202 MEALS ON WHEELS 0 0 0 192. 02 193. 00 19300 NONPALD WORKERS 0 1, 613, 901 215, 073 193. 00

321, 548

13, 169, 486

0

12, 163, 861

364, 600, 285

3, 305, 488

200.00

0 201.00

42, 874, 308 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Provider CCN: 14-0186

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 10: 37 am

2 00 00000 CAP REL COSTS-MYRLE EQUIP   2 00 00000 CAP REL COSTS-MYRLE EQUIP   3 00000 CAP REL COSTS AVERLE EQUIP   4 00 00000 CAP REL COSTS AVERLE EQUIP   5 00 00000						72/31/2021	5/26/2022 10:	
Description		Cost Center Description				HOUSEKEEPI NG	DI ETARY	
CREATION   SERVICE COST - CENTERS						0.00	10.00	
1.00   00100   CAP REL OSTS-HUBE & THIX		GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
4.00   ODDISCIPLE RAMIN IS CERETAL 5.02   ODDISCIPLE RAMIN IS CERETAL 6.00   ODDISCIPL	1.00							1.00
1-10   COMMAND ADDRESSING	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
5.02   Composition   Composi	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00   0.0994   PIRKELMASH NG	5.01	01160 COMMUNI CATI ONS						5. 01
5.06   0.0099/   DISH RESIN OFFICE     5.00   0.0099/   DISH RAWIN IS GERIPAL   5.00   0.0099   DISH RAWIN IS GERIPAL   5.00   DISH	5.02	00550 DATA PROCESSING						5. 02
5.00   00092/ OTHER ADMIN & GENERAL   13, 976, 427   7, 675, 007   7, 67	5.03							5. 03
0.00   00000   MAINTENANCE & REPAIRS   13, 976, 427   7, 676, 027   1, 102, 18   4, 716, 445   7, 00000   1, 10	5.05							5. 05
7.00 007000 DOREATHON OF FLANT 0.00 007000 DALBORY S LINEAR SERVICE 0.00 007000 DALBORY S LINEAR SERVICE 0.00 007000 DEFARM SERVI								5. 06
8.00   000000   LAURDRY & LINEN SERVICE   0   0   0   0   0   0   0   0   0			13, 976, 427					
9.00   0.0000   INJEKTEF IN   C			0	7, 676, 027				
10.00   01000   DETAIN			0	0	1, 102, 181			
11-10.0   011-00   CAFETERIA   0   2-99, 884   0   191, 880   1,534, 19   11.00   11.00   011-00   01-		l i	0					
13.00   01300   MURSING ADMINISTRATION   0   0   0   0   13.00			0					1
14.00   01400  CENTRAL SERVICES & SUPPLY   9.601   183, 990   52,090   130,799   0   14,000   16.00			0	269, 834	0	191, 880		1
15.00   01500   PHARMACY   0   68, 295   0   48, 565   0   15.00   17.00   01700   SCOLAL SERVICE   0   15.328   0   10.899   0   17.00   17.00   02100   48 SERVICES-SALARY & FRINCES APPRY   0   7.505   0   0   0   0   0   22.00   02200   48 SERVICES-SALARY & FRINCES APPRY   0   7.505   0   5.337   0   22   23.00   02200   48 SERVICES-SALARY & FRINCES APPRY   0   7.505   0   5.337   0   22   23.00   02200   48 SERVICES-SALARY & FRINCES APPRY   0   0   7.505   0   5.337   0   22   23.00   02200   7.508   0   7.145   0   0   0   5.307   24.00   02200   18 SERVICES-SALARY & FRINCES APPRY   0   0   0   0   5.307   25.00   02200   18 SERVICES-SALARY & FRINCES APPRY   0   0   0   0   0   0   25.00   02200   02200   18 SERVICES APPRY   0   0   0   0   0   0   0   25.00   02200			1	0	0	0		
16.00   01-600   MEDICAL RECORDS & LIBRARY   0   16.3, 811   0   116, 487   0   16.00   21.00   02-100   187 SERVICES-SALARY & FRINGES APPRY   0   7.505   0   0   0   0   21.00   22.00   02-001   188 SERVICES-SALARY & FRINGES APPRY   0   7.505   0   5.337   0   22.00   22.00   02-001   188 SERVICES-SALARY & FRINGES APPRY   0   7.505   0   5.337   0   22.00   22.00   02-001   188 SERVICES-SALARY & FRINGES APPRY   0   7.505   0   5.337   0   22.00   23.00   02-001   02-001   02-001   02-001   02-001   02-001   23.00   02-001   02-001   02-001   02-001   02-001   02-001   23.00   02-001   02-001   02-001   02-001   02-001   02-001   23.00   02-001   02-00					52, 080			
17.00   01700   SOCIAL SERVICE   0   15, 328   0   10, 899   0   17, 00   22.00   0210   18 SERVICES-SALARY & FRINGES APPRV   0   7, 505   0   5, 337   0   22.00   0200   18 SERVICES-OTHER PROBLOSTS APPRV   0   7, 505   0   5, 337   0   22.00   0200   18 SERVICES COST CENTERS   0   10,004   0   7, 143   0   23.00   0200   18 SERVICES COST CENTERS   0   10,004   0   7, 143   0   23.00   0200   18 SERVICES COST CENTERS   0   10,004   0   7, 143   0   23.00   0200   0			0		0			
21.00   02.00   148 SERVICES-SALARY & FRINCES APPRV   0   0   0   0   0   0   21.00   23.00   02.00   148 SERVICES-STHER PROJECTORST APPRV   0   7,505   0   5,337   0   22.00   23.00   02.00   148 SERVICE-STHER PROJECTORST APPRV   0   7,505   0   5,337   0   22.00   30.00   03.000   ADULTS & PEDIATRIC ST   962,484   1,840,891   501,991   1,309   0.64   1,162,919   30.00   30.00   03.000   ADULTS & PEDIATRIC ST   962,484   1,840,891   501,991   1,309   0.64   1,162,919   30.00   32.00   03.000   ADULTS & PEDIATRIC ST   962,484   72,770   187,343   45,287   31.00   32.00   03.000   ADULTS & PEDIATRIC ST   962,484   72,770   187,343   45,287   31.00   32.00   03.000   ADULTS & PEDIATRIC ST   962,484   72,770   187,343   45,287   31.00   32.00   03.000   ADULTS & PEDIATRIC ST   962,484   72,770   187,343   45,287   31.00   32.00   03.000   ADULTS & PEDIATRIC ST   97,202   20.000   60.000   147,779   170,000   147,779   32.00   03.000   ADULTS & PEDIATRIC ST   97,202   20.000   60.000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000   147,779   170,000			0		0		-	
22.00			0	15, 328	0	10, 899		
23.00   03001   PARAMED   EDUCATION PROGRAM   0   10.045   0   7, 143   0   23.00			0	7 505	0	5 227		
IMPATI ENT ROUTINE SERVICE COST CENTERS   962, 484   1,840,891   501,991   1,309,064   1,162,979   30.00   30.00   03100   AUIT.S & PEDIA PRICES   962,484   1,840,891   501,991   1,309,064   1,162,979   31.00   31.00   3100   CORNARY CARE UNIT   456,040   263,454   72,790   187,343   45,287   31.00   32.00		l l	1					
30.00   3000   ADULT'S & PEDIATRICS   992, 484   1,840,891   501,991   1,309,064   1,162,919   31.00	23.00		<u> </u>	10, 045	0	7, 143	0	23.00
31.00 0 3000 (NTENSI VE CARE UNIT	20.00		062 404	1 040 001	E01 001	1 200 044	1 1/2 010	20 00
32.00   03/200   CORDMARY CARE UNIT   0   0   0   0   0   32.00								
40.00   04000 SUBPROVIDER - IPF   19, 202   0   60,598   0   0   0   40.00			1			107, 343		
41.00   04100 SUBPROVI DER   187, 206   230, 894   74, 965   164, 190   141, 778   41. 00   42.00   42.00   42.00   42.00   04.00   0   0   0   0   0   42.00   43.00   43.00   04.00   04.00   04.00   0   0   0   43.00   43.00   04.00			1 "	0	_	0		1
42.00   04200   NURSERY   158, 414   49, 937   0   35, 510   0   42.00				220 004		164 100		
43. 00   04300   NURSERY   158, 414   49, 97   0   35,510   0   43. 00			07,200	230, 094		104, 190		1
ANCILLARY SERVICE COST CENTERS			150 /1/	40.027	ľ	25 510		1
50.00	43.00		150, 414	47, 737	0	33, 310	0	43.00
51.00   05100   RECOVERY ROOM & LABOR ROOM   182, 416   151, 919   0   108, 030   0   52, 00   05200   0ELIVERY ROOM & LABOR ROOM   182, 416   151, 919   0   0   0   0   0   0   0   0   52, 00   53, 00   05300   ARESTHESI OLOGY   0   0   0   0   0   0   0   0   0	50 00		2 755 443	464 762	50 381	330 494	0	50 00
12, 20   05200   DELIVERY ROOM & LABOR ROOM   182, 416   151, 919   0   108, 030   0   52, 00   53. 00   0530   0   0530   0   0500   0   0   0   0   0   0   0					· ·			
53. 00   05300   ANSTHESI DLOGY   0   0   0   0   0   53. 00   54. 01   05400   RADI DLOGY-DLAGNOSTIC   1, 224, 107   215, 769   65, 813   153, 434   0   54. 00   54. 01   05401   NUCLEAR MEDI CI NE-DI AGNOSTIC   86, 408   14, 144   0   10, 058   0   54. 01   55. 00   05500   RADI DLOGY-THERAPEUTIC   297, 626   0   0   0   0   0   0   55. 00   05700   CT   SCAN   72, 006   16, 598   0   11, 803   0   57. 00   59. 00   05700   CT   SCAN   72, 006   16, 598   0   11, 803   0   57. 00   59. 00   05800   MRI   60, 005   34, 408   0   24, 467   0   58. 00   59. 00   05800   CRANITORY   784, 869   100, 307   17, 341   71, 329   0   59. 00   60. 01   06000   LABORATORY   568, 850   194, 293   0   138, 162   0   60. 00   60. 01   06000   MHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   0   0   64. 00   06400   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   0   65. 00   06500   RESPIRATORY   1, 087, 295   0   0   0   0   0   0   0   66. 00   06600   RESPIRATORY   1, 087, 295   0   0   0   0   0   0   0   66. 00   06600   RESPIRATORY   1, 087, 295   0   0   0   0   0   0   0   67. 00   06600   RESPIRATORY   1, 087, 295   0   0   0   0   0   0   67. 00   06600   RESPIRATORY   1, 087, 295   0   0   0   0   0   0   67. 00   06500   RESPIRATORY   1, 087, 295   0   0   0   0   0   0   67. 00   06500   RESPIRATORY   1, 087, 295   0   0   0   0   0   0   67. 00   0500   RESPIRATOR   1, 087, 295   0   0   0   0   0   0   67. 00   0700   0700   DELECTROCARDOR   1, 087, 295   0   0   0   0   0   67. 00   0700   DELECTROCARDOR   1, 087, 295   0   0   0   0   0   0   67. 00   0700   IMPL DEV   CHARGED TO PATI ENT   0   0   0   0   0   0   67. 00   03950   RESPIRATOR   1, 087, 295   0   0   0   0   0   0   67. 00   03950   RESPIRATOR   1, 087, 295   0   0   0   0   0   0   67. 00   03950   RESPIRATOR   1, 087, 295   0   0   0   0   0   0   67. 00   03950   RESPIRATOR   1, 087, 295   0   0   0   0   0   0   67. 00   03950   RESPIRATOR   1, 087, 107, 107, 107, 107, 107, 107, 107, 10								
54. 00   05400   RADI OLOGY-DI AGNOSTI C   1,224, 107   215, 769   65, 813   153, 434   0   54. 00			102, 110	101, 717	o o	100, 000	-	
54. 01   05401   NUCLEAR MEDICINE-DIAGNOSTIC   86, 408   14, 144   0   10, 058   0   54, 01			1 224 107	215 769	65 813	153 434		
54. 02   OSAO4   ILTRASQUIND   276, 024   13, 047   0   9, 278   0   54, 02   55, 00   055, 00   055, 00   055, 00   055, 00   055, 00   0500   0   0   0   0   0   0   0								
55.00         0.05500 RADI OLOGY-THERAPEUTI C         297, 626         0         0         0         0         55, 00         0         0.05700 CT SCAN         72, 006         16, 598         0         11, 803         0         57, 00         58, 00         0         24, 467         0         58, 00         58, 00         0         0.000 CARDIA C CATHETERI ZATI ON         784, 869         100, 307         17, 341         71, 329         0         58, 00         0					· ·			
57. 00   05700   CT SCAN   72. 006   16. 598   0   11. 803   0   57. 00   58. 00   05800   MRI   60. 005   34. 408   0   24. 467   0   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   784, 869   100, 307   17, 341   71, 329   0   59. 00   60. 00   06000   LABORATORY   568, 850   194, 293   0   138, 162   0   60. 00   62. 00   06200   MRI   06000   BLODD LABORATORY   0   0   0   0   0   0   0   0   62. 00   06200   MRI   06000   BLODD LABORATORY   1, 087, 295   0   0   0   0   0   0   65. 00   06200   MRI   06000   MRI   MR				0	o o	7,270		1
58. 00   05900   NR    60. 005   34. 408   0   24. 467   0   58. 00   05900   05900   CARDIAC CATHETERIZATION   784, 869   100, 307   17, 341   71, 329   0   59. 00   06. 01   06000   LABORATORY   568, 850   194, 293   0   138, 162   0   60. 00   06. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   06. 01   06002   LABORATORY   100   0   0   0   0   0   0   0   06. 01   06002   WHOLE B LOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   0   0   06. 01   06000   NESPI RATORY THERAPY   1, 087, 295   0   0   0   0   0   0   06. 00   06600   PHYSI CAL THERAPY   338, 430   528, 929   20, 551   376, 123   0   65. 00   06. 00   06600   PHYSI CAL THERAPY   338, 430   528, 929   20, 551   376, 123   0   66. 00   06. 00   06600   PHYSI CAL THERAPY   338, 430   528, 929   20, 551   376, 123   0   60. 00   07. 00   0700   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   07. 00   0700   MIPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   07. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   07. 00   07300   07300   07300   07300   0   0   0   0   07. 00   07300   07300   07300   0   0   0   0   0   07. 00   07300   07300   07300   0   0   0   0				16, 598	0	11, 803		
59, 00   05900   CARDI ACC CATHETERI ZATI ON   784, 869   100, 307   17, 341   71, 329   0   59, 00								
0.0   0.0								
0.0   0.0	60.00					138, 162	0	60.00
64. 00   06400   INTRAVENOUS THERAPY   1, 087, 295   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   700, 862   36, 139   2, 955   25, 699   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   338, 430   528, 929   20, 551   376, 123   0   66. 00   69. 00   06600   PHYSI CAL THERAPY   338, 435   80, 303   6, 182   57, 104   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   75. 01   03955   RENAL DI ALYSI S (1P)   103, 209   0   0   0   0   0   76. 01   03956   CARDI AC REHAB   208, 818   52, 881   0   37, 604   0   76. 00   76. 01   03950   OP PSY/CDU   19, 202   338, 591   0   240, 773   0   76. 01   76. 02   03957   RIMMS   48, 004   114, 047   1, 984   81, 099   0   76. 03   76. 04   03952   PAIN CLINIC   0   0   0   0   0   0   76. 05   03953   DIABETES   2, 2400   14, 259   0   0   10, 140   0   76. 04   76. 05   03953   DIABETES   2, 2400   14, 259   0   0   10, 140   0   76. 98   76. 08   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   76. 08   09900   BERGENCY   568, 850   250, 696   86, 276   178, 271   14, 976   91. 00   79. 00   09000   08SERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   70. 00   00   0   0   0   0   70. 00   00   00   0   0   0   70. 00   00   00   0   0   7	60. 01		1	0	0	o	0	
64. 00   06400   INTRAVENOUS THERAPY   1, 087, 295   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   700, 862   36, 139   2, 955   25, 699   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   338, 430   528, 929   20, 551   376, 123   0   66. 00   69. 00   06600   PHYSI CAL THERAPY   338, 435   80, 303   6, 182   57, 104   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   75. 01   03955   RENAL DI ALYSI S (1P)   103, 209   0   0   0   0   0   76. 01   03956   CARDI AC REHAB   208, 818   52, 881   0   37, 604   0   76. 00   76. 01   03950   OP PSY/CDU   19, 202   338, 591   0   240, 773   0   76. 01   76. 02   03957   RIMMS   48, 004   114, 047   1, 984   81, 099   0   76. 03   76. 04   03952   PAIN CLINIC   0   0   0   0   0   0   76. 05   03953   DIABETES   2, 2400   14, 259   0   0   10, 140   0   76. 04   76. 05   03953   DIABETES   2, 2400   14, 259   0   0   10, 140   0   76. 98   76. 08   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   76. 08   09900   BERGENCY   568, 850   250, 696   86, 276   178, 271   14, 976   91. 00   79. 00   09000   08SERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   70. 00   00   0   0   0   0   70. 00   00   00   0   0   0   70. 00   00   00   0   0   7	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	0	ol	0	62.00
65. 00   06500   RESPIRATORY THERAPY   338, 430   328, 299   20, 551   376, 123   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   338, 430   528, 929   20, 551   376, 123   0   66. 00   6900   LECETROCARDIO LOGY   398, 435   80, 303   6, 182   57, 104   0   69, 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   071. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   072. 00   073. 00	64.00	1 1	1, 087, 295	0	0	ol	0	64.00
69.00   06900   ELECTROCARDI OLOGY   398, 435   80, 303   6, 182   57, 104   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   71.00   72.00   07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   72.00   73.00   75.01   73.00   75.01   75.	65.00	06500 RESPIRATORY THERAPY	700, 862	36, 139	2, 955	25, 699	0	65. 00
69. 00   0.6900   ELECTROCARDI OLOGY   398, 435   80, 303   6, 182   57, 104   0 69, 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   0   0   0   0   0   0   0   0   0	66.00	06600 PHYSI CAL THERAPY	338, 430	528, 929	20, 551	376, 123	0	66. 00
72. 00	69.00	06900 ELECTROCARDI OLOGY	398, 435	80, 303	6, 182	57, 104	0	69.00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	o	0	71. 00
75. 01	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
76. 00 03956 CARDI AC REHAB 208, 818 52, 881 0 37, 604 0 76. 00 76. 01 03950 OP PSY/CDU 19, 202 338, 591 0 240, 773 0 76. 01 76. 02 03957 RI MMS 48, 004 114, 047 1, 984 81, 099 0 76. 01 76. 03 03951 GENETI C/OAK PLAZA CLINICS 0 0 0 0 0 0 0 0 76. 03 76. 04 03952 PAIN CLINIC 0 0 0 0 0 0 0 0 76. 03 76. 05 03953 DI ABETES 2, 400 14, 259 0 10, 140 0 76. 05 76. 98 07698 HYPERBARI C OXYGEN THERAPY 26, 402 43, 529 1, 130 30, 954 0 76. 98 88. 00 08900 FURAL HEALTH CLINIC 28, 803 167, 794 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 91. 00 09100 EMERGENCY 568, 850 250, 696 86, 276 178, 271 14, 976 91. 00 92. 01 09202 OBSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 92. 01 93. 01 04950 COMMUNITY HEALTH CENTERS 0 0 0 0 0 0 0 93. 00 93. 01 04950 COMMUNITY HEALTH CENTERS 0 0 0 0 0 0 0 93. 01  075. 00 09500 AMBULANCE SERVICES 182, 416 175, 040 6, 442 124, 471 0 95. 00 99. 10 09910 CORF	73. 00		o	0	0	o	0	73. 00
76. 01 03950 OP PSY/CDU 19, 202 338, 591 0 240, 773 0 76. 01 76. 02 03957 RI MMS 48, 004 114, 047 1, 984 81, 099 0 76. 02 76. 03 03951 GENETI C/OAK PLAZA CLINICS 0 0 0 0 0 0 0 76. 03 76. 04 03952 PAIN CLINIC 0 0 0 0 0 0 0 76. 04 76. 05 03953 DI ABETES 2, 400 14, 259 0 10, 140 0 76. 05 76. 98 07698 HYPERBARI C OXYGEN THERAPY 26, 402 43, 529 1, 130 30, 954 0 76. 98  **OUTPATI ENT SERVI CE COST CENTERS**  88. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 88. 00 99. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 92. 01 09202 OBSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 0 92. 01 93. 00 04951 INFUSION 98. 409 0 5, 311 0 0 0 93. 00 99. 10 09500 AMBULANCE SERVI CES 182, 416 175, 040 6, 442 124, 471 0 95. 00 99. 10 09910 CORF**	75. 01	03955 RENAL DIALYSIS (IP)	103, 209	0	0	o	0	75. 01
76. 02   03957   RIMMS	76. 00	03956 CARDI AC REHAB	208, 818		0			76. 00
76. 03	76. 01		19, 202	338, 591	0	240, 773	0	76. 01
76. 04	76. 02		48, 004	114, 047	1, 984	81, 099	0	76. 02
76. 05			0	0	0	o	0	76. 03
76. 98 O7698 HYPERBARI C OXYGEN THERAPY 26, 402 43, 529 1, 130 30, 954 0 76. 98 OUTPATIENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C 28, 803 167, 794 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 91. 00 09100 EMERGENCY 568, 850 250, 696 86, 276 178, 271 14, 976 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 92. 01 09202 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 10 0 92. 01 93. 00 04951 INFUSI ON 98, 409 0 5, 311 0 0 93. 00 93. 01 04950 COMMUNI TY HEALTH CENTERS 0 0 0 0 0 0 0 93. 01  OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 182, 416 175, 040 6, 442 124, 471 0 95. 00 99. 10 09910 CORF	76. 04	03952 PAIN CLINIC	0	0	0	0	0	76. 04
SECTION   SERVICE COST CENTERS   SECTION   S			2, 400	14, 259	0			76. 05
88. 00	76. 98		26, 402	43, 529	1, 130	30, 954	0	76. 98
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   0								1
91. 00			28, 803	167, 794	0	0		1
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0   0   0   0   0   0   0   0   92. 01   93. 00   04951   INFUSI ON   98. 409   0   5, 311   0   0   93. 00   93. 01   04950   COMMUNI TY HEALTH CENTERS   0   0   0   0   0   0   95. 00   09500   AMBULANCE SERVI CES   182, 416   175, 040   0   0   0   0   0   99. 10   99. 10   09910   CORF   0   0   0   0   0   0   0   0   99. 10   09910   CORF   0   0   0   0   0   0   0   91. 00   00   00   00   00   00   00   00			0	0	0	0		89. 00
92. 01   09202   0BSERVATI ON BEDS (DI STI NCT PART)   0   0   0   0   0   0   92. 01   93. 00   04951   INFUSI ON   98, 409   0   5, 311   0   0   93. 00   93. 01   04950   COMMUNI TY HEALTH CENTERS   0   0   0   0   0    OTHER REI MBURSABLE COST CENTERS   182, 416   175, 040   6, 442   124, 471   0   95. 00   99. 10   09910   CORF   0   0   0   0   0   0   99. 10			568, 850	250, 696	86, 276	178, 271	14, 976	1
93. 00   04951   INFUSION   98, 409   0   5, 311   0   0   93. 00   04950   COMMUNITY HEALTH CENTERS   0   0   0   0   0   0   0   0   0		09200 OBSERVATION BEDS (NON-DISTINCT PART						
93. 01 04950 COMMUNITY HEALTH CENTERS 0 0 0 0 0 93. 01  OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 182, 416 175, 040 6, 442 124, 471 0 95. 00  99. 10 09910 CORF 0 0 0 0 0 0 99. 10			0	0	0	0		
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVICES         182, 416         175, 040         6, 442         124, 471         0         95. 00           99. 10         09910 CORF         0         0         0         0         0         99. 10			98, 409	0	5, 311	0		93. 00
95. 00   09500   AMBULANCE SERVICES   182, 416   175, 040   6, 442   124, 471   0   95. 00   99. 10   09910   CORF   0   0   0   0   0   0   99. 10	93. 01		0	0	0	0	0	93. 01
99. 10   09910   CORF   0   0   0   0   99. 10					T			
			182, 416	175, 040	6, 442	124, 471		
101.00 10100 HOME HEALTH AGENCY   2,400  82,209  0  58,459  0 101.00			0	0	0	0		
	101.00	0 10100 HOME HEALTH AGENCY	2, 400	82, 209	0	58, 459	0	101. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS RIVERSIDE MEDICAL CENTER Provider CCN: 14-0186

| Period: | Worksheet B | From 01/01/2021 | Part I | Date/Time Prepared: | 5/26/2022 | 10: 37 am

					5/26/2022 10:	<u>3/ am </u>
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE			
	6.00	7.00	8. 00	9. 00	10.00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 821, 926	6, 815, 435	1, 077, 173	4, 677, 322	2, 899, 179	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37, 063	0	26, 356	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
191. 01 19101 SENI OR ADVAN	0	0	0	0	0	191. 01
191. 02 19102 CARE-A-VAN	0	0	0	0	0	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 154, 501	805, 575	25, 008	0	0	192. 00
192. 01 19201 REFERENCE LAB	0	0	0	0	0	192. 01
192.02 19202 MEALS ON WHEELS	0	0	0	0	0	192. 02
193. 00 19300 NONPALD WORKERS	0	17, 954	0	12, 767	0	193. 00
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)	13, 976, 427	7, 676, 027	1, 102, 181	4, 716, 445	2, 899, 179	202. 00

Provider CCN: 14-0186

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 10: 37 am

					7 127 317 2021	5/26/2022 10:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
			ADMINI STRATION	SUPPLY		LI BRARY	
	T	11. 00	13.00	14.00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00550 DATA PROCESSING						5. 02
5. 03	00591 PURCHASI NG						5. 03
5. 05	00590 BUSI NESS OFFI CE						5. 05
5. 06 6. 00	00592 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS						5. 06 6. 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	2, 886, 311	1				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	54, 554		2 240 225			13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	38, 997 100, 842		2, 240, 325	2, 154, 088		14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	100, 642		0	2, 134, 000	3, 991, 605	1
17. 00	01700 SOCIAL SERVICE	86, 801	il o	0	Ö	0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	C	o	0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	90, 207	54, 648	0	0	0	22. 00
23. 00	02301 PARAMED EDUCATION PROGRAM	13, 641	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				ام	101.000	
30.00	03000 ADULTS & PEDIATRICS	618, 575		0	0	184, 889	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	157, 164	73, 310	0	0	23, 660 0	31. 00 32. 00
40. 00	04000 SUBPROVI DER – I PF	62, 203	37, 683	0	0	11, 730	1
41. 00	04100 SUBPROVI DER – I RF	114, 878		0	0	22, 905	
42. 00	04200 SUBPROVI DER	,	1	0	0	0	42. 00
43.00	04300 NURSERY	30, 584	18, 528	0	0		1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	133, 823		0	0	377, 993	
51.00	05100 RECOVERY ROOM	128, 654			0	45, 614	
52.00	05200 DELIVERY ROOM & LABOR ROOM	64, 838	39, 279	1	0	2, 864	
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY - DI AGNOSTI C	121, 433		0	0	0 276, 055	53. 00 54. 00
54. 00	05401 NUCLEAR MEDICINE-DIAGNOSTIC	6, 771		0	0	26, 020	1
54. 02	05404 ULTRASOUND	29, 054		0	0	54, 475	
55. 00	05500 RADI OLOGY-THERAPEUTI C	46, 415		0	0	137, 152	
57.00	05700 CT SCAN	38, 133	0	0	0	282, 127	57. 00
58. 00	05800 MRI	12, 306		0	0	76, 045	
59. 00	05900 CARDI AC CATHETERI ZATI ON	55, 542		0	0	223, 631	
60.00	06000 LABORATORY	122, 974	. 1	0	0	524, 729	
60. 01 62. 00	06001   BLOOD LABORATORY   06200   WHOLE BLOOD & PACKED RED BLOOD CELL			0	0	0	60.01
64. 00	06400 I NTRAVENOUS THERAPY	27, 479	16, 647	0	0		
65. 00	06500 RESPIRATORY THERAPY	55, 949		l	0	64, 531	
66. 00	06600 PHYSI CAL THERAPY	68, 433			Ö	141, 499	
69. 00	06900 ELECTROCARDI OLOGY	56, 166			0	94, 443	
71. 00		C	0	2, 240, 325	0	35, 388	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	0	0	205, 240	
73. 00	07300 DRUGS CHARGED TO PATIENTS	C	0	0	2, 154, 088		
75. 01	03955 RENAL DIALYSIS (IP)	15 700	0 5/1	0	0	4, 353	1
76. 00 76. 01	03956   CARDI AC REHAB	15, 782 15, 873		0	0	5, 931 14, 520	1
76. 01	03957 RI MMS	13, 673	24, 430	0	0	7, 969	1
76. 02	03951 GENETIC/OAK PLAZA CLINICS			0	0	0	76. 02
76. 04	03952 PAIN CLINIC	d	o o	0	0	0	76. 04
76. 05	03953 DI ABETES		o	0	0	7, 922	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	6, 464	1 0	0	0	14, 375	76. 98
	OUTPATIENT SERVICE COST CENTERS	1	1				
88. 00	08800 RURAL HEALTH CLINIC	C		0	0	.,	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	105.050	1	0	0	0	89.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	195, 050	119, 928	0	O <sub>l</sub>	181, 624	91. 00 92. 00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART	_		0	U	0	92.00
93. 00	04951 I NFUSI ON	15, 337	7 0	0	o	97, 890	1
	04950 COMMUNITY HEALTH CENTERS	, , , , , , , , , , , , , , , , , , ,	1	Ö	Ö		1
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	C		1	0	'	
	09910 CORF	C		0	0		
101.00	0 10100 HOME HEALTH AGENCY	( C	0	0	0	13, 731	101. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 14-0186

					5/26/2022 10:	37 am_
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 584, 922	1, 385, 861	2, 240, 325	2, 154, 088	3, 991, 605	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
191. 01 19101 SENI OR ADVAN	0	0	0	0	0	191. 01
191. 02 19102 CARE-A-VAN	0	0	0	0	0	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	301, 389	80, 976	0	0	0	192. 00
192. 01 19201 REFERENCE LAB	0	0	0	0	0	192. 01
192. 02 19202 MEALS ON WHEELS	0	o	0	o	0	192. 02
193. 00 19300 NONPALD WORKERS	0	o	0	o	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 886, 311	1, 466, 837	2, 240, 325	2, 154, 088	3, 991, 605	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0186

				To	12/31/2021	Date/Time Pre 5/26/2022 10:	
			INTERNS &	RESI DENTS		3/20/2022 10.	37 8111
	Cost Center Description	SOCIAL SERVICE	SERVICES-SALAR	SERVI CES-OTHER	PARAMED	Subtotal	
	oust defiter bescription	SOUTHE SERVICE	Y & FRINGES	PRGM COSTS	EDUCATI ON	Subtotal	
		17.00	APPRV	APPRV	PROGRAM	24.00	
	GENERAL SERVICE COST CENTERS	17. 00	21. 00	22. 00	23. 00	24. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	00550 DATA PROCESSING						5. 01 5. 02
5. 03	00591 PURCHASI NG						5. 03
5.05	00590 BUSINESS OFFICE						5. 05
5.06	00592 OTHER ADMIN & GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	1 1						16. 00
17. 00	1 1	2, 807, 445					17. 00
21. 00		0	1, 987, 041				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0		1, 896, 333	407.704		22. 00
23. 00	02301   PARAMED EDUCATION PROGRAM     I NPATIENT ROUTINE SERVICE COST CENTERS	0			406, 704		23. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 669, 490	333, 513	318, 288	283, 354	36, 840, 185	30.00
31.00		111, 006		259, 111	123, 350	8, 392, 724	31.00
32. 00	1	0	0	0	0	0	32. 00
40.00	1	0	0	0	0	2, 294, 591	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	964, 398		0	0	7, 398, 284 0	41. 00 42. 00
43. 00	1 1				0	2, 175, 224	43. 00
	ANCILLARY SERVICE COST CENTERS			-			
50.00	+ I	50, 804			0	23, 265, 256	50.00
51. 00 52. 00	+ I	0		0	0	7, 578, 788 3, 515, 555	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	3, 313, 333	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	38, 021	36, 285	Ö	13, 701, 733	54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	38, 531	36, 772	0	1, 059, 403	54. 01
54. 02	05404 ULTRASOUND	0	0	0	0	2, 277, 442	54. 02
55. 00 57. 00	05500   RADI OLOGY-THERAPEUTI C   05700   CT   SCAN	0	40, 573	38, 721	0	5, 635, 045 3, 574, 311	55. 00 57. 00
58. 00	1 1		0		0	1, 340, 051	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	178, 367	170, 224	0	13, 920, 827	59. 00
60.00	1	0	0	0	0	18, 001, 521	60. 00
60. 01	+ I	0	0	0	0	0	
62. 00 64. 00	1 1	0	0	0	0	0 3, 694, 824	62. 00 64. 00
65. 00			0		0	4, 500, 790	65. 00
66. 00	1	0	0	Ö	0	11, 909, 993	66. 00
69. 00	+ I	0	31, 131	29, 710	0	4, 159, 999	69. 00
71. 00	1 1	0	0	0	0	3, 384, 620	71.00
72. 00 73. 00	1 1	0	0	0	0	14, 522, 845 41, 284, 364	
75. 00 75. 01		0	0		0	1, 134, 043	75. 00
76. 00	1 1	0	0	Ö	0	1, 128, 598	76. 00
76. 01		0	0	0	0	2, 645, 808	
76. 02	I I	0	0	0	0	1, 791, 455	76. 02
76. 03 76. 04	+ I	0	0	0	0	0	76. 03 76. 04
76. 05	1		0		0	2, 104, 756	76. 04
76. 98		0	1	Ö	Ö	1, 478, 836	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	I I	0	0	0	0	669, 450	88. 00
89. 00 91. 00	1	0	42, 869	40, 912	0	11 247 205	89. 00 91. 00
91.00			42,009	40, 912	U	11, 247, 305	91.00
92. 01		0	0	o	o	0	92. 01
93. 00	04951 I NFUSI ON	0		0	o	1, 465, 032	93. 00
93. 01		0	0	0	0	1, 404, 730	93. 01
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0	0	O	0	8, 942, 594	95 00
73.00	10.000 / MIDOLI MOL OLIVE OLO	1 0	1 0	١	- υ	5, 772, 574	75.00

Provider CCN: 14-0186

			To	12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 37 am
		INTERNS &	RESI DENTS		0,20,2022 10.	J
Cost Center Description	SOCIAL SERVICE			PARAMED	Subtotal	
		Y & FRINGES	PRGM COSTS	EDUCATI ON		
		APPRV	APPRV	PROGRAM		
	17. 00	21. 00	22. 00	23. 00	24. 00	
99. 10   09910   CORF	0	0	0	0	0	1 , ,
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	5, 560, 770	101. 00
SPECIAL PURPOSE COST CENTERS	T					
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 795, 698	1, 052, 593	1, 004, 542	406, 704	274, 001, 752	118. 00
NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	112, 895	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
191. 01 19101 SENI OR ADVAN	0	0	0	0		191. 01
191. 02 19102 CARE-A-VAN	0	0	0	0	•	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	934, 448	891, 791	0	88, 607, 604	
192.01 19201 REFERENCE LAB	0	0	0	0	0	192. 01
192.02 19202 MEALS ON WHEELS	0	0	0	0	0	192. 02
193.00 19300 NONPALD WORKERS	11, 747	0	0	0	1, 871, 442	193. 00
200.00 Cross Foot Adjustments		0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	2, 807, 445	1, 987, 041	1, 896, 333	406, 704	364, 600, 285	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0186

				e Prepared: 2 10:37 am
Cost Center Description	Intern &	Total	37207202	2 10. 37 diii
	Residents Cost			
	& Post Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				1 00
1.00   00100   CAP REL COSTS-BLDG & FIXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP				1. 00 2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01 01160 COMMUNI CATI ONS				5. 01
5. 02 00550 DATA PROCESSI NG				5. 02
5. 03   00591 PURCHASI NG				5. 03
5.05   00590 BUSINESS OFFICE 5.06   00592 OTHER ADMIN & GENERAL	-			5. 05 5. 06
6. 00 00600 MAI NTENANCE & REPAI RS				6. 00
7.00 00700 OPERATION OF PLANT				7. 00
8.00   00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY				9.00
11. 00 01100 CAFETERI A				11.00
13. 00 01300 NURSING ADMINISTRATION				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00   01500   PHARMACY				15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE				16. 00 17. 00
21. 00   02100   L&R SERVICES-SALARY & FRINGES APPR'	v			21. 00
22. 00   02200   1 &R SERVICES-OTHER PRGM COSTS APPR				22. 00
23.00 02301 PARAMED EDUCATION PROGRAM				23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(54,004	0/ 400 004		
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT	-651, 801 -530, 616	36, 188, 384 7, 862, 108		30. 00 31. 00
32. 00   03200   CORONARY CARE UNIT	-530, 616	7, 802, 108		32.00
40. 00   04000   SUBPROVI DER - I PF	Ö	2, 294, 591		40.00
41. 00   04100   SUBPROVI DER - I RF	0	7, 398, 284		41. 00
42. 00   04200   SUBPROVI DER	0	0		42.00
43. 00 O4300 NURSERY  ANCI LLARY SERVI CE COST CENTERS	0	2, 175, 224		43. 00
50. 00 05000 OPERATING ROOM	-152, 602	23, 112, 654		50. 00
51.00   05100   RECOVERY ROOM	0	7, 578, 788		51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 515, 555		52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	-74, 306	0 13, 627, 427		53. 00 54. 00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	-75, 303	984, 100		54. 01
54. 02   05404   ULTRASOUND	0	2, 277, 442		54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	-79, 294	5, 555, 751		55. 00
57. 00   05700   CT SCAN 58. 00   05800   MRI	0	3, 574, 311 1, 340, 051		57. 00 58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	-348, 591	13, 572, 236		59. 00
60. 00   06000   LABORATORY	0	18, 001, 521		60.00
60. 01 06001 BLOOD LABORATORY	0	0		60. 01
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELI	1 .1	0		62.00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	0	3, 694, 824 4, 500, 790		64. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY		11, 909, 993		66.00
69. 00 06900 ELECTROCARDI OLOGY	-60, 841	4, 099, 158		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1	3, 384, 620		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	14, 522, 845		72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 75. 01   03955   RENAL DIALYSIS (IP)	0 0	41, 284, 364 1, 134, 043		73. 00 75. 01
76. 00 03956 CARDI AC REHAB	o	1, 128, 598		76. 00
76. 01 03950 OP PSY/CDU	0	2, 645, 808		76. 01
76. 02   03957   RI MMS	0	1, 791, 455		76. 02
76. 03   03951   GENETIC/OAK PLAZA CLINICS 76. 04   03952   PAIN CLINIC	0	0		76. 03 76. 04
76. 04   03952 PATN CETNIC 76. 05   03953 DI ABETES		2, 104, 756		76. 04
76. 98 07698 HYPERBARI C OXYGEN THERAPY	Ö	1, 478, 836		76. 98
OUTPATIENT SERVICE COST CENTERS				
88. 00   08800   RURAL HEALTH CLINIC	0	669, 450		88. 00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER 91.00   09100   EMERGENCY	0 -83, 781	0 11, 163, 524		89. 00 91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PAR	1	11, 103, 524		92.00
92. 01 09202 OBSERVATION BEDS (DISTINCT PART)		О		92. 01
93. 00   04951   I NFUSI ON	0	1, 465, 032		93. 00
93. 01 04950 COMMUNITY HEALTH CENTERS	0	1, 404, 730		93. 01
95. 00 O7HER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES	0	8, 942, 594		95. 00
75. 55 JOYSSO / MINDSELLINGE SERVI SES	١	5, 772, 574		1 73.00

Heal th Financial	Systems	RI VERSI DE	MEDICAL CENTER		In Lie	eu of Form CMS-2552-10
COST ALLOCATION	- GENERAL SERVICE COSTS		Provi der	- CCN: 14-0186	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/26/2022 10:37 am
Cos	Center Description	Intern &	Total			

			To 12/31/2021	Date/Time Prepared: 5/26/2022 10:37 am
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
99. 10  09910 CORF	0	0		99. 10
101.00 10100 HOME HEALTH AGENCY	0	5, 560, 770		101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-2, 057, 135	271, 944, 617		118. 00
NONRE MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	112, 895		190. 00
191. 00 19100  RESEARCH	0	0		191. 00
191. 01 19101 SENI OR ADVAN	0	0		191. 01
191. 02 19102 CARE-A-VAN	0	6, 592		191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-1, 826, 239	86, 781, 365		192. 00
192. 01 19201 REFERENCE LAB	0	0		192. 01
192.02 19202 MEALS ON WHEELS	0	0		192. 02
193.00 19300 NONPALD WORKERS	0	1, 871, 442		193. 00
200.00 Cross Foot Adjustments	0	0		200. 00
201.00 Negative Cost Centers	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	-3, 883, 374	360, 716, 911		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0186

					10	12/31/2021	Date/lime Pre   5/26/2022 10::	
				CAPI TAL REI	LATED COSTS		0, 20, 2022 101	97 diii
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs				DEI ARTIMENT	
			0	1. 00	2. 00	2A	4. 00	
		AL SERVICE COST CENTERS	1					
1.00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
2. 00 4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	95, 817	7, 752	103, 569	103, 569	4. 00
5. 01		COMMUNI CATI ONS	l o	5, 712		5, 712	0	5. 01
5.02		DATA PROCESSING	0	310, 198	979, 493	1, 289, 691	2, 691	5. 02
5.03		PURCHASING	0	635, 969		790, 636	950	5. 03
5.05	1	BUSI NESS OFFI CE	0	367, 083		396, 257	5, 593	5. 05
5. 06 6. 00	1	OTHER ADMIN & GENERAL MAINTENANCE & REPAIRS	0	1, 731, 165 500, 676		2, 924, 861 1, 118, 648	9, 328 1, 754	5. 06 6. 00
7. 00		OPERATION OF PLANT	0	4, 500, 948		5, 383, 274	860	7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	l o	135, 701		150, 285	516	8. 00
9.00	1	HOUSEKEEPI NG	0	82, 556		111, 435	2, 374	9. 00
10.00		DIETARY	0	347, 362		386, 753	534	10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMINI STRATI ON	0	317, 848 0	1	317, 848 135, 496	600 261	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	216, 659		243, 154	503	14. 00
15. 00		PHARMACY	l o	80, 448		356, 164	0	15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	0	192, 960		195, 677	1, 430	16. 00
17. 00		SOCIAL SERVICE	0	18, 055		19, 389	1, 090	17. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRV	0	0 040	-	1( 200	37	21. 00
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRV   PARAMED EDUCATION PROGRAM	0	8, 840 11, 833		16, 309 11, 833	1, 382 144	22. 00 23. 00
23.00		IENT ROUTINE SERVICE COST CENTERS	١	11,000	١	11, 033	144	23.00
30.00	03000	ADULTS & PEDIATRICS	0	2, 168, 461	117, 044	2, 285, 505	9, 341	30. 00
31. 00		INTENSIVE CARE UNIT	0	310, 334	131, 447	441, 781	2, 193	31. 00
32. 00		CORONARY CARE UNIT	0	0		0	0	32. 00
40. 00 41. 00		SUBPROVIDER - IPF  SUBPROVIDER - IRF	0	0 271, 980	,	14, 307 292, 131	825 1, 772	40. 00 41. 00
42.00		SUBPROVI DER	0	271, 980	20, 131	292, 131	1, 772	42.00
43. 00		NURSERY	0	58, 823		83, 715	744	43. 00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATI NG ROOM	0	547, 462		2, 300, 798	2, 996	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	302, 582 178, 951		329, 376 211, 399	2, 390 1, 349	51. 00 52. 00
53. 00		ANESTHESI OLOGY	0	170, 931		211, 399	1, 349	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	l o	338, 793	-	926, 122	3, 405	54. 00
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	0	16, 661	13, 448	30, 109	114	54. 01
54. 02		ULTRASOUND	0	15, 369		157, 643	567	54. 02
55.00		RADI OLOGY-THERAPEUTI C CT SCAN	0	10 551		159, 454	1, 229	
57. 00 58. 00	05800		0	19, 551 40, 530		385, 874 106, 917	475 159	57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON	l o	118, 156		441, 753	1, 229	
		LABORATORY	0	221, 385		460, 854		60.00
60. 01		BLOOD LABORATORY	0	0	0	0	0	60. 01
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	42, 570	6, 032 99, 660	6, 032 142, 230	552 1, 082	64. 00 65. 00
66. 00		PHYSI CAL THERAPY		623, 048		670, 238	3, 189	
69. 00	1	ELECTROCARDI OLOGY	0	94, 593		313, 798	881	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 75. 01		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS (IP)	0	0	0	0	1, 968 0	73. 00 75. 01
76. 00		CARDI AC REHAB	0	62, 291	26, 560	88, 851	306	
76. 01		OP PSY/CDU	0	398, 840		400, 764	638	
76. 02	03957	RIMMS	0	134, 341		150, 948	900	76. 02
76. 03	1	GENETIC/OAK PLAZA CLINICS	0	0		0	0	76. 03
76. 04		PAIN CLINIC	0	14 707	-	17 (00	0	76. 04
76. 05 76. 98	1	DI ABETES   HYPERBARI C OXYGEN THERAPY		16, 797 51, 275		17, 692 62, 623	714 495	76. 05 76. 98
, 0. 70		TIENT SERVICE COST CENTERS	, 0	51, 275	11, 340	02, 023	490	, 5. 70
88. 00		RURAL HEALTH CLINIC	0	197, 652	942	198, 594	152	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
91.00		EMERGENCY	0	295, 305	109, 240	404, 545	3, 336	
92. 00 92. 01		OBSERVATION BEDS (NON-DISTINCT PART OBSERVATION BEDS (DISTINCT PART)		0		0	0	92. 00 92. 01
93.00	04951	INFUSION		Ö	10, 761	10, 761	332	
		COMMUNITY HEALTH CENTERS	0	1, 005, 398		1, 006, 094		93. 01

Health Financial Systems	RIVERSIDE MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared:
		CAPI TAL REI	ATED COSTS		3/20/2022 10.	37 alli
		CALLIAL KLI	LATED COSTS			
Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
555t 5511td. 5555t. pt. 511	Assigned New	5250 W 11711		oub to tu.	BENEFI TS	
	Capi tal				DEPARTMENT	
	Rel ated Costs				1	
	0	1.00	2.00	2A	4. 00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	206, 187	366, 639	9 572, 826	3, 657	95. 00
99. 10   09910   CORF	0	0		0 0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	96, 837	7, 31	8 104, 155	2, 044	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111. 00
113. 00 11300 I NTEREST EXPENSE					I	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	17, 394, 002	9, 340, 87	8 26, 734, 880	81, 181	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43, 658		3 43, 658		190. 00
191. 00 19100 RESEARCH	0	0	(	0		191. 00
191. 01   19101   SENI OR ADVAN	0	0		0 0		191. 01
191. 02 19102 CARE-A-VAN	0	0		0 0		191. 02
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 192, 535	260, 17:	2, 452, 707		192. 00

20, 879, 623

9, 601, 050

30, 480, 673

0 193. 00

200. 00 0 201. 00

22, 386 192. 00 0 192. 01 0 192. 02

103, 569 202. 00

192. 01 19201 REFERENCE LAB 192. 02 19202 MEALS ON WHEELS 193. 00 19300 NONPAID WORKERS

Cross Foot Adjustments Negative Cost Centers

TOTAL (sum lines 118 through 201)

200. 00 201. 00

202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0186

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/26/2022 10:37 am Cost Center Description COMMUNICATIONS DATA PURCHASI NG **BUSI NESS** OTHER ADMIN & GENERAL PROCESSI NG OFFICE 5.01 5.03 5.02 5.05 5.06 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 01160 COMMUNI CATI ONS 5 01 5.712 5 01 5.02 00550 DATA PROCESSING 398 1, 292, 780 5.02 00591 PURCHASI NG 812, 247 5.03 75 20, 586 5.03 5.05 00590 BUSINESS OFFICE 229 198, 995 1, 324 602, 398 5.05 00592 OTHER ADMIN & GENERAL 201.740 3, 139, 230 5.06 1.177 2.124 0 5.06 5, 173 6.00 00600 MAINTENANCE & REPAIRS 194 28, 820 120, 332 6.00 7.00 00700 OPERATION OF PLANT 85 23, 330 156 0 66,088 7 00 0 00800 LAUNDRY & LINEN SERVICE 5 9, 489 8 00 8.00 3,630 9.00 00900 HOUSEKEEPI NG 40 8, 234 6, 494 0 40,004 9.00 10.00 01000 DI ETARY 70 13, 724 3, 923 0 20, 557 10.00 0 01100 CAFETERI A 7.666 11.00 0 11.00 C 01300 NURSING ADMINISTRATION 15, 096 12, 159 80 13.00 96 13.00 6, 862 14.00 01400 CENTRAL SERVICES & SUPPLY 20 5, 174 0 0 0 15, 509 14.00 01500 PHARMACY 15.00 50 26,075 19, 287 16,672 15.00 39, 799 01600 MEDICAL RECORDS & LIBRARY 254 31, 953 16,00 28 16,00 01700 SOCIAL SERVICE 17 00 45 28, 820 93 23, 198 17 00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 C 17, 108 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 5 0 14, 969 22.00 256 22.00 02301 PARAMED EDUCATION PROGRAM 23.00 0 3, 236 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 815 133, 121 18. 987 27, 885 234, 871 30.00 31.00 03100 INTENSIVE CARE UNIT 94 23.330 9, 202 3.568 31.00 54,660 03200 CORONARY CARE UNIT 32 00 0  $\cap$ Ω 32.00 40.00 04000 SUBPROVIDER - IPF 0 478 1, 769 18, 108 40.00 r 04100 SUBPROVI DER - I RF 41.00 70 20, 586 2, 556 3, 455 47, 762 41.00 04200 SUBPROVI DER 0 42.00 0 0 42.00 04300 NURSERY 43.00 20 4, 117 1, 834 721 16, 164 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 139 34, 309 224, 753 57, 010 162, 446 50.00 51 00 05100 RECOVERY ROOM 104 19, 213 4 160 6.880 50,076 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 30 5, 490 2,652 432 25, 538 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 80 31, 565 10, 412 41, 635 99. 621 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 10 54.01 1, 372 6, 159 3, 924 7, 238 54.01 54.02 05404 ULTRASOUND 20 8, 234 2,565 8, 216 16, 320 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 80 15,096 4,692 20, 686 43, 690 55.00 57 00 05700 CT SCAN 30 10, 979 6, 147 42, 551 27, 152 57 00 05800 MRI 58.00 30 12, 351 2, 525 11, 469 9, 753 58.00 05900 CARDIAC CATHETERIZATION 25 2, 745 252, 557 33, 729 105, 774 59.00 59.00 60.00 06000 LABORATORY 85, 087 150, 283 79, 141 141,650 60.00 164 06001 BLOOD LABORATORY 0 60.01 C0 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 C 0 62.00 0 64.00 06400 I NTRAVENOUS THERAPY 10 4, 117 1,636 171 22,060 64.00 06500 RESPIRATORY THERAPY 10, 979 9, 733 30, 829 65.00 35 7.335 65.00 06600 PHYSI CAL THERAPY 85, 087 21, 341 88, 895 66.00 144 5.430 66 00 69.00 06900 ELECTROCARDI OLOGY 80 16, 469 8,098 14, 244 29,036 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 547 71.00 0 C 5, 337 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 955 72.00 0 123, 270 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73 00 C O 116,006 330 297 73 00 03955 RENAL DIALYSIS (IP) 0 18 8,838 75.01 75.01 657 76.00 03956 CARDI AC REHAB 20 9, 607 177 894 6, 871 76.00 03950 OP PSY/CDU 0 2.190 76.01 16, 469 138 17, 154 76.01 76.02 03957 RI MMS 60 2.825 1, 202 13, 245 76.02 03951 GENETIC/OAK PLAZA CLINICS 0 76.03 C 0 76.03 0 03952 PAIN CLINIC 76.04 76.04 C 0 76.05 03953 DLABETES 20 6, 862 861 1, 195 17, 822 76.05 07698 HYPERBARIC OXYGEN THERAPY 76. 98 4,674 2, 168 11,675 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 20 0 174 4,061 88.00 125 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 Ω 89.00  $\Gamma$ 09100 EMERGENCY 91.00 263 34, 309 16,046 27, 393 82, 376 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 0 C 0 93.00 04951 I NFUSI ON 0 C 2, 154 14, 764 10, 746 93.00 04950 COMMUNITY HEALTH CENTERS 93.01 10 59 4, 216 11, 854 93.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 71, 213 95.00 20 9,607 1, 248 4, 616 99. 10 09910 CORF 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 48, 033 2, 481 2, 071 46, 526 101. 00 Health Financial Systems RIVERSIDE MEDICAL CENTER In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0186 Period: From 01/01/2021 Part II

				rom 01/01/2021	Part II	
			1	o 12/31/2021		
					5/26/2022 10:	37 am
Cost Center Description	COMMUNI CATIONS	DATA	PURCHASI NG	BUSI NESS	OTHER ADMIN &	
		PROCESSI NG		OFFI CE	GENERAL	
	5. 01	5. 02	5. 03	5. 05	5. 06	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	(	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 214	1, 261, 215	801, 034	602, 398	2, 396, 078	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	426	190. 00
191. 00 19100 RESEARCH	0	0	(	0	0	191. 00
191. 01 19101 SENI OR ADVAN	0	0	(	0	0	191. 01
191. 02 19102 CARE-A-VAN	0	0	(	0	57	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	239	0	11, 213	0	726, 922	192. 00
192. 01 19201 REFERENCE LAB	0	0	(	0	0	192. 01
192.02 19202 MEALS ON WHEELS	0	0	(	0	0	192. 02
193.00 19300 NONPALD WORKERS	259	31, 565	(	0	15, 747	193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	o	o	(	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	5, 712	1, 292, 780	812, 247	602, 398	3, 139, 230	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0186

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/26/2022 10:37 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAI RS PLANT LINEN SERVICE 9.00 10.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 01160 COMMUNI CATI ONS 5 01 5 01 5.02 00550 DATA PROCESSING 5.02 00591 PURCHASI NG 5.03 5.03 5.05 00590 BUSINESS OFFICE 5.05 00592 OTHER ADMIN & GENERAL 5.06 5.06 6.00 00600 MAINTENANCE & REPAIRS 1, 274, 921 6.00 7.00 00700 OPERATION OF PLANT 5, 473, 793 7 00 00800 LAUNDRY & LINEN SERVICE 163, 925 8 00 8 00 0 9.00 00900 HOUSEKEEPI NG 0 49, 978 218, 559 9.00 10.00 01000 DI ETARY 0 210, 286 1,024 9, 717 646, 588 10.00 01100 CAFETERI A 0 8,892 342, 169 11.00 192, 419 11.00 C 01300 NURSING ADMINISTRATION 0 13.00 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 876 131, 161 7, 746 6,061 0 14.00 01500 PHARMACY 48, 702 15.00 0 C 2, 250 0 15.00 0 01600 MEDICAL RECORDS & LIBRARY 5, 398 116, 814 0 16,00 0 16,00 01700 SOCIAL SERVICE 17 00 10, 930 0 505 Ω 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 5, 352 0 247 0 22.00 02301 PARAMED EDUCATION PROGRAM 23.00 7, 163 0 331 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 87. 797 1, 312, 742 74. 661 60, 663 259, 359 30.00 03100 INTENSIVE CARE UNIT 31.00 187, 870 10, 100 31.00 41,600 10.826 8.681 03200 CORONARY CARE UNIT 32 00 0 Λ 32.00 40.00 04000 SUBPROVIDER - IPF 1,752 9,013 0 40.00 0 04100 SUBPROVI DER - I RF 41.00 6, 130 164, 651 11, 149 7,609 31, 620 41.00 04200 SUBPROVI DER 42.00 42.00 0 0 04300 NURSERY 43.00 14, 450 35, 610 0 1, 646 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 251, 351 331, 423 7, 493 15, 315 0 50.00 51 00 05100 RECOVERY ROOM 93 709 183, 177 6.470 8 465 0 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 16,640 108, 333 C 5,006 0 52.00 05300 ANESTHESI OLOGY 53.00 53.00 C 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 153, 865 9.788 54.00 111,662 7.110 0 05401 NUCLEAR MEDICINE-DIAGNOSTIC 10, 086 54.01 7,882 0 466 0 54.01 05404 ULTRASOUND 54.02 25, 179 9, 304 0 430 0 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 27, 149 0 0 55.00 57 00 05700 CT SCAN 6 568 11, 836 O 57 00 547 0 05800 MRI 58.00 5, 474 24, 536 0 1, 134 0 58.00 05900 CARDIAC CATHETERIZATION 71, 595 71, 529 2, 579 3, 305 59.00 59.00 0 60.00 06000 LABORATORY 51,890 138, 551 6, 402 60.00 0 0 06001 BLOOD LABORATORY 60 01 0 0 0 0 60 01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 64.00 06400 I NTRAVENOUS THERAPY 99, 182 C 0 0 64.00 06500 RESPIRATORY THERAPY 63, 932 25, 771 1, 191 65.00 439 65.00 0 06600 PHYSI CAL THERAPY 30, 871 3 056 66.00 377, 181 17, 429 0 66.00 69.00 06900 ELECTROCARDI OLOGY 36, 345 57, 265 919 2,646 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 C 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 72.00 0 0 0 07300 DRUGS CHARGED TO PATIENTS 73 00 0 C 0 0 0 73 00 03955 RENAL DIALYSIS (IP) 9, 415 75.01 75.01 0 76.00 03956 CARDI AC REHAB 19,048 37, 710 0 1, 743 0 76.00 03950 OP PSY/CDU 76.01 1.752 241.450 0 11.157 0 76.01 76.02 03957 RI MMS 4, 379 81, 327 295 3, 758 0 76.02 03951 GENETIC/OAK PLAZA CLINICS 76.03 C 0 0 76.03 03952 PAIN CLINIC 76.04 76.04 0 0 0 76.05 03953 DLABETES 219 10, 168 0 470 0 76.05 76. 98 07698 HYPERBARIC OXYGEN THERAPY 2, 408 31, 041 168 1, 434 0 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 119,655 88.00 2,627 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 Λ Λ Λ 89.00 09100 EMERGENCY 51,890 12,832 3, 340 91.00 178, 772 8, 261 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 0 0 0 93.00 04951 I NFUSI ON 8,977 C 790 0 0 93.00 04950 COMMUNITY HEALTH CENTERS 93.01 0 93.01 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95.00 16,640 124, 821 958 5, 768 0 99. 10 09910 CORF 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 219 58, 623 0 2, 709 0 101.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RIVERSIDE MEDICAL CENTER Provider CCN: 14-0186

					5/26/2022 10: 37 am
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	REPAI RS	PLANT	LINEN SERVICE		
	6. 00	7.00	8. 00	9. 00	10. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 169, 608	4, 860, 102	160, 206	216, 746	646, 588 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 430	0	1, 221	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
191. 01 19101 SENI OR ADVAN	0	0	0	0	0 191. 01
191. 02 19102 CARE-A-VAN	0	0	0	0	0 191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	105, 313	574, 458	3, 719	0	0 192. 00
192. 01 19201 REFERENCE LAB	0	0	0	0	0 192. 01
192.02 19202 MEALS ON WHEELS	0	0	0	0	0 192. 02
193.00 19300 NONPALD WORKERS	0	12, 803	0	592	0 193. 00
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	o	0 201. 00
202.00   TOTAL (sum lines 118 through 201)	1, 274, 921	5, 473, 793	163, 925	218, 559	646, 588 202. 00

Provider CCN: 14-0186

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 10: 37 am

	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/26/2022 10: MEDI CAL	
	cost senter bescription	OAI ETERTA	ADMI NI STRATI ON	SERVICES & SUPPLY	TIMININGT	RECORDS & LI BRARY	
		11.00	13. 00	14. 00	15. 00	16. 00	
1 00	GENERAL SERVICE COST CENTERS	T	1				1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00591 PURCHASI NG						5. 03
5. 05	00590 BUSINESS OFFICE						5. 05
5. 06 6. 00	00592 OTHER ADMIN & GENERAL 00600 MAINTENANCE & REPAIRS						5. 06 6. 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	0/0 50/					10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	869, 594 16, 436	1				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	11, 749	1	431, 708			14. 00
15. 00	01500 PHARMACY	30, 382	1	0	499, 582		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	C	1	0	0	391, 353	16. 00
17. 00	01700 SOCIAL SERVICE	26, 152	1	0	0	0	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	07.470	1	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	27, 178	1	0	0	0	22. 00 23. 00
23. 00	02301 PARAMED EDUCATION PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	4, 110	)  0	U	U <sub>I</sub>	U	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	186, 364	45, 888	0	0	18, 135	30.00
31.00	03100 INTENSIVE CARE UNIT	47, 351		0	0	2, 321	31.00
32.00	03200 CORONARY CARE UNIT	C	o	0	0	0	32. 00
40. 00	04000 SUBPROVI DER - I PF	18, 741		0	0	1, 151	
41. 00	04100 SUBPROVI DER – I RF	34, 611	1	0	0	2, 247	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	9, 214	1	0	0	0 469	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	7, 214	2, 209	U		407	43.00
50.00	05000 OPERATING ROOM	40, 319	9, 928	0	0	37, 076	50.00
51.00	05100 RECOVERY ROOM	38, 761		0	0	4, 474	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	19, 535	4, 810	0	0	281	52.00
53. 00	05300 ANESTHESI OLOGY	0, 505	0	0	0	0	53.00
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  NUCLEAR MEDI CI NE-DI AGNOSTI C	36, 585 2, 040	1	0	0	27, 077 2, 552	54. 00 54. 01
54. 01	05404 ULTRASOUND	8, 753	1	0	0	5, 343	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	13, 984		0	Ö	13, 453	55. 00
57.00	05700  CT SCAN	11, 489	o	0	0	27, 672	57. 00
58. 00	05800 MRI	3, 707		0	0	7, 459	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	16, 734	1	0	0	21, 935	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	37, 050	1	0	0	51, 468 0	60. 00 60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		-	0	0	0	62. 00
64. 00	06400 I NTRAVENOUS THERAPY	8, 279	2, 038	0	0	111	1
65.00	06500 RESPI RATORY THERAPY	16, 856		0	0	6, 330	65. 00
66. 00	06600 PHYSI CAL THERAPY	20, 618		0	0	13, 879	66. 00
69. 00	06900 ELECTROCARDI OLOGY	16, 922	4, 167	421 700	0	9, 263	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS			431, 708	0	3, 471 20, 131	
73. 00	07300 DRUGS CHARGED TO PATIENTS			0	499, 582	75, 032	73. 00
75. 01	03955 RENAL DIALYSIS (IP)	C	o	0	0	427	75. 01
76.00	03956 CARDI AC REHAB	4, 755	1, 171	0	0	582	76. 00
76. 01	03950 OP PSY/CDU	4, 782	2, 995	0	0	1, 424	76. 01
76. 02	03957 RI MMS	C	0	0	0	782	76. 02
76. 03 76. 04	03951 GENETIC/OAK PLAZA CLINICS 03952 PAIN CLINIC			0	0	0	76. 03 76. 04
76. 04	03953 DI ABETES			0	0	777	76. 04
	07698 HYPERBARI C OXYGEN THERAPY	1, 948	o	O	Ö	1, 410	76. 98
	OUTPATIENT SERVICE COST CENTERS			-		·	
88. 00	08800 RURAL HEALTH CLINIC	C	1	0	0	113	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	50.7/5	1	0	0	0	89.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	58, 765	14, 686	0	O	17, 815	91. 00 92. 00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART		ا ا	n	n	0	92.00
93. 00	04951 I NFUSI ON	4, 621		0	ol	9, 602	93. 00
	04950 COMMUNITY HEALTH CENTERS	, , s2 ·	1	0	0	2, 742	1
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	C	,	0	0	3, 002	95.00
	09910 CORF  10100 HOME HEALTH AGENCY	C	1	0	0	0 1 347	99. 10 101. 00
101.00	ALIO 100 HOWE HEALTH AUCINCT		1 0	u u	U <sub>I</sub>	1, 347	1101.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RIVERSIDE MEDICAL CENTER Provider CCN: 14-0186

					5/26/2022 10:	37 am_
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	778, 791	169, 708	431, 708	499, 582	391, 353	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
191. 01 19101 SENI OR ADVAN	0	0	0	0	0	191. 01
191. 02 19102 CARE-A-VAN	0	0	0	0	0	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	90, 803	9, 916	0	0	0	192. 00
192. 01 19201 REFERENCE LAB	0	0	0	0	0	192. 01
192.02 19202 MEALS ON WHEELS	0	0	0	0	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	869, 594	179, 624	431, 708	499, 582	391, 353	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0186

				Ť	0 12/31/2021	Date/Time Pre 5/26/2022 10:	
			INTERNS &	RESI DENTS		3/20/2022 10.	37 4111
	Cost Center Description	SOCIAL SERVICE	SERVICES-SALAR	SERVI CES-OTHER	PARAMED	Subtotal	
	odst denter beserretron	SOCIAL SERVICE	Y & FRI NGES	PRGM COSTS	EDUCATI ON	Subtotal	
		17.00	APPRV 21. 00	APPRV	PROGRAM	24.00	
	GENERAL SERVICE COST CENTERS	17. 00	21.00	22. 00	23. 00	24. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	O1160 COMMUNI CATI ONS   O0550 DATA PROCESSI NG						5. 01 5. 02
5. 02	00591 PURCHASI NG						5. 03
5.05	00590 BUSINESS OFFICE						5. 05
5.06	00592 OTHER ADMIN & GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	1 I						14. 00 15. 00
16. 00	1 I						16. 00
17. 00	1 I	110, 222					17. 00
21. 00		0	17, 145				21. 00
22. 00	+ I	0		72, 390			22. 00
23. 00	02301   PARAMED EDUCATION PROGRAM     I NPATIENT ROUTINE SERVICE COST CENTERS	0			26, 826		23.00
30. 00		65, 545				4, 821, 679	30.00
31. 00		4, 358				856, 912	
32. 00	1	0				0	32. 00
40.00	1	0				70, 759	
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	37, 863				672, 734 0	41. 00 42. 00
43. 00	1 1	0				170, 973	1
	ANCILLARY SERVICE COST CENTERS						
50.00	+ I	1, 995				3, 477, 351	1
51. 00 52. 00	+ I	0				756, 799 401, 495	1
53. 00	05300 ANESTHESI OLOGY	0				401, 493	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0				1, 458, 927	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0				71, 952	1
54. 02	05404   ULTRASOUND   05500   RADI OLOGY-THERAPEUTI C	0				242, 574	
55. 00 57. 00	05500 RADI OLOGY - THERAPEUTI C	0				299, 513 531, 320	
58. 00		0				185, 514	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				1, 029, 609	
60.00	I I	0				1, 204, 611	60.00
60. 01		0				0	1
62. 00 64. 00	1 1	0				0 144, 188	1
65. 00	1	0				320, 893	
66. 00		0				1, 350, 945	
69. 00	+ I	0				510, 133	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0				450, 063 174, 356	
73.00		0				1, 022, 885	
75. 01	1	Ö				19, 355	
76. 00	03956 CARDI AC REHAB	0				171, 735	
76. 01		0				700, 913	1
76. 02	03957 RIMMS 03951 GENETIC/OAK PLAZA CLINICS	0				259, 721 0	76. 02 76. 03
76. 03	1 1	0				0	76. 03
76. 05	1 1	0				56, 800	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0				120, 044	1
00.00	OUTPATIENT SERVICE COST CENTERS					205 504	00.00
88. 00 89. 00	I I	0				325, 521 0	88. 00 89. 00
91.00						914, 629	
92. 00						, , 32 /	92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0				0	92. 01
93.00		0				62, 747	1
93. 01	04950 COMMUNITY HEALTH CENTERS  OTHER REIMBURSABLE COST CENTERS	0				1, 025, 004	93. 01
95. 00	09500 AMBULANCE SERVICES	0				833, 031	95. 00
	1	'	<u> </u>	1	<u> </u>	1 230,001	

			T	o 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 37 am
		INTERNS &	RESI DENTS			
Cost Center Description	SOCIAL SERVICES	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED	Subtotal	
Social Social Person	0001712 021111 021	Y & FRINGES	PRGM COSTS	EDUCATI ON	oub to tu.	
		APPRV	APPRV	PROGRAM		
	17. 00	21. 00	22. 00	23. 00	24. 00	
99. 10  09910  CORF	0				0	, ,,
101.00 10100 HOME HEALTH AGENCY	0				268, 302	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0					109. 00
110.00 11000 INTESTINAL ACQUISITION	0					110. 00
111.00 11100 I SLET ACQUI SI TI ON	0				0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	109, 761	0	0	0	24, 983, 987	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
191. 00 19100 RESEARCH	0					191. 00
191. 01 19101 SENI OR ADVAN	0					191. 01
191. 02 19102 CARE-A-VAN	0					191. 02
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0				3, 997, 676	
192. 01 19201 REFERENCE LAB	0					192. 01
192. 02 19202 MEALS ON WHEELS	0					192. 02
193. 00 19300 NONPALD WORKERS	461				1, 310, 855	1
200.00 Cross Foot Adjustments		17, 145	72, 390	26, 826	116, 361	
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	110, 222	17, 145	72, 390	26, 826	30, 480, 673	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0186

				To 12/31/2021 Date/lime Pr 5/26/2022 10	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	0, 20, 2022	
		Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01	01160 COMMUNI CATI ONS				5. 01
5.02	00550 DATA PROCESSING				5. 02
5.03	00591 PURCHASI NG				5. 03
5.05	00590 BUSINESS OFFICE				5. 05
5.06	00592 OTHER ADMIN & GENERAL				5. 06
6.00	00600 MAINTENANCE & REPAIRS				6. 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 13. 00	01100 CAFETERIA				11. 00 13. 00
14. 00	01300   NURSI NG ADMI NI STRATI ON   01400   CENTRAL SERVI CES & SUPPLY				14. 00
15. 00					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00	01700 SOCIAL SERVICE				17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV				21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV				22. 00
23. 00	1 I				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	4, 821, 679		30. 00
31.00	03100 INTENSIVE CARE UNIT	0	856, 912		31.00
32. 00	03200 CORONARY CARE UNIT	0	0		32. 00
40. 00	04000 SUBPROVI DER - I PF	0	70, 759		40. 00
41. 00	04100 SUBPROVI DER – I RF	0	672, 734		41. 00
42.00	04200 SUBPROVI DER	0	0		42. 00
43. 00	04300 NURSERY	0	170, 973		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	3, 477, 351		50.00
51. 00	05100 RECOVERY ROOM		756, 799		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		401, 495		52. 00
53. 00	05300 ANESTHESI OLOGY		0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	O	1, 458, 927		54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	o	71, 952		54. 01
54. 02	05404 ULTRASOUND	0	242, 574		54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C	0	299, 513		55. 00
57.00	05700 CT SCAN	0	531, 320		57. 00
58.00	05800 MRI	0	185, 514		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1, 029, 609		59. 00
60.00		0	1, 204, 611		60.00
	06001 BLOOD LABORATORY	0	0		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62. 00
64. 00		0	144, 188		64. 00
65. 00	1	0	320, 893		65. 00
66. 00	1	0	1, 350, 945		66.00
71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	510, 133 450, 063		69. 00 71. 00
71.00	1		174, 356		72.00
73. 00			1, 022, 885		73. 00
75. 01	03955 RENAL DIALYSIS (IP)		19, 355		75. 00
76. 00			171, 735		76.00
76. 01	03950 OP PSY/CDU	0	700, 913		76. 01
	03957 RI MMS	0	259, 721		76. 02
76. 03	l	0	o		76. 03
76.04	03952 PAIN CLINIC	0	0		76. 04
76. 05	03953 DI ABETES	0	56, 800		76. 05
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	120, 044		76. 98
	OUTPATIENT SERVICE COST CENTERS				
88. 00		0	325, 521		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
91.00		0	914, 629		91.00
92.00	,	0			92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0	() (2 7 4 7 1		92. 01
93. 00 93. 01	04951 I NFUSION 04950 COMMUNI TY HEALTH CENTERS	0	62, 747 1, 025, 004		93. 00 93. 01
73. UI	OTHER REIMBURSABLE COST CENTERS	J U	1,020,004		73.01
95. 00		0	833, 031		95. 00
	<u> </u>	1 91			

Health Financial Systems	RIVERSIDE MEDICA	AL CENTED		In Lie	u of Form CMS-25!	52_10
ALLOCATION OF CAPITAL RELATED COSTS	KI VERSI DE MEDI GA	Provi der CC	CN: 14-0186	Peri od: From 01/01/2021	Worksheet B	red:
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				

			5/26/2022 10	: 37 am
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
99. 10  09910 CORF	0	0		99. 10
101.00 10100 HOME HEALTH AGENCY	0	268, 302		101. 00
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	24, 983, 987		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	71, 735		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
191. 01 19101 SENI OR ADVAN	0	0		191. 01
191. 02 19102 CARE-A-VAN	0	59		191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	3, 997, 676		192. 00
192. 01 19201 REFERENCE LAB	0	0		192. 01
192.02 19202 MEALS ON WHEELS	0	0		192. 02
193. 00 19300 NONPALD WORKERS	0	1, 310, 855		193. 00
200.00 Cross Foot Adjustments	0	116, 361		200. 00
201.00 Negative Cost Centers	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	30, 480, 673		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0186 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 10:37 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** COMMUNI CATI ONS DATA (SQUARE FEET) (DOLLAR VALUE) PROCESSI NG BENEFITS DEPARTMENT (PHONES) (DEVICES) (ACTUAL BEN EFITS) 1.00 2.00 5. 01 5. 02 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 614 075 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 543, 113 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2,818 7, 705 4.00 24, 366, 543 01160 COMMUNI CATI ONS 5 01 1, 149 5 01 168 5.02 00550 DATA PROCESSING 9, 123 973, 582 633, 225 80 942 5.02 5.03 00591 PURCHASI NG 18, 704 153, 734 223, 629 15 15 5.03 5.05 00590 BUSINESS OFFICE 10, 796 28, 998 1, 315, 978 46 145 5.05 00592 OTHER ADMIN & GENERAL 50, 914 1, 186, 493 2, 194, 886 238 147 5 06 5 06 6.00 00600 MAINTENANCE & REPAIRS 14, 725 614, 243 412, 605 39 21 6.00 00700 OPERATION OF PLANT 132, 374 877, 002 202, 272 17 17 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 3, 991 14, 496 121, 314 8.00 0 8.00 9 00 00900 HOUSEKEEPI NG 2.428 28.705 558, 512 8 6 9 00 10.00 01000 DI ETARY 10, 216 39, 153 125, 664 14 10 10.00 01100 CAFETERI A 11.00 9,348 141, 193 0 0 11.00 01300 NURSING ADMINISTRATION 134, 678 61, 321 11 13.00 13.00 16 14.00 01400 CENTRAL SERVICES & SUPPLY 6.372 26, 335 118, 365 4 5 14 00 2, 366 01500 PHARMACY 274, 052 10 19 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 675 2, 701 336, 412 51 29 16.00 01700 SOCIAL SERVICE 17.00 256, 545 9 21 17.00 531 1, 326 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 8, 780 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 260 7, 424 325, 225 02301 PARAMED EDUCATION PROGRAM 33, 794 23.00 23.00 348 0 INPATIENT ROUTINE SERVICE COST CENTERS 97 30.00 03000 ADULTS & PEDIATRICS 63, 775 116, 338 2, 197, 959 164 30.00 03100 INTENSIVE CARE UNIT 31.00 9, 127 130, 654 515, 982 19 17 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 0 C14, 221 04000 SUBPROVI DER - I PF 40.00 0 194, 122 0 0 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 7.999 20,029 416, 869 14 15 04200 SUBPROVI DER 42.00 0 0 42.00 04300 NURSERY 43.00 1,730 24, 742 175, 123 4 3 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 101 1, 742, 754 704. 998 28 25 50.00 05100 RECOVERY ROOM 562, 298 51.00 8.899 26, 632 21 14 51.00 05200 DELIVERY ROOM & LABOR ROOM 4 52.00 5, 263 32, 252 317, 371 6 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 964 583, 785 801, 264 16 23 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 2 54 01 490 13, 367 26, 737 54 01 1 4 54.02 05404 ULTRASOUND 452 141, 415 133, 364 6 54.02 55.00 05500 RADI OLOGY-THERAPEUTI C 158, 492 289, 069 16 11 55.00 57.00 05700 CT SCAN 575 364, 112 111, 679 6 8 57.00 6 05800 MRI 1 192 65, 986 9 58 00 37, 432 58 00 59.00 05900 CARDIAC CATHETERIZATION 3, 475 321, 644 289, 119 2 59.00 06000 LABORATORY 6, 511 238, 024 487, 381 33 62 60.00 60.00 0 60.01 06001 BLOOD LABORATORY 0 60.01 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 0 0 0 62 00 2 64.00 06400 INTRAVENOUS THERAPY 0 5, 996 129, 873 3 64.00 06500 RESPIRATORY THERAPY 1, 252 99, 059 65.00 254, 483 65.00 06600 PHYSI CAL THERAPY 18, 324 46, 905 750, 383 29 66, 00 66, 00 62 06900 ELECTROCARDI OLOGY 16 69.00 2.782 217, 882 207.331 12 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 C 463, 049 0 75. 01 03955 RENAL DIALYSIS (IP) 0 75.01 03956 CARDI AC REHAB 4 76.00 1,832 26, 400 72.067 76.00 0 03950 OP PSY/CDU 11, 730 1, 912 76.01 150,008 12 76.01 3, 951 03957 RI MMS 0 76.02 16, 507 211, 792 12 76.02 76.03 03951 GENETIC/OAK PLAZA CLINICS 0 0 76.03 0 C 03952 PAIN CLINIC 0 76 04 0 76.04 03953 DLABETES 494 167, 916 4 76.05 890 5 76.05 07698 HYPERBARIC OXYGEN THERAPY 76. 98 1,508 11, 280 116, 511 0 0 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 5, 813 936 35, 756 4 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 C 0 0 89.00 91.00 09100 EMERGENCY 8,685 108, 581 784, 948 53 25 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09202 OBSERVATION BEDS (DISTINCT PART) 0 0 92.01 92.01 04951 I NEUSLON 0 93.00 93 00 10, 696 78.012 0

29, 569

692

6,813

2

0 93.01

04950 COMMUNITY HEALTH CENTERS

93.01

0.004250

4. 971279

1, 372. 377919 205. 00

206.00

207.00

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

205.00

206.00

207.00

| Period: | Worksheet B-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0186

				Ť.	0 12/31/2021	Date/Time Prep 5/26/2022 10:	
	Cost Center Description	PURCHASI NG	BUSI NESS	Reconciliation	OTHER ADMIN &	MAINTENANCE &	or alli
		(REQS)	OFFI CE		GENERAL	REPAI RS	
			(GROSS CHARGES)		(ACCUM. COST)	(WORK ORDER)	
		5. 03	5. 05	5A. 06	5. 06	6. 00	
	GENERAL SERVICE COST CENTERS	1					
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00550 DATA PROCESSING						5. 02
5. 03	00591 PURCHASI NG	38, 844, 550	1 240 004 050				5. 03
5. 05 5. 06	00590 BUSINESS OFFICE 00592 OTHER ADMIN & GENERAL	63, 321 101, 564	1, 340, 894, 958	-42, 874, 308	321, 725, 977		5. 05 5. 06
6. 00	00600 MAI NTENANCE & REPAI RS	247, 406	Ö	1		5, 823	6. 00
7.00	00700 OPERATION OF PLANT	7, 464	0	0	6, 773, 385	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	173, 601	0	0	972, 573	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	310, 567 187, 637	0	0	4, 099, 984 2, 106, 933	0	9. 00 10. 00
11. 00	+ I	187, 037	0		785, 676	0	11. 00
13.00	01300 NURSING ADMINISTRATION	4, 600	0	0	1, 246, 209	0	13.00
14. 00	+ I	247, 421	0	0	1, 589, 481	4	14.00
15. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	922, 370	0	0		0	15. 00
16. 00 17. 00		1, 329 4, 470	0	0	3, 274, 886 2, 377, 574	0	16. 00 17. 00
21. 00		0	0	o o	1, 753, 380	Ö	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	12, 232	0	0	1, 534, 186	0	22. 00
23. 00		436	0	0	331, 675	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	908, 057	62, 105, 776	0	24, 072, 073	401	30. 00
31. 00	1 1	440, 066	7, 947, 509				31. 00
32. 00	1 1	0	0	1		0	32. 00
40.00	04000 SUBPROVI DER - I PF	22, 852	3, 940, 340	1	.,,	8	40.00
41. 00	1	122, 221	7, 694, 143	1	4, 895, 138	28	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	87, 710	1, 606, 072	0	1, 656, 694	0 66	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	07,710	1,000,072		1,050,074	00	43.00
50.00	1	10, 748, 591	126, 970, 992				50.00
51.00	1	198, 961	15, 322, 267	1			51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	126, 838	961, 984 0	0	_, _, ,	76 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	497, 944	92, 729, 174	1	10, 210, 177	510	54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	294, 547	8, 740, 392		741, 839	36	54. 01
54. 02	I I	122, 675	18, 298, 488		1, 672, 660		54. 02
55. 00 57. 00	+ I	224, 372 293, 972	46, 070, 691 94, 768, 810	1	4, 477, 829 2, 782, 800		55. 00 57. 00
58. 00	1 1	120, 734	25, 544, 055		999, 609		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	12, 077, 905	75, 119, 624		10, 840, 882	327	59. 00
60.00	06000 LABORATORY	7, 187, 112	176, 261, 056		, ,	237	60.00
60. 01 62. 00	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	-	0	60. 01 62. 00
64. 00	I I	78, 231	381, 821		_	0 453	64. 00
65. 00	06500 RESPI RATORY THERAPY	350, 781	21, 676, 462		3, 159, 691	292	65. 00
66. 00	1 1	259, 698	47, 530, 599		9, 110, 927	141	66. 00
69. 00		387, 285	31, 724, 057		2, 975, 920		69. 00
71. 00 72. 00	1 1	0	11, 887, 122 68, 942, 017	1	978, 508 12, 633, 965	0	71. 00 72. 00
73. 00	+ I	l o	257, 611, 764	1	33, 852, 341	Ö	73. 00
75. 01	03955 RENAL DIALYSIS (IP)	863	1, 462, 369	0	905, 775	43	75. 01
76. 00		8, 444	1, 992, 166	1	704, 180	87	76. 00
76. 01	+ +	6, 614	4, 877, 382	1	1, 758, 103	8 20	76. 01
76. 02 76. 03	1 1	135, 093	2, 676, 911 0		1, 357, 454 0	0	76. 02 76. 03
76. 04	03952 PAIN CLINIC	o	0	Ö	0	0	76. 04
76. 05	03953 DI ABETES	41, 166	2, 661, 003	1	1, 826, 615	1	76. 05
76. 98		223, 548	4, 828, 679	0	1, 196, 529	11	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	6, 000	387, 825	Λ .	416, 230	12	88. 00
89. 00	1 1	0,000	007,020	o o		0	89. 00
91. 00	09100 EMERGENCY	767, 399	61, 008, 971	0	8, 442, 747	237	91. 00
92.00			-		_		92.00
92. 01 93. 00	09202 OBSERVATION BEDS (DISTINCT PART) 04951 INFUSION	0 103, 013	0 32, 882, 122	0	0 1, 101, 320	0 41	92. 01 93. 00
93. 00	04950 COMMUNITY HEALTH CENTERS	2, 826	9, 389, 087				93. 00
_	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES 09910 CORF	59, 688	10, 280, 861			76 0	95. 00 99. 10
77. IU	07710  COIN	0	0	, U	1 0	ا ا	7 7. IU

Health Financial Systems	RI VERSI DE MEDI CAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BAS	SIS Provider CCN: 14-0186	Peri od: Worksheet B-1

Hearth Financial Systems	RIVERSIDE MED	ICAL CENTER		in Lie	eu of form CMS	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
				rom 01/01/2021		
			T	o 12/31/2021		
	BURGULAGING	BUGINESS	5	OTHER ARMS	5/26/2022 10:	3/ am
Cost Center Description	PURCHASI NG		Reconciliation	OTHER ADMIN &	MAINTENANCE &	
	(REQS)	OFFI CE		GENERAL	REPAI RS	
		(GROSS		(ACCUM. COST)	(WORK ORDER)	
		CHARGES)				
	5. 03	5. 05	5A. 06	5. 06	6. 00	
101.00 10100 HOME HEALTH AGENCY	118, 652	4, 612, 367	C	4, 768, 506	<u> </u>	101. 00
SPECIAL PURPOSE COST CENTERS						1
109. 00 10900 PANCREAS ACQUISITION	0	0	[ C	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	[ C	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	[ C	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	38, 308, 276	1, 340, 894, 958	-42, 874, 308	245, 575, 233	5, 342	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	43, 658	0	190. 00
191. 00 19100 RESEARCH	0	0	C	0	0	191. 00
191. 01 19101 SENI OR ADVAN	0	0	C	0	0	191. 01
191. 02 19102 CARE-A-VAN	0	0	l c	5, 817	0	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	536, 274	0	l	74, 487, 368	481	192. 00
192. 01 19201 REFERENCE LAB	o	0	l	0	ĺ	192. 01
192.02 19202 MEALS ON WHEELS	o	0	l	0	ĺ	192. 02
193. 00 19300 NONPALD WORKERS	o	0	l c	1, 613, 901	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	3, 305, 488	12, 163, 861		42, 874, 308	13, 976, 427	202. 00
Part I)	., ,	,,				
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 085095	0. 009071		0. 133263	2, 400. 210716	203. 00
204.00 Cost to be allocated (per Wkst. B,	812, 247	602, 398		3, 139, 230		
Part II)	, ,	,			, , ,	
205.00 Unit cost multiplier (Wkst. B, Part	0. 020910	0. 000449		0.009757	218. 945732	205. 00
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)						

Heal th	Financial Systems	RIVERSIDE MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2021 o 12/31/2021	Date/Time Pre	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/26/2022 10: CAFETERI A	37 am
	cost center bescriptron	PLANT	LINEN SERVICE		(MEALS SERVED)	(HOURS)	
		(SQUARE FEET)	(POUNDS OF				
		7. 00	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00591 PURCHASI NG						5. 03
5. 05 5. 06	00590 BUSINESS OFFICE 00592 OTHER ADMIN & GENERAL						5. 05 5. 06
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7.00	00700 OPERATION OF PLANT	265, 925					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 2, 428	263, 332	229, 776			8. 00 9. 00
10.00	01000 DI ETARY	10, 216	1, 645	1			10.00
11. 00	01100 CAFETERI A	9, 348	0	9, 348	586, 082	2, 133, 015	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	12 442	( )77	1	40, 316	
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	6, 372 2, 366	12, 443 0	6, 372 2, 366		28, 819 74, 523	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 675	0	5, 675		0	1
17.00	01700 SOCIAL SERVICE	531	0	531		64, 147	
21. 00 22. 00	02100   1 &R SERVI CES-SALARY & FRINGES APPRV   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRV	0 260	0	260		0 66, 664	21. 00 22. 00
23. 00	02301 PARAMED EDUCATION PROGRAM	348	O	348		10, 081	ł
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	63, 775 9, 127	119, 935 17, 391	63, 775 9, 127		457, 134 116, 146	
32.00	03200 CORONARY CARE UNIT	9, 127	17, 391	9, 127		116, 146	1
40.00	04000 SUBPROVI DER - I PF	O	14, 478	(	o	45, 969	
41.00	04100 SUBPROVI DER – I RF	7, 999	17, 910	7, 999		84, 896	
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	1, 730	0	1, 730	0	0 22, 602	
	ANCILLARY SERVICE COST CENTERS	.,		.,	-	,	
50.00	05000 OPERATI NG ROOM	16, 101	12, 037	16, 101		98, 897	1
51. 00 52. 00	05100 RECOVERY ROOM   05200 DELIVERY ROOM & LABOR ROOM	8, 899 5, 263	10, 393 0			95, 077 47, 916	1
53. 00	05300 ANESTHESI OLOGY	0, 200	0	0, 200		0	ı
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 475	15, 724			89, 740	
54. 01 54. 02	05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C   05404   ULTRASOUND	490 452	0	490 452		5, 004 21, 471	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	432		34, 301	1
57.00	05700 CT SCAN	575	0	575		28, 181	
58.00	05800 MRI	1, 192				9, 094 41, 046	
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	3, 475 6, 731	4, 143 0	3, 475 6, 731		90, 879	1
60. 01	06001 BLOOD LABORATORY	0	0	. (	1	0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(	0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 252	706	1, 252	0	20, 307 41, 347	1
66.00	06600 PHYSI CAL THERAPY	18, 324	4, 910			50, 573	
69. 00	06900 ELECTROCARDI OLOGY	2, 782	1, 477	2, 782		41, 507	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	o o	Ö		o o	0	
75. 01	03955 RENAL DIALYSIS (IP)	o	0	(	o	0	
76. 00	03956   CARDI AC REHAB   03950   OP PSY/CDU	1, 832	0	1, 832		11, 663	
76. 01 76. 02	03957 RI MMS	11, 730 3, 951	474	11, 730 3, 951		11, 730 0	ı
76. 03	03951 GENETIC/OAK PLAZA CLINICS	0	0	(		0	76. 03
76. 04	03952 PAIN CLINIC	0	0	(		0	
76. 05 76. 98	03953   DI ABETES   07698   HYPERBARI C OXYGEN THERAPY	494 1, 508	270	49 <sup>2</sup> 1, 508		0 4, 777	76. 05 76. 98
	OUTPATIENT SERVICE COST CENTERS		210	T			
88. 00	08800 RURAL HEALTH CLINIC	5, 813	0			0	
89. 00 91. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY	0 8, 685	0 20, 613	8, 685	1	0 144, 144	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0,000	20,013	0, 363	3, 721	,	92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0	0			0	
93. 00 93. 01	04951   I NFUSI ON 04950   COMMUNI TY   HEALTH   CENTERS	0	1, 269			11, 334 0	1
75.01	OTHER REIMBURSABLE COST CENTERS			, ,	, U		73.01
	09500 AMBULANCE SERVICES	6, 064	1, 539			0	
99. 10	09910  CORF	0	0	(	0	0	99. 10

Heal th Finan	cial Systems	RIVERSIDE MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	ION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
					rom 01/01/2021	5	
					o 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	37 alli
	cost center bescription		LI NEN SERVI CE		(MEALS SERVED)		
		(SQUARE FEET)	(POUNDS OF	(SQUARE TELT)	(WLALS SERVED)	(HOUKS)	
		(SQUARE TELT)	LAUNDRY)				
		7.00	8. 00	9, 00	10, 00	11. 00	
101. 00 10100	HOME HEALTH AGENCY	2, 848					101. 00
	AL PURPOSE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
109. 00 10900	PANCREAS ACQUISITION	0	0	C	0	0	109. 00
110.00 11000	INTESTINAL ACQUISITION	o	0		0	0	110.00
111. 00 11100	ISLET ACQUISITION	o	0	l c	0	0	111. 00
113.00 11300	INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	236, 111	257, 357	227, 870	1, 107, 506	1, 910, 285	118. 00
	MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 284	0	1, 284	0	0	190. 00
191. 00 19100	RESEARCH	o	0	C	0	0	191. 00
191. 01 19101	SENI OR ADVAN	o	0	C	0	0	191. 01
191. 02 19102	CARE-A-VAN	o	0	C	0	0	191. 02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	27, 908	5, 975	[ c	0	222, 730	192. 00
192. 01 19201	REFERENCE LAB	o	0	C	0	0	192. 01
192. 02 19202	MEALS ON WHEELS	o	0	C	0	0	192. 02
193. 00 19300	NONPALD WORKERS	622	0	622	0	0	193. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	7, 676, 027	1, 102, 181	4, 716, 445	2, 899, 179	2, 886, 311	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	28. 865383	4. 185519	20. 526273	2. 617755	1. 353160	203. 00
204. 00	Cost to be allocated (per Wkst. B,	5, 473, 793	163, 925	218, 559	646, 588	869, 594	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	20. 583973	0. 622503	0. 951183	0. 583823	0. 407683	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)						

	ALLOCATION - STATISTICAL BASIS	KI VERSI DE MEDI	Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	,	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		(DI RECT NRS	SUPPLY	REQUI S. )	LI BRARY (GROSS	(TIME SPENT)	
		I NG)	(COSTED REQUIS.)		CHARGES)		
		13. 00	14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVI CE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00591 PURCHASI NG						5. 03 5. 05
5. 05 5. 06	00590 BUSINESS OFFICE 00592 OTHER ADMIN & GENERAL						5.06
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION	1, 789, 373					13. 00
	01400 CENTRAL SERVICES & SUPPLY	28, 819	41, 246, 515	04 450 07			14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	31, 159, 96	3 0 1, 340, 894, 958		15. 00 16. 00
	01700 SOCIAL SERVICE		o		0	9, 560	17. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRV	O	0		0 0	0	21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	66, 664	0		0	0	
23. 00	O2301   PARAMED EDUCATION PROGRAM     I NPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	457, 134	ol		62, 105, 776	5, 685	30.00
	03100 INTENSIVE CARE UNIT	89, 430	0		7, 947, 509	378	
32. 00	1 1	0	0		0 0	0	
40. 00 41. 00	04000   SUBPROVI DER	45, 969 84, 896	0		3, 940, 340 7, 694, 143	2 294	
41.00	04200 SUBPROVI DER	04, 690	0		7, 694, 143	3, 284 0	1
43. 00	04300 NURSERY	22, 602	ō		1, 606, 072	0	
<b>50.00</b>	ANCILLARY SERVICE COST CENTERS	00.00=	al.			170	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	98, 897 95, 077	0		126, 970, 992 15, 322, 267	173 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	47, 916	0		961, 984	0	1
53.00		0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		92, 729, 174	0	54.00
54. 01 54. 02	05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C   05404   ULTRASOUND	0	0		8, 740, 392 18, 298, 488	0	
55. 00	1 1		0		46, 070, 691	0	
57. 00	05700 CT SCAN	0	0		94, 768, 810	0	1
	05800 MRI	0	0		25, 544, 055	0	
59. 00 60. 00	O5900   CARDI AC   CATHETERI ZATI ON   O6000   LABORATORY	41, 046	0		75, 119, 624 0 176, 261, 056	0	
60. 00	06001 BL00D LABORATORY		0		0 170, 201, 030	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62. 00
64.00		20, 307	0		381, 821	0	64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	41, 347 135, 349	0		21, 676, 462 47, 530, 599	0	65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	41, 507	0		31, 724, 057	0	69.00
71. 00		0	41, 246, 515		11, 887, 122	0	71. 00
72.00		0	0	04 450 04	68, 942, 017	0	72.00
73. 00 75. 01	07300 DRUGS CHARGED TO PATIENTS 03955 RENAL DIALYSIS (IP)	0	0	31, 159, 96	8 257, 611, 764 0 1, 462, 369	0	73. 00 75. 01
76. 00	03956 CARDI AC REHAB	11, 663	0		1, 992, 166	0	76.00
76. 01	03950 OP PSY/CDU	29, 834	0		4, 877, 382	0	76. 01
76. 02	03957 RI MMS	0	0		2, 676, 911	0	76. 02
76. 03 76. 04	03951   GENETIC/OAK PLAZA CLINICS   03952   PAIN CLINIC	0	0		0	0	76. 03 76. 04
76. 04	03953 DI ABETES		0		2, 661, 003	0	76.04
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	O		4, 828, 679	0	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	1 1	0	0		387, 825	0	
89. 00 91. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY	146, 298	0		61, 008, 971	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1 10, 270	٩		31,000,771		92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0	О		0 0	0	92. 01
93.00	04951 I NFUSI ON	0	O		32, 882, 122	0	
93. 01	O4950   COMMUNITY HEALTH CENTERS   OTHER REIMBURSABLE COST CENTERS	0	O		9, 389, 087	0	93. 01
95. 00	09500 AMBULANCE SERVICES	185, 836	0		0 10, 280, 861	0	95. 00
			-1				

Health Financial Systems	RIVERSIDE MED	ICAL CENTER		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/26/2022 10:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
oost oontol boson per on	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	SOUTHE SERVICE	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(DIRECT NRS	(COSTED	,	(GROSS		
	I NG)	REQUIS.)		CHARGES)		
	13.00	14.00	15. 00	16. 00	17. 00	
99. 10   09910   CORF	0	0		0 0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0		0 4, 612, 367	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	•	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		0 0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 690, 591	41, 246, 515	31, 159, 96	8 1, 340, 894, 958	9, 520	118. 00
NONREI MBURSABLE COST CENTERS	,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191. 00
191. 01 19101 SENI OR ADVAN	0	0		0 0		191. 01
191. 02 19102 CARE-A-VAN	0	0		0 0		191. 02
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	98, 782	0		0 0	1	192. 00
192. 01 19201 REFERENCE LAB	0	0		0	1	192. 01
192.02 19202 MEALS ON WHEELS	0	0		0 0		192. 02
193. 00 19300 NONPALD WORKERS	0	0		0 0	40	193. 00
200.00 Cross Foot Adjustments						200. 00

1, 466, 837

0.819749

0. 100384

179, 624

2, 240, 325

0. 054315

431, 708

0. 010467

2, 154, 088

0.069130

0. 016033

499, 582

3, 991, 605

0.002977

0.000292

391, 353

201. 00

206. 00

207. 00

2, 807, 445 202. 00

293. 665795 203. 00 110, 222 204. 00

11. 529498 205. 00

201.00

202.00

203.00

204.00

205.00

206.00

207.00

Negative Cost Centers

Part I)

Part II)

H)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

NAHE adjustment amount to be allocated (per Wkst. B-2)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0186 

COST Center Description						10 12/31/2021	Date/lime Prepared: 5/26/2022 10:37 am
Part			INTERNS &	RESI DENTS			
APPROX		Coot Conton Decemintion	CEDVI CEC CALAD	CEDVI CEC OTHER	DADAMED		
APPRIV   ASSIGNED   PRODUCTS   PRODUCTS   APPRIV   ASSIGNED   AS		Cost Center Description					
BUTTON STRUCT CHAT CHATTERS							
CHREME SERVICE COST CENTERS   1.00							
0.000   0.00		CENEDAL SERVICE COST CENTERS	21.00	22. 00	23.00		
2 00 00000 CAP REL COSTS-AVELE EQUIP 4 00 00000 ENTRES TO PROPRIMENT 5 0 0 00000 FUND COMMUNICATIONS 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00						1 00
5.01 01160 COMMUNICATIONS 5.02 5.02 00500 JUNIA PRODUCTS ING 5.03 5.03 005001 PIRROLING IN FIG. 5.03 5.03 005001 PIRROLING IN FIG. 5.03 5.03 005001 PIRROLING IN FIG. 5.03 6.00 00500 JUNIA PIRROLING IN FIG. 5.03 6.00 00500 JUNIA PIRROLING IN FIG. 7.00 6.00 00500 JUNIA PIRROLING IN FIG.							
5.02   0.0590   DATA PROCESSING   5.003	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.03   0.0591   PURCHASH NG		1 1					5. 01
5.05   0.0590   BUSINESS OFFICE     5.05							
0.00590   OTHER ADMIN & GENERAL     0.0050   0.0070   OFHERATION OF PLANT   0.0070   OFHERATION OF PLANT   0.0070   OTHERATION   0.00		1 1					
0.00   0.000   DAMIN REFANCE & REPAIR S		i i					
0.00   0.000		1 1					
9.00 09900   IOUSELECEP INS		i i					
10.00   01000   01 ETARY		1 1					
11.00   10100 (CAFETERIA   11.00   13.00   1300 (MIRS) MURS MA CARMINISTRATION   13.00   1300 (MIRS) MURS MA CARMINISTRATION   14.00		1 1					
13.00   01300   MURSING ADMINISTRATION     14.00   1400   01500   CHYRIAL SERVICE GENTRAL SERVICE SERVICE     15.00		1 1					
15.00   1500   PHARMACY		1 1					
16.00   01600   MEDICAL RECORDS & LIBRARY							
17.00   01700   SOCIAL SERVICE     17.00   21.00   220   18. SERVICES-SALARY & FRINGES APPRV   7.787   21.00   220   18. SERVICES-OTHER PROM COSTS APPRV   7.787   22.00   220   18. SERVICES-OTHER PROM COSTS APPRV   7.787   3.706   23.00   230   200   200							
21.00		1 1					
22.00   02200   BAR SERVICES-OTHER PROM COSTS APPRV   7,787   22.00		1 1	7, 787				
INPATT   ENT ROUTH NE SERVICE COST CENTERS   30.00   31.00   30.00		1 1	.,	7, 787			
30.00	23. 00				3, 70	16	23. 00
31.00	20.00		1 207	1 207	2.50		20.00
32.00							
40.00   0.0000   0.0000   0.		1 1	0				
A2 00   04200   SUBPROVIDER		1 1	0	0		0	
A3 .00   O4300   NURSERY   O   O   O   O   O		1 1	0	0		-	
ANCILLARY SERVICE COST CENTERS   50.00   50.00   50.00   55.		1 1	0	_	•		
50.00   05000   05000   05000   05000   05000   0	43.00		ı o	0	1	<u> </u>	43.00
S2.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   53.00	50.00		306	306		0	50.00
53.00   05300   ANESTHESI OLOGY   0 0 0   55.00			0		•		
54. 00   05400   RADI OLOGY-DI AGNOSTI C   149   149   0   54. 00   54. 00   05401   NUCLEAR MEDI CINE-DI AGNOSTI C   151   151   0   0   0   0   0   0   0   0   0			0	-	1	-	
54. 01   05401   NUCLEAR MEDICINE-DIAGNOSTIC   151   151   0   0   0   0   54. 02   54. 02   05404   ULTRASOUND   0   0   0   0   0   55. 00   55. 00   05500   RADIOLOGY-THERAPEUTIC   159   159   0   0   55. 00   57. 00   05500   RADIOLOGY-THERAPEUTIC   159   159   0   0   0   58. 00   05500   RADIOLOGY-THERAPEUTIC   159   159   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   59. 00   05900   CARDIAC CATHETERIZATION   699   699   0   0   0   60. 01   06000   BLOOD LABORATORY   0   0   0   0   60. 01   06001   BLOOD LABORATORY   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   64. 00   06400   INTERVAINOUS THERAPY   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   66. 00   06600   RESPIRATORY THERAPY   0   0   0   0   66. 00   06600   RESPIRATORY THERAPY   0   0   0   0   66. 00   06600   ELECTROCARDIOLOGY   122   122   122   0   66. 00   06600   ELECTROCARDIOLOGY   122   122   122   0   67. 00   07200   IMPL DE UY. CHARGED TO PATIENT   0   0   0   0   71. 00   07200   DRUGS CHARGED TO PATIENTS   0   0   0   72. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   75. 01   03955   RENAL DIALYSIS (IP)   0   0   0   76. 01   03955   RENAL DIALYSIS (IP)   0   0   0   76. 01   03950   OP PSYCOU   0   0   0   76. 02   03957   RIMMS   0   0   0   76. 03   03951   DENETIC OLAR PLAZA CLINICS   0   0   0   76. 04   03952   PAIN CLINIC   0   0   0   76. 05   03953   DABSETES   0   0   0   76. 06   00   00   00   76. 07   00   00   00   76. 08   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   77. 08   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   77. 09   07200   08900   RURAL HEALTH CLINIC   0   0   0   77. 00   07200   08900   RURAL HEALTH CLINIC   0   0   0   77. 00   07200   08900   RURAL HEALTH CLINIC   0   0   0   77. 00   07200   08900   RURAL HEALTH CLINIC   0   0   0   77. 00   07200   08900   RURAL HEALTH CLINIC   0   0   0   77. 00   09200   08800   RURAL HEALTH CLINIC   0   0   0   77. 00   0720		1 1	149	_		-	
55. 00   05500   RADI OLOGY-THERAPEUTI C   159   159   0   0   0   0   0   0   0   0   0			1		1	-	
57.00   05700   05700   05700   05700   05700   058.00   058.00   05800   05	54. 02	05404 ULTRASOUND	0	0		0	54. 02
58. 00   05800   MR    0   0   0   0   0   0   0   0   0			159		1	-	
59. 00   05900   CARDIAC CATHETERIZATION   699   699   0   59. 00   60. 00   660. 00   660. 00   660. 00   660. 00   60.		1 1	0		1	-	
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			699				
62. 00   662.00   662.00   662.00   664.00   664.00   664.00   664.00   664.00   664.00   664.00   665.00   665.00   665.00   665.00   665.00   665.00   665.00   665.00   665.00   665.00   665.00   665.00   665.00   666			0	0		0	
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0			0	0		0	
65. 00		l l	0	0		0	l l
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 66. 00 69. 00 69. 00 6900 ELECTROCARDI OLOGY 122 122 0 66. 00 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 771. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 772. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 773. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 773. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 775. 01 03955 RENAL DI ALYSI S (I P) 0 0 0 0 0 755. 01 03955 RENAL DI ALYSI S (I P) 0 0 0 0 0 756. 01 03950 OP PSY/CDU 0 0 0 0 766. 00 76. 01 03950 OP PSY/CDU 0 0 0 0 0 766. 00 766. 00 766. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0	
71. 00		I I	Ö	0		Ö	
72. 00	69. 00	1 1	122	122		0	69. 00
73. 00			0	0		-	
75. 01 03955 RENAL DIALYSIS (IP) 0 0 0 0 75. 01 76. 00 03956 CARDIAC REHAB 0 0 0 0 76. 00 76. 01 03950 OP PSY/CDU 0 0 0 0 76. 01 76. 02 03957 RIMMS 0 0 0 0 76. 02 76. 03 03951 GENETIC/OAK PLAZA CLINICS 0 0 0 76. 02 76. 04 03952 PAIN CLINIC 0 0 0 0 76. 04 76. 05 03953 DIABETES 0 0 0 0 76. 04 76. 05 03953 DIABETES 0 0 0 0 0 76. 05 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76. 98 00TPATIENT SERVICE COST CENTERS  88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89. 00 91. 00 09100 EMERGENCY 168 168 168 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 92. 01 09202 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 93. 00		1 1	0	0		0	
76. 00			0	0		0	•
76. 02			o	0		0	
76. 03	76. 01		0	0		0	76. 01
76. 04			0	0		0	
76. 05			0	0	1	-	
76. 98   07698   HYPERBARI C 0XYGEN THERAPY   0   0   0   0   76. 98				0		~	
88. 00   08800   RURAL HEALTH CLINIC   0   0   0   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   91. 00   09100   EMERGENCY   168   168   0   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   92. 00   92. 01   09202   0BSERVATION BEDS (DISTINCT PART)   0   0   0   93. 00   04951   INFUSION   0   0   0   93. 00   0950   0950   0950   0950   0950   94. 00   0950   0950   0950   0950   0950   0950   95. 00   0950   0950   0950   0950   96. 00   00   00   00   97. 00   00   00   00   98. 00   0950   0950   0950   98. 00   0950   0950   0950   99. 00   0950   0950   0950   99. 00   0950   0950   0950   99. 00   0950   0950   0950   99. 00   0950   0950   0950   99. 00   0950   99. 00   0950   0950   99. 00   0950   0950   99. 00   0950   0950   99. 00   0950   0950   99. 00   0950   99. 00   0950   0950   99. 00   09		07698 HYPERBARI C OXYGEN THERAPY	0	0		0	
89. 00					T		
91. 00			0		1		
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   92. 00   92. 01   09202   0BSERVATI ON BEDS (DISTINCT PART)   0   0   0   92. 01   93. 00   04951   INFUSI ON   0   0   0   93. 00			1	_		-	
92. 01   09202   0BSERVATI ON BEDS (DI STINCT PART)			130	100			
		09202 OBSERVATION BEDS (DISTINCT PART)	0	0		0	92. 01
73. UT			0	0		-	
	93.01	O4320 COMMONITY HEALTH CENTERS	1 0	0	1	<u>Ч</u>	93.01

| Peri od: | Worksheet B-1 | To | 12/21/2021 | T Provider CCN: 14-0186

				o 12/31/2021	Date/Time Pre 5/26/2022 10:	epared:
	INTERNS & RI	FSLDENTS			3/20/2022 10.	37 alli
	TIVIENNO & N	LOIDLINIO				
Cost Center Description	SERVI CES-SALARISE	RVI CES-OTHER	PARAMED			
	Y & FRINGES	PRGM COSTS	EDUCATI ON			
	APPRV	APPRV	PROGRAM			
	(ASSI GNED	(ASSI GNED	(ASSI GNED			
	TIME)	TIME)	TIME)			
	21.00	22.00	23. 00			
OTHER REIMBURSABLE COST CENTERS	•					
95. 00 09500 AMBULANCE SERVI CES	0	0	0			95. 00
99. 10 09910 CORF	ol	0	0			99. 10
101.00 10100 HOME HEALTH AGENCY	ol	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	ol	0	0			111.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 4, 125	4, 125	3, 706			118. 00
NONREI MBURSABLE COST CENTERS		•				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
191. 00 19100 RESEARCH	o	0	0			191. 00
191. 01 19101 SENI OR ADVAN	o	0	0			191. 01
191. 02 19102 CARE-A-VAN	o	0	0			191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	3, 662	3, 662	0			192. 00
192. 01 19201 REFERENCE LAB	o	0	0			192. 01
192.02 19202 MEALS ON WHEELS	o	0	0			192. 02
193.00 19300 NONPALD WORKERS	o	0	0			193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 987, 041	1, 896, 333	406, 704			202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I	) 255. 174136	243. 525491	109. 742040			203. 00
204.00 Cost to be allocated (per Wkst. B,	17, 145	72, 390	26, 826			204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	2. 201747	9. 296263	7. 238532			205. 00
206.00 NAHE adjustment amount to be allocate	ed		0			206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,			0. 000000			207. 00
Parts III and IV)	1	I		I		1

Provider CCN: 14-0186

				Т	o 12/31/2021	Date/Time Prep 5/26/2022 10:	pared: 37 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	odst denter beserretron	(from Wkst. B,	Adj .	10101 00313	Di sal I owance	10141 00313	
		Part I, col.	•				
		26) 1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30.00	03000 ADULTS & PEDIATRICS	36, 188, 384		36, 188, 384	0	36, 188, 384	30. 00
	03100 INTENSIVE CARE UNIT	7, 862, 108		7, 862, 108		7, 862, 108	
	03200 CORONARY CARE UNIT	0 204 501		0 204 501	0	0 204 501	32.00
	04000  SUBPROVI DER	2, 294, 591 7, 398, 284		2, 294, 591 7, 398, 284		2, 294, 591 7, 398, 284	
	04200 SUBPROVI DER	o		0		0	42. 00
	04300 NURSERY	2, 175, 224		2, 175, 224	0	2, 175, 224	43. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	22 112 (54		22 112 454		22 112 /54	F0 00
	05100 RECOVERY ROOM	23, 112, 654 7, 578, 788		23, 112, 654 7, 578, 788		23, 112, 654 7, 578, 788	
	05200 DELIVERY ROOM & LABOR ROOM	3, 515, 555		3, 515, 555		3, 515, 555	
	05300 ANESTHESI OLOGY	0		0	_	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	13, 627, 427		13, 627, 427		13, 627, 427	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRASOUND	984, 100 2, 277, 442		984, 100 2, 277, 442		984, 100 2, 277, 442	
	05500 RADI OLOGY-THERAPEUTI C	5, 555, 751		5, 555, 751		5, 555, 751	
	05700 CT SCAN	3, 574, 311		3, 574, 311		3, 574, 311	
	05800 MRI	1, 340, 051		1, 340, 051		1, 340, 051	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	13, 572, 236		13, 572, 236		13, 572, 236	
	06001 BLOOD LABORATORY	18, 001, 521 0		18, 001, 521	0	18, 001, 521 0	60. 00 60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	l o		ĺ	ő	0	62. 00
	06400 INTRAVENOUS THERAPY	3, 694, 824		3, 694, 824		3, 694, 824	64. 00
	06500 RESPI RATORY THERAPY	4, 500, 790	0			4, 500, 790	
	06600  PHYSI CAL THERAPY 06900  ELECTROCARDI OLOGY	11, 909, 993 4, 099, 158	0	11, 909, 993 4, 099, 158		11, 909, 993 4, 099, 158	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 384, 620		3, 384, 620		3, 384, 620	
	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 522, 845		14, 522, 845		14, 522, 845	
	07300 DRUGS CHARGED TO PATIENTS	41, 284, 364		41, 284, 364		41, 284, 364	
	03955 RENAL DIALYSIS (IP) 03956 CARDIAC REHAB	1, 134, 043 1, 128, 598		1, 134, 043 1, 128, 598		1, 134, 043 1, 128, 598	
	03950 OP PSY/CDU	2, 645, 808		2, 645, 808		2, 645, 808	
76. 02	03957 RI MMS	1, 791, 455		1, 791, 455		1, 791, 455	
	03951 GENETIC/OAK PLAZA CLINICS	0		0		0	76. 03
	03952 PAIN CLINIC 03953 DIABETES	2, 104, 756		2, 104, 756	0	0 2, 104, 756	76. 04 76. 05
	03753 DIABETES 07698 HYPERBARI C OXYGEN THERAPY	1, 478, 836		1, 478, 836		1, 478, 836	
Ī	OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		, , , , , ,	-	,	
	08800 RURAL HEALTH CLINIC	669, 450		669, 450		669, 450	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09100 EMERGENCY	0 11, 163, 524		0 11, 163, 524		0 11, 163, 524	89. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 129, 440		2, 129, 440		2, 129, 440	
	09202 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92. 01
	04951   NFUSI ON	1, 465, 032		1, 465, 032		1, 465, 032	
	04950 COMMUNITY HEALTH CENTERS OTHER REIMBURSABLE COST CENTERS	1, 404, 730		1, 404, 730	0	1, 404, 730	93. 01
	09500 AMBULANCE SERVICES	8, 942, 594		8, 942, 594	O	8, 942, 594	95. 00
	09910 CORF	0		0		0	1
	10100 HOME HEALTH AGENCY	5, 560, 770		5, 560, 770		5, 560, 770	101. 00
	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION					0	109. 00
	11000 INTESTINAL ACQUISITION	0		0			110.00
	11100   SLET ACQUISITION			Ö			111.00
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	274, 074, 057	0			274, 074, 057	
201. 00 202. 00	Less Observation Beds Total (see instructions)	2, 129, 440 271, 944, 617	0	2, 129, 440 271, 944, 617		2, 129, 440 271, 944, 617	
232.00	1.014. (000 111011 4011 0113)	2.1, 7, 7, 017	0		, Y	2.1, 714, 017	

| Peri od: | Worksheet C | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 10: 37 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0186

							5/26/2022 10:	37 am
				Title	XVIII	Hospi tal	PPS	
				Charges				
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
					+ col. 7)	Ratio	I npati ent	
							Ratio	
			6.00	7. 00	8. 00	9. 00	10.00	
		ENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46, 835, 569		46, 835, 569			30.00
31.00	03100	INTENSIVE CARE UNIT	7, 947, 509		7, 947, 509			31.00
32.00	03200	CORONARY CARE UNIT	0		(			32.00
40.00	04000	SUBPROVIDER - IPF	3, 940, 340		3, 940, 340			40.00
41.00	04100	SUBPROVIDER - IRF	7, 694, 143		7, 694, 143	3		41.00
42.00	04200	SUBPROVI DER	0		(			42.00
43.00	04300	NURSERY	1, 606, 072		1, 606, 072	2		43.00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	44, 620, 315	82, 350, 677	126, 970, 992	0. 182031	0. 000000	50.00
51.00	05100	RECOVERY ROOM	4, 061, 770	11, 260, 497	15, 322, 267	0. 494626	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	279, 716	682, 268	961, 984	3. 654484	0.000000	52.00
53.00	05300	ANESTHESI OLOGY	o	0		0. 000000	0.000000	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	6, 717, 862	86, 011, 312	92, 729, 174	0. 146959	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	1, 301, 590	7, 438, 802	8, 740, 392	0. 112592	0.000000	54. 01
54.02	05404	ULTRASOUND	5, 052, 688	13, 245, 800	18, 298, 488	0. 124461	0.000000	54. 02
55.00	05500	RADI OLOGY-THERAPEUTI C	483, 790	45, 586, 901	46, 070, 691	0. 120592	0.000000	55. 00
57.00	05700	CT SCAN	33, 804, 971	60, 963, 839	94, 768, 810	0. 037716	0.000000	57. 00
58.00	05800	MRI	7, 013, 993	18, 530, 062	25, 544, 055	0. 052460	0.000000	58. 00
59.00	05900	CARDIAC CATHETERIZATION	18, 977, 002	56, 142, 622	75, 119, 624	0. 180675	0.000000	59. 00
60.00		LABORATORY	49, 413, 399	126, 847, 657			0. 000000	
60. 01	06001	BLOOD LABORATORY	0	0		0. 000000	0.000000	60. 01
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	o	0		0. 000000	0.000000	
64.00		INTRAVENOUS THERAPY	291, 011	90, 810	381, 821		0.000000	
65.00		RESPI RATORY THERAPY	15, 363, 812	6, 312, 650	1		0.000000	
66.00	1	PHYSI CAL THERAPY	18, 681, 234	28, 849, 365			0.000000	
69.00	1	ELECTROCARDI OLOGY	9, 153, 063	22, 570, 994			0.000000	
71. 00	4	MEDICAL SUPPLIES CHARGED TO PATIENT	4, 198, 208	7, 688, 914			0. 000000	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	29, 588, 803	39, 353, 214			0. 000000	
73. 00		DRUGS CHARGED TO PATIENTS	77, 518, 901	180, 092, 863			0. 000000	
75. 01		RENAL DIALYSIS (IP)	1, 369, 517	92, 852			0. 000000	
76. 00		CARDI AC REHAB	214, 619	1, 777, 547			0. 000000	
76. 01		OP PSY/CDU	9, 164	4, 868, 218			0. 000000	
76. 02		RIMMS	,,	2, 676, 911		1	0. 000000	
76. 03	4	GENETIC/OAK PLAZA CLINICS	0	_, _, _, 0			0. 000000	
76. 04		PAIN CLINIC	0	0		0. 000000	0. 000000	
76. 05		DI ABETES	1, 931	2, 659, 072	2, 661, 003		0. 000000	
76. 98		HYPERBARI C OXYGEN THERAPY	1, 476, 611	3, 352, 068			0. 000000	
70.70		TIENT SERVICE COST CENTERS	17 1707011	0,002,000	1,020,077	0.000201	0.00000	70.70
88. 00		RURAL HEALTH CLINIC	0	387, 825	387, 825			88. 00
89. 00	4	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
91. 00		EMERGENCY	16, 749, 008	44, 259, 963	61, 008, 971	0. 182982	0. 000000	
92. 00	4	OBSERVATION BEDS (NON-DISTINCT PART	4, 692, 940	10, 577, 267			0. 000000	
92. 01		OBSERVATION BEDS (DISTINCT PART)	0	0			0. 000000	
93. 00		I NFUSI ON	184, 152	32, 697, 970			0. 000000	
	4	COMMUNITY HEALTH CENTERS	0	9, 389, 087				
		REI MBURSABLE COST CENTERS	-1	.,,,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
95.00		AMBULANCE SERVICES	116, 637	10, 164, 224	10, 280, 861	0. 869829	0. 000000	95. 00
	09910		0	0				99. 10
	1	HOME HEALTH AGENCY	ol	4, 612, 367		,		101. 00
30		AL PURPOSE COST CENTERS		., : . = , 30,	., , ,			1
109. 00		PANCREAS ACQUISITION	O	0				109. 00
		INTESTINAL ACQUISITION	ا	0	•			110.00
		ISLET ACQUISITION	اً ما	0				111. 00
	4	INTEREST EXPENSE		· ·	]			113. 00
200.00	4	Subtotal (see instructions)	419, 360, 340	921, 534, 618	1, 340, 894, 958	<sub>3</sub>		200.00
201.00	4	Less Observation Beds		, , 3 . 0				201. 00
202.00	1	Total (see instructions)	419, 360, 340	921, 534, 618	1, 340, 894, 958	<sub>3</sub>		202. 00
	1	· · · · · · · · · · · · · · · · · · ·		,		1	1	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: 5/26/2022 10: 37 am | Hospital | PPS Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES RIVERSIDE MEDICAL CENTER Provider CCN: 14-0186

Title XVIII

		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32. 00
40. 00   04000   SUBPROVI DER -   PF					40.00
41. 00   04100   SUBPROVI DER -   RF					41. 00
42. 00   04200   SUBPROVI DER					42. 00
43. 00   04300   NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM	0. 182031				50.00
51. 00   05100   RECOVERY   ROOM					51.00
	0. 494626				1
52. 00   05200   DELI VERY ROOM & LABOR ROOM	3. 654484				52.00
53. 00   05300   ANESTHESI OLOGY	0.000000				53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 146959				54.00
54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	0. 112592				54. 01
54. 02   05404   ULTRASOUND	0. 124461				54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 120592				55. 00
57. 00  05700   CT   SCAN	0. 037716				57. 00
58. 00  05800 MRI	0. 052460				58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 180675				59. 00
60. 00   06000   LABORATORY	0. 102130				60.00
60. 01   06001   BLOOD LABORATORY	0. 000000				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
64.00 06400 INTRAVENOUS THERAPY	9. 676849				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 207635				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 250575				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 129213				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 284730				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210653				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 160258				73. 00
75. 01   03955   RENAL DI ALYSI S (I P)	0. 775483				75. 01
76. 00   03956   CARDI AC   REHAB	0. 566518				76. 00
76. 01 03950 OP PSY/CDU	0. 542465				76. 01
76. 02 03957 RI MMS	0. 669225				76. 02
76. 03 03951 GENETIC/OAK PLAZA CLINICS	0. 000000				76. 03
76. 04   03952   PAIN CLINIC	0. 000000				76. 04
76. 05 03953 DI ABETES	0. 790963				76. 05
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 306261				76. 98
OUTPATIENT SERVICE COST CENTERS	0. 300201				70. 70
88. 00 08800 RURAL HEALTH CLINIC					88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER					89. 00
91. 00   09100   EMERGENCY	0. 182982				91.00
	0. 182982				1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1				92.00
92. 01   09202   OBSERVATI ON BEDS (DISTINCT PART)	0. 000000				92. 01
93. 00   04951   I NFUSI ON	0. 044554				93. 00
93. 01 04950 COMMUNITY HEALTH CENTERS	0. 149613				93. 01
OTHER REIMBURSABLE COST CENTERS	0.040000				05.00
95. 00   09500   AMBULANCE   SERVI CES	0. 869829				95. 00
99. 10   09910   CORF					99. 10
101. 00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION					109. 00
110.00 11000 INTESTINAL ACQUISITION					110. 00
111. 00 11100 I SLET ACQUI SI TI ON					111. 00
113.00 11300 INTEREST EXPENSE					113. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Provider CCN: 14-0186 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 10:37 am Hospi tal Title XIX Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 36, 188, 384 36, 188, 384 36, 188, 384 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 7, 862, 108 7, 862, 108 7, 862, 108 03200 CORONARY CARE UNIT 0 32.00 32.00 04000 SUBPROVI DER - I PF 0 2, 294, 591 40.00 2, 294, 591 2, 294, 591 40.00 04100 SUBPROVI DER - I RF 0 41.00 7, 398, 284 7, 398, 284 7, 398, 284 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 2, 175, 224 2, 175, 224 2, 175, 224 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 112, 654 23, 112, 654 0 23, 112, 654 50.00 51.00 05100 RECOVERY ROOM 7, 578, 788 7, 578, 788 0 7, 578, 788 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 515, 555 3, 515, 555 3, 515, 555 52.00 05300 ANESTHESI OLOGY 53.00 0  $\cap$ Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 627, 427 13, 627, 427 0 13, 627, 427 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 984, 100 984, 100 0 0 0 0 0 984, 100 54.01 05404 ULTRASOUND 2. 277. 442 54 02 2 277 442 2 277 442 54 02 55.00 05500 RADI OLOGY-THERAPEUTI C 5, 555, 751 5, 555, 751 5, 555, 751 55.00 05700 CT SCAN 3, 574, 311 3, 574, 311 3, 574, 311 57.00 57.00 05800 MRI 58.00 1, 340, 051 1, 340, 051 1, 340, 051 58.00 05900 CARDIAC CATHETERIZATION 13, 572, 236 13 572 236 13, 572, 236 59 00 59 00 0 60.00 06000 LABORATORY 18,001,521 18, 001, 521 18, 001, 521 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 62 00 0 0 06400 I NTRAVENOUS THERAPY 64.00 3, 694, 824 3, 694, 824 3, 694, 824 64.00 06500 RESPIRATORY THERAPY 4, 500, 790 4, 500, 790 4, 500, 790 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 11, 909, 993 11, 909, 993 0 11, 909, 993 66.00 06900 ELECTROCARDI OLOGY 4. 099. 158 4, 099, 158 69 00 4 099 158 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 3, 384, 620 3, 384, 620 3, 384, 620 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14, 522, 845 14, 522, 845 14, 522, 845 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 41, 284, 364 41, 284, 364 41, 284, 364 73.00 03955 RENAL DIALYSIS (IP) 1, 134, 043 1, 134, 043 1, 134, 043 75.01 75 01 0 76.00 03956 CARDI AC REHAB 1, 128, 598 1, 128, 598 1, 128, 598 76.00 03950 OP PSY/CDU 0 76.01 2, 645, 808 2, 645, 808 2, 645, 808 76.01 0 76.02 03957 RI MMS 1, 791, 455 1, 791, 455 1, 791, 455 76.02 03951 GENETIC/OAK PLAZA CLINICS 76.03 0 C 0 76.03 76.04 03952 PAIN CLINIC 0 76.04 0 76.05 03953 DI ABETES 2, 104, 756 2, 104, 756 0 2, 104, 756 76.05 07698 HYPERBARIC OXYGEN THERAPY 1, 478, <u>836</u> 1, 47<u>8, 836</u> 1, 478, <u>836</u> 76.98 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 669, 450 669, 450 0 669, 450 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 09100 EMERGENCY 0 91.00 11, 163, 524 11, 163, 524 11, 163, 524 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 2, 129, 440 2, 129, 440 2, 129, 440 92.00 92.01 09202 OBSERVATION BEDS (DISTINCT PART) 0 92.01 04951 | NFUSI ON 1, 465, 032 1, 465, 032 0 1, 465, 032 93.00 93.00 04950 COMMUNITY HEALTH CENTERS 93.01 1, 404, 730 1, 404, 730 0 1, 404, 730 93.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 8, 942, 594 8, 942, 594 8, 942, 594 95.00 99. 10 09910 CORF 0 99.10 101.00 10100 HOME HEALTH AGENCY 5, 560, 770 5, 560, 770 5, 560, 770 101. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113.00 200.00 274, 074, 057 274, 074, 057 274, 074, 057 200. 00 Subtotal (see instructions) 0 0 2, 129, 440 201. 00

2, 129, 440

271, 944, 617

2, 129, 440

271, 944, 617 202. 00

271, 944, 617

201.00

202.00

Less Observation Beds

Total (see instructions)

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/26/2022 10:37 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0186

						10 12/31/2021	5/26/2022 10:	
				Ti tl	e XIX	Hospi tal	Cost	
				Charges				
		Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
					+ col . 7)	Ratio	Inpatient	
			/ 00	7.00	0.00	0.00	Ratio	
	LNDAT	IENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
30. 00		ADULTS & PEDIATRICS	46, 835, 569		46, 835, 50	sol		30. 00
31. 00	4	INTENSIVE CARE UNIT	7, 947, 509		7, 947, 50			31. 00
32. 00		CORONARY CARE UNIT	7, 747, 307		7, 747, 30	ó		32. 00
40. 00		SUBPROVIDER - IPF	3, 940, 340		3, 940, 3	-		40.00
41.00		SUBPROVI DER - I RF	7, 694, 143		7, 694, 1			41.00
42.00	04200	SUBPROVI DER	0			0		42. 00
43.00	04300	NURSERY	1, 606, 072		1, 606, 0°	72		43.00
	ANCI LI	LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	44, 620, 315	82, 350, 677	1		0. 000000	1
51. 00		RECOVERY ROOM	4, 061, 770	11, 260, 497	1		0. 000000	1
52. 00		DELIVERY ROOM & LABOR ROOM	279, 716	682, 268	1		l e	1
53.00		ANESTHESI OLOGY	0	0		0.000000	0.000000	
54.00		RADI OLOGY-DI AGNOSTI C	6, 717, 862	86, 011, 312				
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC ULTRASOUND	1, 301, 590 5, 052, 688	7, 438, 802	1		0.000000	1
55. 00		RADI OLOGY-THERAPEUTI C	483, 790	13, 245, 800 45, 586, 901			0. 000000 0. 000000	
57. 00		CT SCAN	33, 804, 971	60, 963, 839			0. 000000	1
58. 00	05800		7, 013, 993	18, 530, 062			0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	18, 977, 002	56, 142, 622			0. 000000	1
60.00		LABORATORY	49, 413, 399	126, 847, 657			0.000000	
60. 01	4	BLOOD LABORATORY	0	0	1	0. 000000	0. 000000	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	O	0		0. 000000	0. 000000	62. 00
64. 00	06400	INTRAVENOUS THERAPY	291, 011	90, 810	381, 83	9. 676849	0. 000000	64. 00
65.00		RESPI RATORY THERAPY	15, 363, 812	6, 312, 650	21, 676, 4	0. 207635	0. 000000	1
66. 00	1	PHYSI CAL THERAPY	18, 681, 234	28, 849, 365			0. 000000	1
69. 00	4	ELECTROCARDI OLOGY	9, 153, 063	22, 570, 994			0. 000000	1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	4, 198, 208	7, 688, 914			0. 000000	1
72.00		IMPL. DEV. CHARGED TO PATIENTS	29, 588, 803	39, 353, 214			0.000000	
73. 00 75. 01		DRUGS CHARGED TO PATIENTS	77, 518, 901	180, 092, 863				1
76. 00		RENAL DIALYSIS (IP) CARDIAC REHAB	1, 369, 517 214, 619	92, 852 1, 777, 547			0. 000000 0. 000000	
76. 00		OP PSY/CDU	9, 164	4, 868, 218			0.000000	
76. 02		RIMMS	7, 104	2, 676, 911			0. 000000	1
76. 03		GENETIC/OAK PLAZA CLINICS	o o	2,070,711		0. 000000	0. 000000	1
76. 04		PAIN CLINIC	o	0		0. 000000	0.000000	1
76. 05	03953	DI ABETES	1, 931	2, 659, 072	2, 661, 00	0. 790963	0. 000000	76. 05
76. 98		HYPERBARI C OXYGEN THERAPY	1, 476, 611	3, 352, 068	4, 828, 6	0. 306261	0. 000000	76. 98
		TIENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC	0	387, 825	387, 83		i e	1
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0. 000000	0. 000000	
91.00		EMERGENCY	16, 749, 008	44, 259, 963			0.000000	1
92.00		OBSERVATION BEDS (NON-DISTINCT PART	4, 692, 940	10, 577, 267			0.000000	
92. 01 93. 00		OBSERVATION BEDS (DISTINCT PART)	104 153	0 32, 697, 970	•	0.000000	0.000000	
		INFUSION COMMUNITY HEALTH CENTERS	184, 152 0				l	
93.01		REIMBURSABLE COST CENTERS	U U	9, 389, 087	9, 389, 0	0. 149013	0.00000	93.01
95. 00		AMBULANCE SERVICES	116, 637	10, 164, 224	10, 280, 80	0. 869829	0.000000	95. 00
	09910		0	0, 101, 221		0.007027	0.00000	99. 10
		HOME HEALTH AGENCY	o	4, 612, 367	4, 612, 3	57		101. 00
		AL PURPOSE COST CENTERS	-	., ,				
109.00		PANCREAS ACQUISITION	0	0		0		109. 00
110.00	11000	INTESTINAL ACQUISITION	o	0		0		110. 00
		ISLET ACQUISITION	0	0		0		111. 00
		INTEREST EXPENSE						113. 00
200.00	4	Subtotal (see instructions)	419, 360, 340	921, 534, 618	1, 340, 894, 9	58		200. 00
201.00		Less Observation Beds	410 0/0 0/0	004 504 /10	1 240 204 3			201. 00
202.00	기	Total (see instructions)	419, 360, 340	921, 534, 618	1, 340, 894, 9	ואס	l	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES RIVERSIDE MEDICAL CENTER Provider CCN: 14-0186

| In Lieu of Form CMS-2552-10 | Worksheet C | Part | | B1/2021 | Date/Time Prepared: | 5/26/2022 | 10: 37 am | | Peri od: From 01/01/2021 To 12/31/2021

			Title XIX	Hospi tal	Cost	<u> </u>
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11.00				
I NP	PATIENT ROUTINE SERVICE COST CENTERS					
30.00 030	000 ADULTS & PEDIATRICS					30.00
31.00 031	100 INTENSIVE CARE UNIT					31. 00
32. 00 032	200 CORONARY CARE UNIT					32. 00
	000 SUBPROVI DER - I PF					40. 00
41.00 041	100 SUBPROVI DER - I RF					41. 00
42. 00 042	200 SUBPROVI DER					42. 00
43.00 043	NURSERY					43.00
	CILLARY SERVICE COST CENTERS					
	OOO OPERATING ROOM	0. 000000				50. 00
	100 RECOVERY ROOM	0. 000000				51. 00
	200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
	300 ANESTHESI OLOGY	0. 000000				53. 00
	100 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
	101 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54. 01
	104 ULTRASOUND	0. 000000				54. 02
	500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
	700 CT SCAN	0. 000000				57. 00
	800 MRI	0. 000000				58. 00
	POO CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
	000 LABORATORY	0. 000000				60. 00
	001 BLOOD LABORATORY	0. 000000				60. 01
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62. 00
	100 I NTRAVENOUS THERAPY	0. 000000				64.00
	500 RESPI RATORY THERAPY	0. 000000				65. 00
	500 PHYSI CAL THERAPY	0. 000000				66. 00
	900 ELECTROCARDI OLOGY	0. 000000				69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
	BOO DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	P55 RENAL DIALYSIS (IP)	0. 000000				75. 01
	956 CARDI AC REHAB	0. 000000				76. 00
	950 OP PSY/CDU	0. 000000				76. 01
	P57 RI MMS	0. 000000				76. 02
	951 GENETIC/OAK PLAZA CLINICS	0. 000000				76. 03
	PS2 PAIN CLINIC	0. 000000				76. 04
	P53 DI ABETES	0.000000				76. 05
	598 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
	PATIENT SERVICE COST CENTERS	0.000000				00 00
	RURAL HEALTH CLINIC	0. 000000				88. 00
	POOFEDERALLY QUALIFIED HEALTH CENTER	0.000000				89. 00 91. 00
	· ·	0. 000000				
	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92. 00 92. 01
	202 OBSERVATION BEDS (DISTINCT PART) P51 INFUSION	0. 000000				92.01
	· ·	0. 000000				
	P50 COMMUNITY HEALTH CENTERS  HER REIMBURSABLE COST CENTERS	0. 000000				93. 01
	500 AMBULANCE SERVICES	0.000000				05 00
95.00 095		0. 000000				95. 00 99. 10
	100 HOME HEALTH AGENCY					101.00
	CLIAL PURPOSE COST CENTERS					101.00
	POO PANCREAS ACQUISITION	T				109. 00
	000 INTESTINAL ACQUISITION					110.00
	100 ISLET ACQUISITION					111.00
	300 INTEREST EXPENSE					113. 00
200. 00	Subtotal (see instructions)					200. 00
200.00	Less Observation Beds					201.00
201.00	Total (see instructions)					201.00
202.00	Total (See Histractions)	1			ŀ	202.00

Health Financial Systems	RIVERSIDE MED	OLCAL CENTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider C	CN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/26/2022 10:	pared:
		Titl∈	XVIII	Hospi tal PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 821, 679	0	4, 821, 67			30.00
31.00 INTENSIVE CARE UNIT	856, 912		856, 91	4, 159	206. 04	31.00
32. 00 CORONARY CARE UNIT	0			0	0.00	32. 00
40. 00 SUBPROVI DER - I PF	70, 759	0	70, 75	3, 118	22. 69	40.00
41. 00 SUBPROVI DER - I RF	672, 734	0	672, 73	8, 505	79. 10	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43. 00 NURSERY	170, 973		170, 97	1, 818	94. 04	43.00
200.00 Total (lines 30 through 199)	6, 593, 057		6, 593, 05	61, 938		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	12, 544	1, 364, 160	)			30.00
31.00 INTENSIVE CARE UNIT	1, 565	322, 453	s			31. 00
32.00 CORONARY CARE UNIT	0	0	)			32.00
40. 00 SUBPROVIDER - IPF	1, 499	34, 012	2			40.00
41. 00 SUBPROVI DER - I RF	6, 142	485, 832	2			41.00
42. 00 SUBPROVI DER	0	0	)			42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	21, 750	2, 206, 457	'			200. 00

Health Financial Systems	RIVERSIDE MEDIC	AL CENTER	In Lie	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLA	Y SERVICE CAPITAL COSTS	Provi der CCN: 14-0186	Peri od:	Worksheet D		

APPORTIOMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS    Cost Center Description   Capital   Title XVIII   No. Program   Capital   Title XVIII	Hearth Financial Systems	RIVERSIDE MEL	DICAL CENTER		In Lie	u or form CMS-2	<u> 2552-10</u>
Cost Center Description	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der Co		From 01/01/2021	Part II Date/Time Pre	pared: 37 am
Cost Center Description			Title	: XVIII	Hospi tal		
Related Cost   Cfrom Wisst, C,   Col. 1 + col.   Col. 1 + co	Cost Center Description	Capi tal				Capital Costs	
ANCILLARY SERVICE COST CENTERS	, and the second						
ANCILLARY SERVICE COST CENTERS		(from Wkst. B,				column 4)	
ANCILLARY SERVICE COST CENTERS		Part II, col.	8)	2)		ŕ	
MACILLARY SERVICE COST CENTERS		26)	,	,			
50.00   05000   0FECATITING ROOM   3, 477, 351   126, 970, 992   0. 027387   16, 947, 456   464, 140   50.00   05200   0FELOVERY ROOM   756, 799   153, 232, 267   757, 51.00   05200   0FELOVERY ROOM   240, 475   591, 984   0. 417361   5, 616   2, 344   52.00   05200   0FELOVERY ROOM   240, 475   591, 984   0. 417361   5, 616   2, 344   52.00   054, 00   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			2.00	3.00	4. 00	5. 00	
50.00   05000   0FECATITING ROOM   3, 477, 351   126, 970, 992   0. 027387   16, 947, 456   464, 140   50.00   05200   0FELOVERY ROOM   756, 799   153, 232, 267   757, 51.00   05200   0FELOVERY ROOM   240, 475   591, 984   0. 417361   5, 616   2, 344   52.00   05200   0FELOVERY ROOM   240, 475   591, 984   0. 417361   5, 616   2, 344   52.00   054, 00   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	ANCILLARY SERVICE COST CENTERS	*		•	*		
51.00   OSTOO   RECOVERY ROOM & LABOR ROOM   756, 799   15, 322, 267   0.049392   1, 513, 552   74, 757   51.00		3, 477, 351	126, 970, 992	0. 02738	7 16, 947, 456	464, 140	50.00
53.00   08300   AMESTHESI OLOGY   0   0   0   0   0   0   0   0   53.00	51.00 05100 RECOVERY ROOM	756, 799	15, 322, 267	0. 04939			51.00
54. 00   05400   RADIO LOGY-DI AGROSTIC   1,458, 927   92,729,174   0.015733   3,091,523   48,639   54.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	401, 495	961, 984	0. 41736	1 5, 616	2, 344	52.00
54.01   OS401   NUCLEAR MEDI CINE-DI AGNOSTI C   71,952   8,740,392   0.008232   6.35,751   5.234   54.01     54.02   OS404   ULTRASQUIND   242,574   18,298,488   0.013257   1,842,860   24,431   54.02     55.00   OS500   RADI OLOGY-THERAPEUTI C   299,513   46,070,691   0.006501   192,120   1,249   55.00     57.00   OS700   CT SCAN   531,320   94,768,810   0.005066   14,522,504   81,413   57.00     59.00   OS900   CARDI AC CATHETERI ZATI ON   1.029,609   75,119,624   0.013706   13,235,375   181,404   59.00     60.01   OS000   LABORATORY   1.204,611   176,261,056   0.006834   17,781,579   121,519   60.00     60.01   OS000   LABORATORY   0   0   0.000000   0   0.00000   0	53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54. 02   05404   ILTRASQUIND	54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 458, 927	92, 729, 174	0. 01573	3, 091, 523	48, 639	54.00
54. 02   05404   ILTRASQUIND	54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	71, 952	8, 740, 392	0. 00823	2 635, 751	5. 234	54. 01
55 00         05500 RADIOLOCY-THERAPEUTI C         299, 513         46, 070, 691         0, 065001         1,92, 120         1,249         55, 00           57, 00         05700 CT SCAN         531, 320         94, 768, 810         0, 005606         14, 522, 504         81, 413         57, 00           59, 00         05900 CARDIA CATHETERI ZATI ON         1, 029, 609         75, 119, 624         0, 013706         13, 235, 375         181, 404         59, 00           60, 01         06000 CARDRATORY         1, 204, 611         176, 261, 056         0, 06834         17, 781, 579         121, 519         60, 00           60, 01         06001 BLOOD LABORATORY         0         0         0, 000000         0         0, 00         0         0, 00         0							
57. 00   05700   CT SCAN   531,320   94,768,810   0,005606   14,522,504   81,413   57.00							
58 00         05800 MRI         185, 514         25, 544, 055         0.007263         2, 736, 507         19, 875         88. 00           59. 00         05900 CARDIAC CATHETERIZATION         1, 029, 609         75, 119, 624         0.013706         13, 235, 375         181, 404         59. 00           60. 01         06000 LABORATORY         1, 204, 611         176, 261, 056         0.006034         17, 781, 579         121, 519         60. 00           60. 01         06000 LABORATORY         0         0         0.000000         0         0         0.000000           64. 00         0         0.000000         0         0.000000         0         0         0.000000           64. 00         0         0.6500         RESPIRATORY THERAPY         320, 893         21, 676, 462         0.01804         5, 659, 869         83, 789         65. 00           66. 00         06600         PHYSI CAL THERAPY         1, 350, 945         47, 530, 599         0.028423         2, 738, 264         77, 830         66. 00           69. 00         06900         PHYSI CAL THERAPY         1, 356, 945         47, 530, 599         0.028423         2, 738, 264         77, 830         66. 00           71. 00         07000         DATORO MINICAL THERAPY         <		•				-	
59. 00   05000   CARDI AC CATHETERI ZATI ON   1,029,609   75, 119,624   0,013706   13,235,375   181,404   59. 00							
0.0   0.0							1
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0							
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   0   0   0							
64. 00   06400   NTRAVENOUS THERAPY   144, 188   381, 821   0.377632   108, 474   40, 963   64. 00   65. 00   06500   RESPIRATORY THERAPY   320, 893   21, 676, 462   0.014804   5, 659, 869   83, 789   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 350, 945   47, 530, 569   0.028423   2, 738, 264   77, 830   66. 00   06. 00   06000   ELECTROCARDI OLOGY   510, 133   31, 724, 057   0.016080   4, 107, 959   66, 056   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   450, 063   11, 887, 122   0.037861   1, 805, 796   68, 369   71. 00   72. 00   17020   IMPL. DEV. CHARGED TO PATI ENTS   174, 356   68, 942, 017   0.002529   7, 719, 554   19, 523   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 022, 885   257, 611, 764   0.003971   28, 128, 573   111, 699   73. 00   75. 01   03956   RENAL DI ALYSI S (IP)   19, 355   1, 462, 369   0.013235   573, 392   7, 589   75. 01   76. 00   03950   OP PSY/CDU   700, 913   4, 877, 382   0.143707   420   60   76. 01   76. 02   76. 03   76.							
65. 00 06500 RESPIRATORY THERAPY 320, 893 21, 676, 462 0. 014804 5, 659, 869 83, 789 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 3350, 945 47, 530, 599 0. 028423 2, 738, 264 77, 830 66. 00 690 00 DECTROCARDIOLOGY 510, 133 31, 724, 057 0. 016080 4, 107, 959 66. 056 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 450, 063 11, 887, 122 0. 037861 1, 805, 796 68, 369 71. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 174, 356 68, 942, 017 0. 002529 7, 719, 554 19, 523 72. 00 7300 DRUGS CHARGED TO PATI ENTS 174, 356 68, 942, 017 0. 002529 7, 719, 554 19, 523 72. 00 7300 DRUGS CHARGED TO PATI ENTS 174, 356 68, 942, 017 0. 003951 28, 128, 573 111, 699 73. 00 7300 DRUGS CHARGED TO PATI ENTS 174, 356 68, 942, 017 0. 003951 28, 128, 573 111, 699 73. 00 7300 DRUGS CHARGED TO PATI ENTS 174, 356 68, 942, 017 0. 003951 28, 128, 573 392 75. 00 75. 00 03956 CARDI AC REHAB 171, 735 1, 992, 166 0. 0086205 82, 079 7. 076 76. 00 03956 CARDI AC REHAB 171, 735 1, 992, 166 0. 086205 82, 079 7. 076 76. 00 76. 01 03950 0P PSY/CDU 700, 913 4, 877, 382 0. 143707 420 60 76. 01 76. 02 76. 03 03951 GENETIC/OAK PLAZA CLINICS 0 0 0. 0. 000000 0 0 0 76. 02 76. 02 76. 03 03951 GENETIC/OAK PLAZA CLINICS 0 0 0. 0. 000000 0 0 0 76. 04 76. 05 76. 04 03952 PAIN CLINIC 0. 0. 000000 0 0 0 0 0. 000000 0 0 0 76. 04 76. 05 76. 04 03952 PAIN CLINIC 0. 000000 0 0 0 0. 000000 0 0 0 0 000000		_	_			_	
66. 00   06600   PHYSI CAL THERAPY   1, 350, 945   47, 530, 599   0. 028423   2, 738, 264   77, 830   66. 00   69. 00   06900   ELECTROCARDI OLOGY   510, 133   31, 724, 057   0. 016080   4, 107, 959   66, 056   69. 00   71. 00   PHYSI CAL SUPPLIES CHARGED TO PATIENT   450, 063   11, 887, 122   0. 037861   1, 805, 796   68, 369   71. 00   71. 00   71. 00   71. 00   PHYSI CAL SUPPLIES CHARGED TO PATIENT   174, 356   68, 942, 017   0. 002529   7, 719, 554   19, 523   72. 00   73. 00   73. 00   70. 00   PRUGS CHARGED TO PATIENTS   1, 022, 885   257, 611, 764   0. 003971   28, 128, 573   111, 699   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 0						-	
69. 00   06900   ELECTROCARDI OLOGY   510, 133   31, 724, 057   0. 016080   4, 107, 959   66, 056   69. 00   71. 00   7100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   450, 063   11, 887, 122   0. 037861   1, 805, 796   68, 369   71. 00   72. 00   7						-	
71. 00						-	
72. 00		•				-	
73. 00						-	
75. 01 03955 RENAL DI ALYSIS (I P) 19, 355 1, 462, 369 0.013235 573, 392 7, 589 75. 01 76. 00 03956 CARDI AC REHAB 171, 735 1, 992, 166 0.086205 82, 079 7, 076 76. 00 76. 01 03950 OP PSY/CDU 700, 913 4, 877, 382 0.143707 420 60 76. 01 76. 02 03957 RI MMS 259, 721 2, 676, 911 0.097023 0 0 0 76. 02 76. 03 03951 GENETI C/OAK PLAZA CLINICS 0 0 0.000000 0 0 0 76. 03 76. 04 03952 PAIN CLINIC 0 0 0.000000 0 0 0 76. 03 76. 05 03953 DI ABETES 56, 800 2, 661, 003 0.021345 1, 931 41 76. 05 76. 98 07698 HYPERBARIC OXYGEN THERAPY 120, 044 4, 828, 679 0.024861 533, 106 13, 254 76. 98  88. 00 08800 RURAL HEALTH CLINIC 325, 521 387, 825 0.839350 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0 0 0 89. 00 91. 00 09100 EMERGENCY 914, 629 61, 008, 971 0.014992 6, 613, 662 99, 152 91. 00 92. 01 09202 OBSERVATI ON BEDS (NON-DISTINCT PART) 283, 722 15, 270, 207 0.018580 1, 936, 385 35, 978 92. 00 93. 00 04951 INFUSION 62, 747 32, 882, 122 0.001908 3, 271 6 93. 00 0THER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES				•		-	
76. 00 03956 CARDI AC REHAB 171, 735 1, 992, 166 0. 086205 82, 079 7, 076 76. 00 76. 01 03950 0P PSY/CDU 700, 913 4, 877, 382 0. 143707 420 60 76. 01 76. 02 03957 RI MMS 259, 721 2, 676, 911 0. 097023 0 0 76. 02 76. 03 03951 GENETI C/OAK PLAZA CLINI CS 0 0 0. 000000 0 0 0 76. 02 76. 04 03952 PAI N CLINI C 0 0 0. 000000 0 0 0 76. 03 03953 DI ABETES 56, 800 2, 661, 003 0. 021345 1, 931 41 76. 05 76. 98 07698 HYPERBARI C OXYGEN THERAPY 120, 044 4, 828, 679 0. 024861 533, 106 13, 254 76. 98 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0. 000000 0 0 0 0 89. 00 91. 00 09100 EMERGENCY 914, 629 61, 008, 971 0. 014992 6, 613, 662 99, 152 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 283, 722 15, 270, 207 0. 018580 1, 936, 385 35, 978 92. 00 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0				•		-	
76. 01 03950 OP PSY/CDU 700, 913 4, 877, 382 0. 143707 420 60 76. 01 76. 02 03957 RIMMS 259, 721 2, 676, 911 0. 097023 0 0 0 76. 02 76. 03 03951 GENETIC/OAK PLAZA CLINICS 0 0 0. 000000 0 0 0 76. 03 76. 04 03952 PAIN CLINIC 0 0 0.000000 0 0 0 0 76. 04 76. 05 03953 DIABETES 5 56, 800 2, 661, 003 0. 021345 1, 931 41 76. 05 76. 98 07698 HYPERBARIC OXYGEN THERAPY 120, 044 4, 828, 679 0. 024861 533, 106 13, 254 76. 98 000 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0. 0. 000000 0 0 0 89. 00 99. 00 09100 EMERGENCY 914, 629 61, 008, 971 0. 014992 6, 613, 662 99, 152 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0. 000000 0 0 0 92. 01 09202 0BSERVATI ON BEDS (DISTINCT PART) 0 0. 000000 0 0 0 93. 01 04951 INFUSION 62, 747 32, 882, 122 0. 001908 3, 271 6 93. 00 09300 O9500 AMBULANCE SERVICES 95. 00						-	
76. 02							
76. 03							
76. 04   03952   PAI N CLINI C   0   0   0   0   0   0   0   0   76. 04   76. 05   03953   DIABETES   56, 800   2, 661, 003   0   0   0   0   1, 931   41   76. 05   76. 98   07698   HYPERBARI C OXYGEN THERAPY   120, 044   4, 828, 679   0   0   0   0   00TPATI ENT SERVI CE COST CENTERS							
76. 05		_	_			_	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY 120, 044 4, 828, 679 0. 024861 533, 106 13, 254 76. 98 OUTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C 325, 521 387, 825 0. 839350 0 0 89. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 0000000 0 0 89. 00 91. 00 09100 EMERGENCY 914, 629 61, 008, 971 0. 014992 6, 613, 662 99, 152 91. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 283, 722 15, 270, 207 0. 018580 1, 936, 385 35, 978 92. 00 92. 01 09202 08SERVATI ON BEDS (DI STI NCT PART) 0 0 0. 0000000 0 0 0 92.01 093. 01 04951 INFUSI ON 62, 747 32, 882, 122 0. 001908 3, 271 6 93. 00 04951 INFUSI ON 0 0 0. 001908 3, 271 6 93. 00 04951 INFUSI ON 0 0 0. 001908 3, 271 6 93. 00 07500 O7500 O		_	_			_	
SECTION   SERVICE COST CENTERS   SECTION   SERVICE COST CENTERS   SECTION							
88. 00   08800   RURAL HEALTH CLINIC   325, 521   387, 825   0. 839350   0   0   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0. 0000000   0   0   89. 00   91. 00   09100   EMERGENCY   914, 629   61, 008, 971   0. 014992   6, 613, 662   99, 152   91. 00   92. 00   09200   08SERVATI ON BEDS (NON-DI STINCT PART   283, 722   15, 270, 207   0. 018580   1, 936, 385   35, 978   92. 00   92. 01   09202   08SERVATI ON BEDS (DI STINCT PART)   0   0. 0000000   0   0. 0000000   0		120, 044	4, 828, 679	0. 02486	1 533, 106	13, 254	76. 98
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0000000   0   0					_		
91. 00   09100   EMERGENCY   914, 629   61, 008, 971   0. 014992   6, 613, 662   99, 152   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   283, 722   15, 270, 207   0. 018580   1, 936, 385   35, 978   92. 00   92. 01   09202   0BSERVATI ON BEDS (DISTINCT PART)   0   0   0. 000000   0   0   92. 01   93. 00   04951   NFUSI ON   62, 747   32, 882, 122   0. 001908   3, 271   6   93. 00   04950   COMMUNI TY HEALTH CENTERS   1, 025, 004   9, 389, 087   0. 109170   0   0   0   0. 000000   0   0   0		•	· ·				
92. 00   09200   08SERVATI ON BEDS (NON-DISTINCT PART   283, 722   15, 270, 207   0.018580   1, 936, 385   35, 978   92. 00   92. 01   09202   08SERVATI ON BEDS (DISTINCT PART)   0   0   0.000000   0   0   92. 01   93. 00   04951   INFUSI ON   62, 747   32, 882, 122   0.001908   3, 271   6   93. 00   93. 01   04950   COMMUNITY HEALTH CENTERS   1, 025, 004   9, 389, 087   0.109170   0   0   93. 01   07HER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   95. 00   9500   AMBULANCE SERVICES   95. 00   0.0018580   1, 936, 385   35, 978   92. 00   92. 01   92. 01   92. 01   92. 01   93. 0		1	_				
92. 01   09202   0BSERVATI ON BEDS (DISTINCT PART)   0   0   0   0000000   0   0   92. 01   93. 00   04951   INFUSI ON   62,747   32,882,122   0.001908   3,271   6   93. 00   93. 01   04950   COMMUNITY HEALTH CENTERS   1,025,004   9,389,087   0.109170   0   0   93. 01   95. 00   09500   AMBULANCE SERVICES   95. 00				•		· ·	
93. 00   04951   INFUSION   62,747   32,882,122   0.001908   3,271   6   93. 00   04950   COMMUNITY HEALTH CENTERS   1,025,004   9,389,087   0.109170   0   0   93. 01   07HER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   95. 00	· ·						
93. 01   04950   COMMUNI TY   HEALTH   CENTERS   1, 025, 004   9, 389, 087   0. 109170   0   0   93. 01		1	_			_	
OTHER REIMBURSABLE COST CENTERS         95.00           95.00   09500   AMBULANCE SERVICES         95.00							
OTHER REIMBURSABLE COST CENTERS         95.00           95.00   09500   AMBULANCE SERVICES         95.00	93. 01 04950 COMMUNITY HEALTH CENTERS	1, 025, 004	9, 389, 087	0. 10917	0 0	0	93. 01
	OTHER REIMBURSABLE COST CENTERS						
200, 00 Total (Lines 50 through 199) 17, 573, 319 1, 257, 978, 097 132, 517, 578 1, 656, 390 200, 00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)	17, 573, 319	1, 257, 978, 097		132, 517, 578	1, 656, 390	200. 00

Health Financial Systems	RIVERSIDE MED	DICAL CENTER		In lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P		TS Provider C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/26/2022 10:	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS				283, 354	0	30.00
31. 00   03000   ADULTS & PEDITATRICS 31. 00   03100   INTENSIVE CARE UNIT 32. 00   03200   CORONARY CARE UNIT	0	1		283, 354 123, 350 0	Ĭ	31.00
40. 00   04000   SUBPROVI DER -   I PF 41. 00   04100   SUBPROVI DER -   I RF	0	C		0 0	0	41. 00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	0			0 0	0	43. 00
200.00 Total (lines 30 through 199)  Cost Center Description	Swi ng-Bed	Total Costs	Total Dationt	406,704 Per Diem (col.	Inpati ent	200. 00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,		0 1 0011 0)	l og. a bajo	
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00   03000   ADULTS & PEDI ATRI CS	0					
31. 00 03100 I NTENSI VE CARE UNIT		123, 350				1
32. 00 03200 CORONARY CARE UNIT			0	0.00		02.00
40. 00   04000   SUBPROVI DER -   1 PF 41. 00   04100   SUBPROVI DER -   1 RF			3, 118 8, 505			1
41.00   04100   SUBPROVI DER - 1 RF 42.00   04200   SUBPROVI DER			8, 505			1
43. 00   04300   NURSERY		1	1			
200.00 Total (lines 30 through 199)		406, 704				200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x		, 3., 700	-1	2.,700	

9.00

126, 574

30. 00 31. 00

32.00

40. 00 41. 00

42.00

43.00

200.00

30. 00 03000 ADULTS & PEDIATRICS
31. 00 03100 INTENSIVE CARE UNIT

Total (lines 30 through 199)

32.00 03200 CORONARY CARE UNIT

40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF

42. 00 | 04200 | SUBPROVI DER

43. 00 | 04300 | NURSERY

200.00

THROUGH COSTS

					10	12/31/2021	5/26/2022 10:	
			Title	: XVIII		Hospi tal	PPS	or am
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Δ		Allied Health	
	<b>'</b>	Anestheti st	Program	Program		Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
			Adjustments					
		1. 00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000  OPERATI NG ROOM	0	0	)	0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	)	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	0	0	54. 01
54. 02	05404 ULTRASOUND	0	0		0	0	0	54. 02
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
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
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)	0	0	0	62. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	)	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	)	0	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	)	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73. 00
75. 01	03955 RENAL DIALYSIS (IP)	0	0		0	0	0	75. 01
76. 00	03956 CARDI AC REHAB	0	0		0	0	0	76. 00
76. 01	03950 OP PSY/CDU	0	0		0	0	0	76. 01
76. 02	03957 RI MMS	0	0	)	0	0	0	76. 02
76. 03	03951 GENETIC/OAK PLAZA CLINICS	0	0	)	0	0	0	76. 03
76. 04	03952 PAIN CLINIC	0	0		0	0	0	76. 04
76. 05	03953 DI ABETES	0	0	1	0	0	0	76. 05
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS			,				
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89. 00
91. 00	09100 EMERGENCY	0	0		0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		16, 674	92. 00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0	0	1	0	0	0	92. 01
93. 00	04951   I NFUSI ON	0	0		0	0	0	93. 00
93. 01	04950 COMMUNITY HEALTH CENTERS	0	0		0	0	0	93. 01
	OTHER REIMBURSABLE COST CENTERS			1				
95. 00	09500 AMBULANCE SERVICES							95. 00
200.00	Total (lines 50 through 199)	0	0	1	0	0	16, 674	200. 00

Health Financial Systems	RIVERSIDE MEDI	CAL CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL THROUGH COSTS	ARY SERVICE OTHER PASS	Provi der Co	CN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prep 5/26/2022 10:3	
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	

THROUGH COSTS				To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared:
		Title	xVIII	Hospi tal	PPS	07 dili
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00			7.00	instructions)	
ANOLLI ADV. CEDVI CE, COCT, CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0	I	0 126, 970, 992	0.000000	FO 00
50.00   05000   OPERATING ROOM 51.00   05100   RECOVERY ROOM	0	0	1	0 126, 970, 992 0 15, 322, 267	0. 000000 0. 000000	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0		0 961, 984	0.000000	
53. 00   05300   ANESTHESI OLOGY	0	0		0 901, 904	0.000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0 92, 729, 174	0.000000	
54. 01   05401   NUCLEAR   MEDICINE-DI AGNOSTI C	0	0		0 8, 740, 392	0.000000	
54. 02   05404   ULTRASOUND	0	0	1	0 18, 298, 488		
55. 00 05500 RADI OLOGY-THERAPEUTI C		0		0 46, 070, 691	0.000000	
57. 00 05700 CT SCAN	0	0		94, 768, 810	0. 000000	
58. 00 05800 MRI	0	0	•	0 25, 544, 055	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	Ö	0		0 75, 119, 624	0. 000000	
60. 00   06000   LABORATORY	0	0		0 176, 261, 056		
60. 01   06001   BLOOD   LABORATORY	0	0		0 0	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	,	o o	0. 000000	
64.00 06400 INTRAVENOUS THERAPY	0	0	)	381, 821	0.000000	
65. 00 06500 RESPIRATORY THERAPY	O	0	,	0 21, 676, 462	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 47, 530, 599	0.000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	)	0 31, 724, 057	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0 11, 887, 122	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 68, 942, 017	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 257, 611, 764	0. 000000	
75.01 03955 RENAL DIALYSIS (IP)	0	0	)	0 1, 462, 369	0.000000	
76. 00   03956   CARDI AC REHAB	0	0	)	0 1, 992, 166		
76. 01  03950  OP PSY/CDU	0	0		0 4, 877, 382	0. 000000	1
76. 02   03957   RI MMS	0	0		0 2, 676, 911	0. 000000	
76.03 03951 GENETIC/OAK PLAZA CLINICS	0	0		0	0. 000000	
76. 04   03952   PAIN CLINIC	0	0		0 0	0. 000000	76. 04
76. 05 03953 DI ABETES	0	0		0 2, 661, 003	0.000000	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0		0 4, 828, 679	0.000000	76. 98
OUTPATIENT SERVICE COST CENTERS  88. 00   08800   RURAL   HEALTH   CLINIC	0	0	ı	0 387, 825	0.000000	00 00
	1	0			0.000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 91.00 09100 EMERGENCY	0	0		0 (1 000 071	0. 000000 0. 000000	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0	17 774	1	0 61, 008, 971 4 15, 270, 207	0. 001092	91.00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		16, 674		0 15, 270, 207	0.001092	
93. 00   04951   NFUSION		0	•	0 32, 882, 122		
93. 00   04951 TNF05TON 93. 01   04950  COMMUNITY HEALTH CENTERS	0	0	•	0 32, 662, 122	0.000000	
OTHER REIMBURSABLE COST CENTERS	ı o	0		0 7, 307, 007	0.000000	13.01
95. 00 09500 AMBULANCE SERVI CES			1			95. 00
200.00 Total (lines 50 through 199)	0	16, 674	16. 67	4 1, 257, 978, 097		200.00
	١		. 3, 0,		1	

Health Financial Systems		RI VERSI DE MEDI	CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERTHROUGH COSTS		SERVI CE OTHER PASS	Provider Co	CN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 10:	
			Title	xVIII	Hospi tal	PPS	
Cost Center Des	scription	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	

			10	12/31/2021	5/26/2022 10:	
-		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	,	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATI NG ROOM	0. 000000	16, 947, 456	0	23, 893, 974	0	50.00
51.00   05100   RECOVERY ROOM	0. 000000	1, 513, 552	0	3, 174, 358	0	51.00
52.00  05200 DELIVERY ROOM & LABOR ROOM	0. 000000	5, 616	0	650	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	3, 091, 523	0	26, 790, 603	0	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	635, 751	0	3, 431, 029	0	54. 01
54. 02   05404   ULTRASOUND	0. 000000	1, 842, 860	0	3, 034, 370	0	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	192, 120	0	11, 292, 453	0	55. 00
57. 00  05700 CT SCAN	0. 000000	14, 522, 504	0	16, 080, 001	0	57. 00
58. 00   05800   MRI	0. 000000	2, 736, 507	0	5, 636, 012	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000	13, 235, 375	0	34, 543, 102	0	59. 00
60. 00   06000   LABORATORY	0. 000000	17, 781, 579	0	11, 170, 736	0	60.00
60. 01   06001   BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	0	o	0	62. 00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	108, 474	0	21, 942	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	5, 659, 869	0	1, 939, 001	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 738, 264	0	59, 824	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	4, 107, 959	0	8, 222, 166	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 805, 796	0	3, 599, 452	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	7, 719, 554	0	8, 449, 119	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	28, 128, 573	0	95, 930, 898	0	73. 00
75. 01   03955   RENAL DIALYSIS (IP)	0. 000000	573, 392	0	29, 167	0	75. 01
76. 00   03956   CARDI AC REHAB	0. 000000	82, 079	0	706, 834	0	76. 00
76. 01  03950  OP PSY/CDU	0. 000000	420	0	o	0	76. 01
76. 02   03957   RI MMS	0. 000000	0	0	22, 038	0	76. 02
76.03 03951 GENETIC/OAK PLAZA CLINICS	0. 000000	0	0	o	0	76. 03
76. 04   03952   PALN CLINIC	0. 000000	0	0	o	0	76. 04
76. 05   03953   DI ABETES	0. 000000	1, 931	0	27, 421	0	76. 05
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	533, 106	0	1, 536, 342	0	76. 98
OUTPATIENT SERVICE COST CENTERS						]
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
91. 00   09100   EMERGENCY	0. 000000	6, 613, 662	0	8, 124, 400	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 001092	1, 936, 385	2, 115	3, 182, 873	3, 476	92.00
92.01 09202 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	0	o	0	92. 01
93. 00   04951   I NFUSI ON	0. 000000	3, 271	0	771, 333	0	93.00
93. 01   04950   COMMUNITY HEALTH CENTERS	0. 000000	0	0	o	0	93. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)		132, 517, 578	2, 115	271, 670, 098	3, 476	200. 00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Peri od:	Worksheet D	
					From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	pared.
						5/26/2022 10:	37 am
	·		Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not Subject To		
		Part I, col. 9		Subject To Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 182031	23, 893, 974		0 0	4, 349, 444	50. 00
51.00	05100 RECOVERY ROOM	0. 494626	3, 174, 358		0 0	1, 570, 120	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3. 654484	650		0	2, 375	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 146959	26, 790, 603		0	3, 937, 120	54. 00
54. 01	05401   NUCLEAR MEDICINE-DIAGNOSTIC	0. 112592	3, 431, 029		0	386, 306	54. 01
54. 02	05404 ULTRASOUND	0. 124461	3, 034, 370		0		54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 120592	11, 292, 453		0	1, 361, 779	55. 00
57. 00	05700 CT SCAN	0. 037716	16, 080, 001	1	0		57. 00
58. 00	05800 MRI	0. 052460	5, 636, 012		0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 180675	34, 543, 102		0	6, 241, 075	59. 00
60.00	06000 LABORATORY	0. 102130	11, 170, 736	1		.,	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0		0	1	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	21 042	1	0	0	62. 00
64.00	06400 I NTRAVENOUS THERAPY	9. 676849	21, 942	•	0		64. 00
65.00	06500 RESPI RATORY THERAPY	0. 207635	1, 939, 001		0 0	402, 604	65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0. 250575 0. 129213	59, 824	1	0 0		66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 129213	8, 222, 166 3, 599, 452			1, 062, 411 1, 024, 872	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210653	8, 449, 119	•	0 0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 160258	95, 930, 898		-	., ,	73. 00
75. 00	03955 RENAL DIALYSIS (IP)	0. 775483	29, 167		0 7, 020	22, 619	75. 00
76. 00	03956 CARDI AC REHAB	0. 566518	706, 834		o o	1	76. 00
76. 01	03950 OP PSY/CDU	0. 542465	700,001	1	0 0		76. 01
76. 02	03957 RI MMS	0. 669225	22, 038		o o	14, 748	
76. 03	03951 GENETIC/OAK PLAZA CLINICS	0. 000000	0		o o		76. 03
76. 04	03952 PAIN CLINIC	0. 000000	0		0 0	0	76. 04
76. 05	03953 DI ABETES	0. 790963	27, 421		0 0	21, 689	76. 05
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 306261	1, 536, 342		0 0	470, 522	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
91. 00	09100 EMERGENCY	0. 182982	8, 124, 400		0 0	1, 486, 619	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 139451	3, 182, 873		0	443, 855	92. 00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0	0	92. 01
93. 00	04951   I NFUSI ON	0. 044554	771, 333		0		
93. 01	04950 COMMUNITY HEALTH CENTERS	0. 149613	0		0 0	0	93. 01
	OTHER REIMBURSABLE COST CENTERS			1	_		
95. 00	09500 AMBULANCE SERVICES	0. 869829	274 /70 222		0 (20	42 024 440	95. 00
200.00	1 1		271, 670, 098	2, 50	. 1	43, 034, 469	
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0		201. 00
202.00			271, 670, 098	2, 50	7 9, 628	43, 034, 469	202 00
202.00	1 ondriges (11116 200 11116 201)	1	2,1,070,070	2, 30	., 520	10,004,407	1-02.00

Provider CCN: 14-0186 Peri od: Worksheet D From 01/01/2021 Part V To 12/31/2021 Date/Ti me Prepared: 5/26/2022 10:37 am

					12,01,2021	5/26/2022 10:	
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
	·	Reimbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50. 00
51. 00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53.00	05300 ANESTHESI OLOGY	0	0				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0				54. 01
54. 02	05404 ULTRASOUND	0	0				54. 02
55.00	05500   RADI OLOGY-THERAPEUTI C	0	0				55. 00
57.00	05700 CT SCAN	0	0				57. 00
58.00	05800 MRI	0	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	184	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
64.00	06400 I NTRAVENOUS THERAPY	o	0				64. 00
65.00	06500 RESPI RATORY THERAPY	o	0				65. 00
66.00	06600 PHYSI CAL THERAPY	o	0				66. 00
69.00	06900 ELECTROCARDI OLOGY	o	0				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	113	1, 543				73. 00
75. 01	03955 RENAL DIALYSIS (IP)	o	0				75. 01
76.00	03956 CARDI AC REHAB	o	0				76. 00
76. 01	03950 OP PSY/CDU	o	0				76. 01
76. 02	03957 RI MMS	o	0				76. 02
76. 03	03951 GENETIC/OAK PLAZA CLINICS	o	0				76. 03
76. 04	03952 PAIN CLINIC	o	0				76. 04
76. 05	03953 DI ABETES	o	0				76. 05
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	0				76. 98
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>		<u>'</u>			
88.00	08800 RURAL HEALTH CLINIC						88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
91.00	09100 EMERGENCY	o	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0				92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	o	0				92. 01
93.00	04951 I NFUSI ON	ol	0				93.00
93. 01	04950 COMMUNITY HEALTH CENTERS	o	0				93. 01
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>		<u>'</u>			
95.00	09500 AMBULANCE SERVICES	0					95. 00
200.00		297	1, 543				200. 00
201.00	1 1	o					201.00
	Only Charges						
202.00		297	1, 543				202. 00
		•					•

Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	RIVERSIDE MED COSTS	Provider C		Peri od:	u of Form CMS-2 Worksheet D	2552-10
				From 01/01/2021	Part II	
		Component	CCN: 14-S186	To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 37 am
		Title	: XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	3, 477, 351	126, 970, 992	0. 02738	7 0	0	50.00
51. 00   05100   RECOVERY ROOM	756, 799		0. 02738		2, 198	
52. 00   05200   DELI VERY   ROOM & LABOR   ROOM	401, 495		0. 41736		2, 190	1
53. 00   05300   ANESTHESI OLOGY	401, 473	701, 704	0. 00000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 458, 927	92, 729, 174	0. 01573		296	
54. 01   05401   NUCLEAR MEDICINE-DIAGNOSTIC	71, 952		0. 00823		0	1
54. 02   05404   ULTRASOUND	242, 574		0. 01325		147	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	299, 513		0. 00650		0	
57. 00   05700   CT   SCAN	531, 320		0. 00560		606	1
58. 00   05800 MRI	185, 514		0.00726		251	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	1, 029, 609		0. 01370		0	59.00
60. 00 06000 LABORATORY	1, 204, 611	176, 261, 056	0. 00683		3, 283	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0.00000	o	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000	0 0	0	62. 00
64. 00 06400 I NTRAVENOUS THERAPY	144, 188		0. 37763		0	
65. 00 06500 RESPI RATORY THERAPY	320, 893		0. 01480		301	1
66. 00   06600   PHYSI CAL THERAPY	1, 350, 945		0. 02842		2, 212	1
69. 00 06900 ELECTROCARDI OLOGY	510, 133		0. 01608		784	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	450, 063		0. 03786		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	174, 356		0. 00252		0	1 / 2 . 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 022, 885		0.00397	· ·	972	1
75. 01 03955 RENAL DIALYSIS (IP)	19, 355		0. 01323		0	
76. 00   03956   CARDI AC   REHAB 76. 01   03950   OP   PSY/CDU	171, 735		0.08620		0	
76. 01   03950   OP PSY/CDU 76. 02   03957   RI MMS	700, 913 259, 721	4, 877, 382 2, 676, 911	0. 14370 0. 09702		618 0	1
76. 03   03951   GENETI C/OAK PLAZA CLINICS	239, 721	2,676,911	0.00000		0	1
76. 04   03952   PAIN CLINIC	0	0	0. 00000		0	1
76. 05   03953 DI ABETES	56, 800	2, 661, 003	0. 02134		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	120, 044	4, 828, 679	0. 02134		714	
OUTPATIENT SERVICE COST CENTERS	1207011	170207077	0.02.00	., 20,,02	,	70.70
88. 00 08800 RURAL HEALTH CLINIC	325, 521	387, 825	0. 83935	ol o	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
91. 00   09100   EMERGENCY	914, 629	61, 008, 971	0. 01499.		1, 843	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	15, 270, 207	0. 00000		0	92.00
92. 01   09202   OBSERVATI ON BEDS (DISTINCT PART)	0	0	0.00000		0	92. 01
93. 00   04951   I NFUSI ON	62, 747		0. 00190		0	
93. 01 04950 COMMUNITY HEALTH CENTERS	1, 025, 004	9, 389, 087	0. 10917	0 0	0	93. 01
OTHER REIMBURSABLE COST CENTERS		Ī				1
	47 000 5	1, 257, 978, 097		1, 245, 261	14, 225	95. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RIVERSIDE MED RVICE OTHER PAS:	S Provider Component	CCN: 14-S186	То	d: 01/01/2021 12/31/2021	Date/Time Pre 5/26/2022 10:	pared:
		Title	XVIII	Subp	rovider - IPF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post	-Stepdown ustments	Allied Health	
ANOULL ADV. CEDVLOE, COCT. CENTERS	1.00	2A	2. 00		3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1 0	0		0	0	Ο	50.00
51.00   05100   RECOVERY ROOM 52.00   05200   DELI VERY ROOM & LABOR ROOM 53.00   05300   ANESTHESI OLOGY	0 0	0 0		0 0 0	0	0 0	51. 00 52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C 54. 02   05404   ULTRASOUND	0 0	1		0 0 0	0 0 0	ő	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN 58. 00   05800   MRI	000000000000000000000000000000000000000	O		0 0 0	0 0 0	0	57. 00 58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   060. 00   06000   LABORATORY   060. 01   06001   BLOOD   LABORATORY   62. 00   06200   WHOLE   BLOOD & PACKED   RED   BLOOD   CELL	0 0 0	0		0 0 0	0 0 0 0	0	60. 00 60. 01
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   64. 00   06400   INTRAVENOUS THERAPY   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSICAL THERAPY	0	0		0	0	0	64. 00 65. 00
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	0	69. 00 71. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 75. 01   03955   RENAL DIALYSIS (IP) 76. 00   03956   CARDIAC REHAB	0 0 0			0 0 0	0 0 0	0	75. 01
76. 01   03950   OP PSY/CDU 76. 02   03957   RI MMS 76. 03   03951   GENETI C/OAK PLAZA CLINICS	0 0	0		0 0 0	0 0 0	0	76. 02 76. 03
76. 04   03952   PAIN CLINIC 76. 05   03953   DIABETES 76. 98   07698   HYPERBARI C   0XYGEN   THERAPY	0 0	O		0 0 0	0 0 0	0	76. 05
OUTPATIENT SERVICE COST CENTERS  88. 00   O8800   RURAL HEALTH CLINIC	1 0	0		0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 91.00 09100 EMERGENCY	0	0		0	0	0	89. 00 91. 00
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART 92. 01   09202   0BSERVATION BEDS (DISTINCT PART) 93. 00   04951   INFUSION	0			0 0	0		92. 01 93. 00
93. 01   04950   COMMUNI TY HEALTH CENTERS   OTHER REI MBURSABLE COST CENTERS	0	0		0	0	0	93. 01
95. 00 09500 AMBULANCE SERVICES			1				95. 00

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	RIVERSIDE MED ERVICE OTHER PASS		CN: 14-0186	Peri od:	worksheet D Part IV	2002 10
THROUG	COSTS		Component	CCN: 14-S186	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 37 am
			Title	XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medical Education Cost	(sum of cols. 1, 2, 3, and	Outpatient Cost (sum of	(from Wkst. C, Part I, col.	to Charges (col. 5 ÷ col.	
		Luucati oii cost	1, 2, 3, and 4)	col s. 2, 3,	8)	7)	
			.,	and 4)		(see	
				,		instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0			0 126, 970, 992	0.000000	
51. 00	05100 RECOVERY ROOM	0			0 15, 322, 267	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 961, 984	0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0 92, 729, 174	0.000000	
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 8, 740, 392	0.000000	
54. 02	05404 ULTRASOUND	0	0		0 18, 298, 488 0 46, 070, 691	0.000000	
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		10,0,0,0,	0.000000	
58.00	05700 CT SCAN	0	0		0 94, 768, 810 0 25, 544, 055	0. 000000 0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 75, 119, 624	0.00000	
60.00	06000 LABORATORY		0		0 176, 261, 056	0.000000	1
60. 01	06001 BLOOD LABORATORY		0		0 170, 201, 030	0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	l o		0 381, 821	0. 000000	1
65. 00	06500 RESPIRATORY THERAPY	0	0		0 21, 676, 462	0.000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 47, 530, 599	0.000000	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 31, 724, 057	0.000000	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 11, 887, 122	0.000000	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 68, 942, 017	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 257, 611, 764		
75. 01	03955 RENAL DIALYSIS (IP)	0	0		0 1, 462, 369	0.000000	1
76. 00	03956 CARDI AC REHAB	0	0		0 1, 992, 166	0.000000	
76. 01	03950 OP PSY/CDU	0	0		0 4, 877, 382	0. 000000	
76. 02	03957 RI MMS	0	0		0 2, 676, 911	0.000000	1
76. 03 76. 04	03951 GENETIC/OAK PLAZA CLINICS	0	0		0 0	0.000000	
76. 04 76. 05	03952 PAIN CLINIC 03953 DIABETES	0	0		0 0 2, 661, 003	0. 000000 0. 000000	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY				0 4, 828, 679	0.00000	
70. 70	OUTPATIENT SERVICE COST CENTERS		0		4, 020, 077	0.000000	70. 70
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 387, 825	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0.000000	
91. 00	09100 EMERGENCY	0	Ō		0 61, 008, 971	0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 15, 270, 207	0. 000000	92.00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0. 000000	92. 01
93. 00	04951   I NFUSI ON	0	-		0 32, 882, 122	0. 000000	
93. 01	04950 COMMUNITY HEALTH CENTERS	0	0		0 9, 389, 087	0.000000	93. 01
	OTHER REIMBURSABLE COST CENTERS						1
95. 00 200. 00	09500 AMBULANCE SERVICES	_	_				95. 00 200. 00
	Total (lines 50 through 199)	0	0		0 1, 257, 978, 097	i	

Health Financial Systems  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RIVERSIDE MEDIO	CAL CENTER Provider Co	^N: 14_0104	Period:	eu of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	KVICE UINEK PASS	Provider Co	CN. 14-0100	From 01/01/2021	Part IV	
THROUGH COSTS		Component	CCN: 14-S186	To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 37 am
		Title	· XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col . 10)	10.00	x col . 12)	
ANOLILIADY CERVILOE COCT OFNITERO	9. 00	10. 00	11. 00	12.00	13. 00	
ANCI LLARY SERVI CE COST CENTERS	0.000000		1	0 0		F0 00
50. 00   05000   OPERATING ROOM	0. 000000	0			_	
51. 00   05100   RECOVERY ROOM	0. 000000	44, 492		0 0		•
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 000000	0		0 0	1	0 - 1 - 0 - 0
53. 00   05300   ANESTHESI OLOGY	0. 000000	10.020		0	0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0.000000	18, 828	1			•
54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C 54. 02   05404   ULTRASOUND	0. 000000 0. 000000	11 055	1	0 0	0	
	1	11, 055		0 0		
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN	0. 000000 0. 000000	108, 091		-	0	1
58. 00   05800   MRI	0. 000000			0 8, 187	0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	34, 565 0				
60. 00   06000 LABORATORY	0. 000000	480, 452			0	
60. 01   06001   BL00D   LABORATORY	0. 000000	460, 452	1		0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	1	0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	20, 364			0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	77, 836	l .		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	48, 734		0 1, 516	-	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	l o	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	l o	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	244, 849		0 2, 100	l o	
75. 01 03955 RENAL DIALYSIS (IP)	0. 000000	0	1	0 0	0	
76. 00   03956   CARDI AC   REHAB	0. 000000	0		0 0		
76. 01 03950 OP PSY/CDU	0. 000000	4, 300		0 0	0	76. 01
76. 02 03957 RI MMS	0. 000000	0		0 0	0	76. 02
76. 03 03951 GENETIC/OAK PLAZA CLINICS	0. 000000	0		0 0	0	76. 03
76. 04 03952 PAIN CLINIC	0. 000000	0		0 0	0	76. 04
76. 05 03953 DI ABETES	0. 000000	0		0 0	0	76. 05
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	28, 732		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	_	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	1	0		
91. 00   09100   EMERGENCY	0. 000000	122, 963	1	0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	
92. 01 09202 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	l .	0	0	1
93. 00   04951   I NFUSI ON	0. 000000	0		0	0	
93. 01 04950 COMMUNITY HEALTH CENTERS	0. 000000	0		0 0	0	93. 01
OTHER REIMBURSABLE COST CENTERS						
						0 - 0 -
95. 00   09500   AMBULANCE SERVICES   200. 00   Total (Lines 50 through 199)		1, 245, 261		0 13, 413		95. 00 200. 00

							37 4111
			litle	xVIII	Subprovi der -	PPS	
				Ch =	IPF	C+-	
	0 1 0 1 5 11	0 1 1 01	DDC D ! I	Charges	0 1	Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		1. 00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	0. 182031	0		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 494626					
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3. 654484				0	1
53. 00	05300 ANESTHESI OLOGY	0. 000000				0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 146959	1, 610			237	
54. 00	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 112592	1,010			0	1
54. 01	05404 ULTRASOUND	0. 124461					1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 120592				0	55.00
57. 00	05700 CT SCAN		0 107			309	
		0. 037716	8, 187			l .	
58. 00	05800 MRI	0. 052460	0			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 180675	0	(		0	1
60.00	06000 LABORATORY	0. 102130	0	(		0	
60. 01	06001 BLOOD LABORATORY	0. 000000	0	(		0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	(		0	
64. 00	06400 I NTRAVENOUS THERAPY	9. 676849	0	(		0	
65.00	06500 RESPI RATORY THERAPY	0. 207635	0	(		0	
66. 00	06600 PHYSI CAL THERAPY	0. 250575	0	(		0	
69. 00	06900 ELECTROCARDI OLOGY	0. 129213	1, 516				1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 284730	0	(		0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210653	0	(		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 160258	2, 100			337	
	03955 RENAL DIALYSIS (IP)	0. 775483	0	(		0	
76. 00	03956 CARDI AC REHAB	0. 566518	0	(		0	
76. 01	03950 OP PSY/CDU	0. 542465	0	(	0	0	
76. 02	03957 RI MMS	0. 669225	0	(	0	0	
76. 03	03951 GENETIC/OAK PLAZA CLINICS	0. 000000	0	(	0	0	
76. 04	03952 PAIN CLINIC	0. 000000	0	(	0	0	76. 04
76. 05	03953  DI ABETES	0. 790963	0	(		0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 306261	0	(	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS		,				
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
91.00	09100 EMERGENCY	0. 182982	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 139451	0	(	0	0	92. 00
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	(	0	0	92. 01
93.00	04951 I NFUSI ON	0. 044554	0	(	0	0	93. 00
93. 01	04950 COMMUNITY HEALTH CENTERS	0. 149613	0	(	0	0	93. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0. 869829		(			95. 00
200.00	Subtotal (see instructions)		13, 413		0	1, 079	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		13, 413	(	0	1, 079	202. 00

					5/26/2022 10:	37 am
		Title	e XVIII	Subprovi der - I PF	PPS	
	Cos	sts		I FI		
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANGLILADY CEDVICE COCT CENTEDS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS  50. 00 OPERATING ROOM	0	0	J			50.00
51. 00   05100   RECOVERY   ROOM	0	0	1			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	•			52.00
53. 00   05300   ANESTHESI OLOGY	0	0	•			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1			54. 00
54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	j o	0				54. 01
54. 02   05404   ULTRASOUND	0	Ö	5			54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1			55.00
57. 00   05700 CT SCAN	0	0				57.00
58. 00   05800 MRI	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00   06000   LABORATORY	0	0				60.00
60. 01   06001   BL00D   LABORATORY	0	0				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	)			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	•			73. 00
75. 01   03955   RENAL DIALYSIS (IP)	0	0	1			75. 01
76. 00   03956   CARDI AC REHAB	0	0	•			76. 00
76. 01   03950   OP   PSY/CDU	0	0				76. 01
76.02   03957 RIMMS 76.03   03951 GENETIC/OAK PLAZA CLINICS	0	0				76. 02
76. 03   03951   GENETIC/OAK PLAZA CLINICS 76. 04   03952   PAIN CLINIC	0	0	1			76. 03 76. 04
76. 05   03953   DI ABETES	0	0	•			76. 05
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	Ö	1			76. 98
OUTPATIENT SERVICE COST CENTERS	<u> </u>		′1			70.70
88. 00 08800 RURAL HEALTH CLINIC						88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
92.01 09202 OBSERVATION BEDS (DISTINCT PART)	0	0				92. 01
93. 00   04951   I NFUSI ON	0	0				93. 00
93. 01 04950 COMMUNITY HEALTH CENTERS	0	0	)			93. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00   09500   AMBULANCE   SERVI CES	0					95. 00
200.00 Subtotal (see instructions)	0	0	)			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges		,				202 00
202.00   Net Charges (line 200 - line 201)	0	0	<b>'</b> I			202. 00

	Financial Systems TONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.		Provider C	CN: 14-0186	Peri od:	worksheet D	2002 10
			Component	CCN: 14-T186	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/26/2022 10:	pared:
			Title	XVIII	Subprovider -	PPS	37 am
	Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2.00	2.00	4.00	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	3, 477, 351	126, 970, 992	0. 02738	814, 734	22, 313	50.00
51. 00	05100 RECOVERY ROOM	756, 799				4, 040	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	401, 495				4, 040	
53. 00	05300 ANESTHESI OLOGY	401, 493				0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 458, 927	-			3, 564	
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	71, 952				132	
54. 02	05404 ULTRASOUND	242, 574				2, 263	
55. 00	05500 RADI OLOGY-THERAPEUTI C	299, 513		0. 00650		0	
57. 00	05700 CT SCAN	531, 320				3, 510	
58. 00	05800 MRI	185, 514				2, 117	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 029, 609				1, 107	
60.00	06000 LABORATORY	1, 204, 611				10, 491	
60. 01	06001 BLOOD LABORATORY	0		i		0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0	62.00
64.00	06400 I NTRAVENOUS THERAPY	144, 188	381, 821	0. 37763	4, 902	1, 851	64.00
65.00	06500 RESPIRATORY THERAPY	320, 893	21, 676, 462	0. 01480	624, 731	9, 249	65.00
66.00	06600 PHYSI CAL THERAPY	1, 350, 945			9, 520, 214	270, 593	66.00
69. 00	06900 ELECTROCARDI OLOGY	510, 133		0. 01608		1, 937	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	450, 063				118	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	174, 356				567	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 022, 885				8, 369	
75. 01	03955 RENAL DIALYSIS (IP)	19, 355				1, 616	
76.00	03956 CARDI AC REHAB	171, 735				0	
76. 01	03950 OP PSY/CDU	700, 913				0	
76. 02	03957 RIMMS	259, 721		0. 09702		0	
76. 03	03951 GENETIC/OAK PLAZA CLINICS	0				0	
76. 04 76. 05	03952 PAIN CLINIC	1	-	0.0000		0	
76. 98	03953 DI ABETES 07698 HYPERBARI C OXYGEN THERAPY	56, 800 120, 044				5, 214	
70. 90	OUTPATIENT SERVICE COST CENTERS	120, 044	4,020,079	0.02460	209, 733	3, 214	70. 90
88. 00	08800 RURAL HEALTH CLINIC	325, 521	387, 825	0. 83935	50 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	325, 521		0. 00000		0	
91. 00	09100 EMERGENCY	914, 629				831	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0.00000		0.00	
92. 01	09202 OBSERVATION BEDS (DISTINCT PART)	Ö				Ö	
93. 00	04951   I NFUSI ON	62, 747				0	
93. 01	04950 COMMUNITY HEALTH CENTERS	1, 025, 004				0	
1	OTHER REIMBURSABLE COST CENTERS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , , ,				1
							1 05 00
95.00	O9500 AMBULANCE SERVICES   Total (lines 50 through 199)					349, 882	95. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS	RIVERSIDE MED ERVICE OTHER PAS:	S Provider Component	CCN: 14-T186	То	iod: m 01/01/2021 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 10:	pared:
		Title	xVIII	Su	bprovider - IRF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Po	ost-Stepdown Adjustments	Allied Health	
ANOULL ADV. CEDVLOE, COCT. CENTERS	1. 00	2A	2. 00		3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00   05000   OPERATI NG ROOM	0	0		0	0	0	50.00
51. 00   05100   RECOVERY ROOM   52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	0 0 0	0 0		0 0 0	0	0 0 0	51. 00 52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   NUCLEAR MEDI CI NE-DI AGNOSTI C 54. 02   05404   ULTRASOUND	0 0	0		0 0 0	0 0 0	0 0 0	54. 01 54. 02
55. 00   05500   RADI OLOGY - THERAPEUTI C 57. 00   05700   CT   SCAN 58. 00   05800   MRI	0 0 0	O		0 0 0	0 0 0	0 0	57. 00 58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON   060. 00   LABORATORY   060. 01   06001   BLOOD LABORATORY   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0 0 0 0	60. 00 60. 01
64. 00   06400   NTRAVENOUS THERAPY   65. 00   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	0	64. 00 65. 00
69. 00   06900   ELECTROCARDIOLOGY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS	0 0 0	0		0 0 0	0 0 0	0 0 0	71. 00 72. 00
73.00   07300   DRUGS CHARGED TO PATIENTS 75.01   03955   RENAL DIALYSIS (IP) 76.00   03956   CARDIAC REHAB	0 0	0		0 0	0	0 0	75. 01 76. 00
76. 01   03950   OP PSY/CDU 76. 02   03957   RIMMS 76. 03   03951   GENETIC/OAK PLAZA CLINICS 76. 04   03952   PAIN CLINIC	0 0 0	0		0 0 0	0 0 0	0 0 0 0	76. 02 76. 03
76. 05 03953 DI ABETES 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0UTPATI ENT SERVI CE COST CENTERS	0	O		0	0	0	76. 05
88. 00   08800   RURAL   HEALTH   CLINI   C 89. 00   08900   FEDERALLY   QUALI   FI ED   HEALTH   CENTER 91. 00   09100   EMERGENCY	0 0	0		0 0 0	0	0 0 0	89. 00
92. 00	0	0		0	0	0	92. 00 92. 01
93. 01 04950 COMMUNITY HEALTH CENTERS	0	0		0	0	0	93. 01
OTHER REIMBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVI CES			1				95. 00

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RI VERSI DE MED RVI CE OTHER PASS		^N: 14_0186		u of Form CMS-2	
				Peri od:	Worksheet D	
				From 01/01/2021	Part IV	
		Component	CCN: 14-T186	To 12/31/2021	Date/Time Pre	pared:
		T' 11	V0.41.1	6.1	5/26/2022 10:	37 am
		litie	xVIII	Subprovi der  - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
cost center bescriptron	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	, ·	Cost (sum of		(col . 5 ÷ col .	
	EddCatron cost	4)	col s. 2, 3,	8)	7)	
		.,	and 4)	9	(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			<u> </u>			
50. 00 05000 OPERATING ROOM	0	0		0 126, 970, 992	0.000000	50.00
51.00   05100   RECOVERY ROOM	0	0		0 15, 322, 267	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 961, 984	0.000000	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0		0 0	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0 92, 729, 174	0.000000	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 8, 740, 392	0.000000	54. 01
54. 02   05404   ULTRASOUND	0	0		0 18, 298, 488	0.000000	54. 02
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	0		0 46, 070, 691	0.000000	55. 00
57.00 05700 CT SCAN	0	0		0 94, 768, 810	0.000000	57. 00
58. 00  05800 MRI	0	0		0 25, 544, 055	0.000000	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0 75, 119, 624	0.000000	59.00
60. 00  06000   LABORATORY	0	0		0 176, 261, 056	0.000000	60.00
60. 01   06001   BLOOD LABORATORY	0	0		0 0	0.000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.000000	62.00
64. 00 06400 INTRAVENOUS THERAPY	0	0		0 381, 821	0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 21, 676, 462	0.000000	65.00
66. 00   06600 PHYSI CAL THERAPY	0	0		0 47, 530, 599	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 31, 724, 057	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 11, 887, 122	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 68, 942, 017	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 257, 611, 764	0.000000	73. 00
75.01 03955 RENAL DIALYSIS (IP)	0	0		0 1, 462, 369	0.000000	75. 01
76. 00   03956   CARDI AC REHAB	0	0		0 1, 992, 166	0.000000	76. 00
76. 01   03950   OP PSY/CDU	0	0		0 4, 877, 382	0.000000	76. 01
76. 02   03957   RI MMS	0	0		0 2, 676, 911	0.000000	76. 02
76.03 03951 GENETIC/OAK PLAZA CLINICS	0	0		0 0	0.000000	76. 03
76.04   03952   PAIN CLINIC	0	0		0 0	0.000000	76. 04
76. 05   03953   DI ABETES	0			0 2, 661, 003	0.000000	76. 05
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 4, 828, 679	0.000000	76. 98
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 387, 825	0.000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	
91. 00   09100   EMERGENCY	0	0		0 61, 008, 971	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 15, 270, 207	0. 000000	
92.01 09202 OBSERVATION BEDS (DISTINCT PART)	0	0		0	0.000000	
93. 00   04951   I NFUSI ON	0			0 32, 882, 122	0. 000000	1
93. 01 04950 COMMUNITY HEALTH CENTERS	0	0		0 9, 389, 087	0. 000000	93. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	0	0	1	0 1, 257, 978, 097		200. 00

THROUGH COSTS  Component CC  Title >  Cost Center Description  Outpatient Ratio of Cost Program to Charges  Charges   I	N: 14-0186 F	Peri od:	u of Form CMS-:   Worksheet D	1002 10
Cost Center Description	F	From 01/01/2021	Part IV	
Cost Center Description	JN: 14-1186	To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared: 37 am
Ratio of Cost to Charges (col 6 + col 7)	XVIII	Subprovi der - I RF	PPS	
To Charges	Inpati ent	Outpati ent	Outpati ent	
ANCILLARY SERVICE COST CENTERS   9.00   10.00	Program	Program	Program	
ANCILLARY SERVICE COST CENTERS	Pass-Through		Pass-Through	
ANCI LLARY SERVI CE COST CENTERS   9.00   10.00	Costs (col. 8	3	Costs (col. 9	
ANCI LLARY SERVICE COST CENTERS	x col . 10)	12.00	x col . 12)	
50. 00   05000   OPERATI NG ROOM   0.000000   814, 734     51. 00   05100   RECOVERY ROOM   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000	11. 00	12.00	13. 00	
51. 00         05100         RECOVERY ROOM         0.000000         81,799           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0.000000         0           53. 00         05300         ANESTHESI OLOGY         0.000000         0           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         16,069           54. 01         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         16,069           54. 02         05404         ULTRASOUND         0.000000         170,701           55. 00         05500         RADI OLOGY-THERAPEUTI C         0.000000         0           57. 00         05700         CT SCAN         0.000000         626,074           58. 00         05800         MRI         0.000000         291,425           59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         80,745           60. 01         06000         LABORATORY         0.000000         1,535,183           60. 01         06001         BLOOD & PACKED RED BLOOD CELL         0.000000         1           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0.000000         4,902           65. 00         06500         <		0 0	0	50.00
52. 00         05200         DELIVERY ROOM & LABOR ROOM         0.000000         0           53. 00         05300         ANESTHESI OLOGY         0.000000         0           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         16, 069           54. 01         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         16, 069           54. 02         05404         ULTRASOUND         0.000000         170, 701           55. 00         05500         RADI OLOGY-THERAPEUTI C         0.000000         0           57. 00         05700         CT SCAN         0.000000         626, 074           58. 00         05800         MRI         0.000000         291, 425           59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         80, 745           60. 01         06001         BLOOD LABORATORY         0.000000         1, 535, 183           60. 01         06001         BLOOD LABORATORY         0.000000         0           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0.000000         4, 902           65. 00         06500 RESPI RATORY THERAPY         0.000000         4, 902           65. 00         06500 RESPI RATORY THERAPY <td>-</td> <td></td> <td>0</td> <td>51.00</td>	-		0	51.00
53. 00   05300   ANESTHESI OLOGY   0. 000000   0   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 000000   16, 069   54. 01   05401   NUCLEAR MEDI CI NE-DI AGNOSTI C   0. 000000   170, 701   55. 00   05404   ULTRASOUND   0. 000000   170, 701   55. 00   05500   RADI OLOGY-THERAPEUTI C   0. 000000   626, 074   68. 00   05800   MRI   0. 000000   291, 425   69. 00			0	52.00
54. 00         05400  RADI OLOGY-DI AGNOSTI C         0.000000         226, 555           54. 01         05401  NUCLEAR MEDI CI NE-DI AGNOSTI C         0.000000         16, 669           54. 02         05404  ULTRASOUND         0.000000         170, 701           55. 00         05500  RADI OLOGY-THERAPEUTI C         0.000000         0           57. 00         05700  CT SCAN         0.000000         626, 074           58. 00         05800 MRI         0.000000         291, 425           59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         291, 425           60. 01         06000 LABORATORY         0.000000         1, 535, 183           60. 01         06001 BLOOD LABORATORY         0.000000         0           62. 00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         0.000000         0           64. 00         06400         INTRAVENOUS THERAPY         0.000000         4, 902           65. 00         06500         RESPI RATORY THERAPY         0.000000         624, 731           66. 00         06600         PHYSI CAL THERAPY         0.000000         9, 520, 214           69. 00         O6900 ELECTROCARDI OLOGY         0.000000         120, 465           71. 00         07100 MEDI CAL SUPPL			0	53.00
54. 01         05401         NUCLEAR MEDICINE-DIAGNOSTIC         0.000000         16, 069           54. 02         05404         ULTRASOUND         0.000000         170, 701           55. 00         05500         RADI OLOGY-THERAPEUTIC         0.000000         0           57. 00         05700         CT SCAN         0.000000         626, 074           58. 00         05800         MRI         0.000000         291, 425           59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         80, 745           60. 01         06000         LABORATORY         0.000000         1, 535, 183           60. 01         06001         BLOOD LABORATORY         0.000000         0           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0.000000         0           64. 00         06400         INTRAVENOUS THERAPY         0.000000         4, 902           65. 00         06500         RESPI RATORY THERAPY         0.000000         624, 731           66. 00         06600         PHYSI CAL THERAPY         0.000000         9, 520, 214           69. 00         06900         ELECTROCARDI OLOGY         0.000000         3, 112           72. 00         07200 <td< td=""><td></td><td>0 0</td><td>0</td><td>54.00</td></td<>		0 0	0	54.00
54. 02       05404       ULTRASOUND       0.000000       170, 701         55. 00       05500       RADI OLOGY-THERAPEUTI C       0.000000       0         57. 00       05700       CT SCAN       0.000000       626, 074         58. 00       05800       MRI       0.000000       291, 425         59. 00       05900       CARDI AC CATHETERI ZATI ON       0.000000       80, 745         60. 00       06000       LABORATORY       0.000000       1, 535, 183         60. 01       06001       BLOOD LABORATORY       0.000000       0         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0.000000       0         64. 00       06400       INTRAVENOUS THERAPY       0.000000       4, 902         65. 00       06500       RESPI RATORY THERAPY       0.000000       624, 731         66. 00       06600       PHYSI CAL THERAPY       0.000000       9, 520, 214         69. 00       O6900       ELECTROCARDI OLOGY       0.000000       120, 465         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       224, 279         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       22, 107, 493         <	-	0 0	0	
55. 00         05500         RADI OLOGY-THERAPEUTI C         0.000000         0           57. 00         05700         CT SCAN         0.000000         626, 074           58. 00         05800         MRI         0.000000         291, 425           59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         80, 745           60. 01         06000         LABORATORY         0.000000         1, 535, 183           60. 01         06001         BLOOD LABORATORY         0.000000         0           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0.000000         0           64. 00         06400         INTRAVENOUS THERAPY         0.000000         4, 902           65. 00         06500         RESPI RATORY THERAPY         0.000000         624, 731           66. 00         06600         PHYSI CAL THERAPY         0.000000         624, 731           69. 00         06900         ELECTROCARDI OLOGY         0.000000         3, 112           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         224, 279           73. 00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         2, 107, 493           75. 01		0 0	0	54. 02
57. 00         05700         CT SCAN         0.000000         626, 074           58. 00         05800         MRI         0.000000         291, 425           59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         80, 745           60. 01         06000         LABORATORY         0.000000         1, 535, 183           60. 01         06001         BLOOD LABORATORY         0.000000         0           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0.000000         0           64. 00         06400         I NTRAVENOUS THERAPY         0.000000         4, 902           65. 00         06500         RESPI RATORY THERAPY         0.000000         624, 731           66. 00         06600         PHYSI CAL THERAPY         0.000000         9, 520, 214           69. 00         06900         ELECTROCARDI OLOGY         0.000000         120, 465           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENT         0.000000         3, 112           72. 00         07200         I MPL. DEV. CHARGED TO PATI ENTS         0.000000         2, 107, 493           75. 01         03955         RENAL DI ALYSI S (I P)         0.000000         122, 096           76	(	0 0	0	55. 00
58. 00       05800 MRI       0.000000       291, 425         59. 00       05900 CARDI AC CATHETERI ZATI ON       0.000000       80, 745         60. 00       06000 LABORATORY       0.000000       1, 535, 183         60. 01       06001 BLOOD LABORATORY       0.000000       0         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELL       0.000000       0         64. 00       06400 INTRAVENOUS THERAPY       0.000000       4, 902         65. 00       06500 RESPI RATORY THERAPY       0.000000       624, 731         66. 00       06600 PHYSI CAL THERAPY       0.000000       9, 520, 214         69. 00       06900 ELECTROCARDI OLOGY       0.000000       120, 465         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       3, 112         72. 00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0.000000       224, 279         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.000000       2, 107, 493         75. 01       03955 RENAL DI ALYSI S (I P)       0.000000       122, 096         76. 02       03957 RIMMS       0.000000       0         76. 03       03951 GENETI C/OAK PLAZA CLINI CS       0.000000       0         76. 04       03952 PAI N CLINI C       0.000	(	0 0	0	57. 00
59. 00       05900 CARDI AC CATHETERI ZATI ON       0.000000       80, 745         60. 00       06000 LABORATORY       0.000000       1, 535, 183         60. 01       06001 BLOOD LABORATORY       0.000000       0         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELL       0.000000       0         64. 00       06400 INTRAVENOUS THERAPY       0.000000       4, 902         65. 00       06500 RESPI RATORY THERAPY       0.000000       624, 731         66. 00       06600 PHYSI CAL THERAPY       0.000000       9, 520, 214         69. 00       06900 ELECTROCARDI OLOGY       0.000000       120, 465         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       3, 112         72. 00       07200 I IMPL. DEV. CHARGED TO PATI ENTS       0.000000       224, 279         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.000000       2, 107, 493         75. 01       03955 RENAL DI ALYSI S (I P)       0.000000       122, 096         76. 00       03956 CARDI AC REHAB       0.000000       0         76. 01       03955 I GENETI C/OAK PLAZA CLI NI CS       0.000000       0         76. 03       03951 I GENETI C/OAK PLAZA CLI NI CS       0.000000       0         76. 98       07698	(	o o	0	58.00
60. 00    06000    LABORATORY	(	o o	0	59. 00
60. 01	(	0 0	0	60.00
62. 00	(	0 0	0	60. 01
65. 00	(	0 0	0	62.00
66. 00	(	0 0	0	64.00
69. 00	(	0 0	0	65. 00
71. 00	(	0 0	0	66. 00
72. 00    07200    IMPL. DEV. CHARGED TO PATIENTS	(	0 0	0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 2, 107, 493 75. 01 03955 RENAL DIALYSIS (IP) 0. 000000 122, 096 76. 00 03956 CARDIAC REHAB 0. 000000 0 76. 01 03950 OP PSY/CDU 0. 000000 0 76. 02 03957 RIMMS 0. 000000 0 76. 03 03951 GENETIC/OAK PLAZA CLINICS 0. 000000 0 76. 04 03952 PAIN CLINIC 0. 000000 0 76. 05 03953 DIABETES 0. 000000 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0. 000000 209, 733 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0. 000000 0 91. 00 09100 EMERGENCY 0. 000000 55, 448 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0. 0000000 0	(	0 0	0	71. 00
75. 01   03955   RENAL DIALYSIS (IP)   0.000000   122,096   76. 00   03956   CARDIAC REHAB   0.000000   0   0   0   0   0   0   0	(	0 0	0	72. 00
76. 00		0 0	0	73. 00
76. 01 03950 OP PSY/CDU 0.000000 0 76. 02 03957 RI MMS 0.000000 0 76. 03 03951 GENETI C/OAK PLAZA CLINI CS 0.000000 0 76. 04 03952 PAIN CLINI C 0.000000 0 76. 05 03953 DI ABETES 0.000000 0 76. 07698 HYPERBARI C OXYGEN THERAPY 0.000000 209, 733 OUTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C 0.000000 0 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0.000000 0 91. 00 09100 EMERGENCY 0.000000 55, 448 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0	(	0	0	75. 01
76. 02       03957       RIMMS       0.000000       0         76. 03       03951       GENETI C/OAK PLAZA CLINI CS       0.000000       0         76. 04       03952       PAI N CLINI C       0.000000       0         76. 05       03953       DI ABETES       0.000000       0         76. 98       07698       HYPERBARI C OXYGEN THERAPY       0.000000       209, 733         0UTDATI ENT SERVI CE COST CENTERS         88. 00       08800       RURAL HEALTH CLINI C       0.000000       0         89. 00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       0.000000       0         91. 00       09100       EMERGENCY       0.000000       55, 448         92. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0.000000       0	-	0	0	76. 00
76. 03	-	0 0	0	76. 01
76. 04 03952 PAIN CLINIC 0.000000 0 76. 05 03953 DIABETES 0.000000 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0.000000 209, 733  OUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 91. 00 09100 EMERGENCY 0.000000 55, 448 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 0		0 0	0	76. 02
76. 05	-	0	0	76. 03
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 209, 733  0UTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C 0. 000000 0  89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 0  91. 00 09100 EMERGENCY 0. 000000 55, 448  92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0. 000000 0	•	0	0	76. 04
OUTPATIENT SERVICE COST CENTERS		0	0	
88. 00   08800   RURAL HEALTH CLINIC   0. 000000   0   0   0   0   0   0   0	(	0 0	0	76. 98
89. 00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       0         91. 00       09100       EMERGENCY       0.000000       55,448         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.000000       0				
91. 00   09100   EMERGENCY		0 0	0	
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0.000000   0		0 0	0	89.00
	•	0 0	0	91.00
AN DI INANDITORIA REPORTATION PEDIS COLISTINAL PARTI DI DIDIDIDI		0 0	0	92. 00 92. 01
93. 00   04951   NFUSI ON	-		0	92.01
93. 00   04951  NFUSI ON	-		0	
OTHER REIMBURSABLE COST CENTERS 0. 000000  0		<u>U</u> U	U	J 73. UT
95. 00 O9500 AMBULANCE SERVICES		T I		95. 00
200.00 Total (lines 50 through 199) 16,835,758	(	0 0	0	200. 00

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0186	Peri od: From 01/01/2021	Worksheet D-1	
			Date/Time Pre 5/26/2022 10:	
	Title XVIII	Hospi tal	PPS	
Cook Cook on Document on				

		Title XVIII	Hospi tal	PPS	37 alli
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		44, 338	1.00
2.00	Inpatient days (including private room days, excluding swing-b			44, 338	
3.00	Private room days (excluding swing-bed and observation bed day	rs). If you have only pri	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od days)		41, 729	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roc		r 31 of the cost	41, 729	ı
0.00	reporting period	days, t sag secese.		Ĭ	0.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Teporting period  Total_swing-bed_NF_type_inpatient_days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	. days, a. ts. Bessings. s	. 01 11.0 0001	١	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	12, 544	9. 00
40.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI>	only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period	( only (including private	a maam daya)	0	12 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			U	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	a through December 21 or	f the cost	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	r the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
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 21 of the	ho cost	0. 00	20. 00
20.00	reporting period	sarter becember 31 of the	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	5)		36, 188, 384	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe	er 31 of the cost reporti	ing period (line	0	22. 00
22.00	5 x line 17)	21 -6			22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		36, 188, 384	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,		337 1337 33 1	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)			0	1
30. 00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ± Average private room per diem charge (line 29 ± line 3)	11 ne 28)		0.000000	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	ı
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	ina private room cost di	rrerential (line	36, 188, 384	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		I		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		816. 19	1
39. 00	Program general inpatient routine service cost (line 9 x line	•		10, 238, 287	ı
40.00	Medically necessary private room cost applicable to the Program	•		10 220 207	ı
41.00	Total Program general inpatient routine service cost (line 39	+ IIIIC 4U)		10, 238, 287	41.00

<u>Heal t</u> h	Financial Systems	RI VERSI DE MEDI	ICAL CENTER		In_Lie	eu of Form CMS-2	<u> 2552-1</u> 0
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 14-0186	Period: From 01/01/2021	Worksheet D-1	
					To 12/31/2021		
			Title	xVIII	Hospi tal	5/26/2022 10: PPS	37 am_
	Cost Center Description	Total	Total	Average Per	<del>_</del>	Program Cost	
	· ·	Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00				42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	7, 862, 108	4, 159				1
45. 00	BURN INTENSIVE CARE UNIT	l o	0	0.0	00 0	0	45. 00
46. 00	1						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	, line 200)			21, 757, 684	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructio	ns)		34, 954, 416	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program input	ationt routing	convices (from	Wkst D sum	of Dorte L and	1, 813, 187	50.00
50.00		attent routine	services (Troil	I WKSt. D, Sun	i oi Parts i and	1,813,187	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	1, 658, 505	51.00
52. 00	and IV)	50 and 51)				2 471 402	52. 00
52.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	3, 471, 692 31, 482, 724	1
00.00	medical education costs (line 49 minus line					017 1027 721	00.00
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57.00		ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)		anding 1007	undated and as	.mnaundad by +ba	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	enaing 1996, u	ipdated and co	impounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	matruoti ona,				0	62.00
63. 00	Allowable Inpatient cost plus incentive payments	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost reporti	ng period (See	0	64. 00
04.00	instructions) (title XVIII only)	ts through becch	inder 31 of the	cost reporti	ng perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 6	5)(title XVII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Tine	or prus rine o	.0)(11 110 7711	1 0111 377. 101		00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	porting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
00.00	(line 13 x line 20)	0 00010 01101 0		т. о осот торс	a tring portion		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service of	-		, ,			71.00
72.00				0.5)			72.00
73. 00 74. 00	Medically necessary private room cost applications and Program general inpatient routine services.						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			art II, column		75. 00
	26, line 45)		`	•			
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line	,					76. 00 77. 00
	Inpatient routine service cost (line 74 minu:	,					78.00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p					79. 00
	Total Program routine service costs for compa		ost limitation	(line 78 mir	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (		•				83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation						85. 00 86. 00
oo. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		i ougii ooj				1 00.00
87. 00	Total observation bed days (see instructions)	)				2, 609	
88. 00	Adjusted general inpatient routine cost per of	•	line 2)			816. 19	
07.00	Observation bed cost (line 87 x line 88) (see	= INSTRUCTIONS)				2, 129, 440	09.00

Health Financial Systems	RIVERSIDE MED	ICAL CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	4, 821, 679	36, 188, 384	0. 13323	8 2, 129, 440	283, 722	90.00
91.00 Nursing Program cost	0	36, 188, 384	0.00000	0 2, 129, 440	0	91.00
92.00 Allied health cost	283, 354	36, 188, 384	0.00783	0 2, 129, 440	16, 674	92.00
93.00 All other Medical Education	0	36, 188, 384	0. 00000	0 2, 129, 440	0	93. 00

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0186	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 14-S186		
	Title XVIII	Subprovi der -	PPS
		LDE	

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 118	
2.00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day			3, 118	
3. 00	do not complete this line.	(S). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 118	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember a	or or the cost	Ö	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 21	l of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i oi the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 499	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv. (i poludi pa privato re	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (including private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar ye		, I	0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed c	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		- II	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0.00	18. 00
19. 00	reporting period	through Docombon 21 of	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s till ough becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		2, 294, 591	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)	04 6 11			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
25 00	7 x line 19)	)1 -6 +b++!		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (Tine 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 294, 591	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	line 20)		0. 000000	30.00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 28)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	, ,	tions)	0. 00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dif	ferential (line	2, 294, 591	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		T	735. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 103, 144	39. 00
40.00	Medically necessary private room cost applicable to the Program general inputions routing service cost (Line 20)	,		1 102 144	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	I	1, 103, 144	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	RIVERSIDE MEDIC	Provider CCN:	14-0186	Period: From 01/01/2021	worksheet D-1	
			Component CCN	l: 14-S186	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
			Title XV	/111	Subprovider -	PPS	
	Cost Center Description	Total Inpatient Costlr		verage Per em (col. 1		Program Cost (col. 3 x col.	
				col . 2)		4)	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00 0	42.0
	Intensive Care Type Inpatient Hospital Units						
3. 00 4. 00	INTENSIVE CARE UNIT	0	0	0. ( 0. (		0	
5. 00	BURN INTENSIVE CARE UNIT		Ĭ	0. (	0	0	45. (
6. 00	4						46. (
7.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.0
	·					1. 00	
8. 00 9. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			١		184, 009 1, 287, 153	
7. 00	PASS THROUGH COST ADJUSTMENTS	41 through 40) (30	ee matructrons,	<u> </u>		1, 207, 155	47.0
0.00	Pass through costs applicable to Program inp	oatient routine se	ervices (from W	kst. D, sum	n of Parts I and	34, 012	50. C
1. 00		natient ancillary	services (from	Wkst D s	sum of Parts II	14, 225	51.0
	and IV)	,					
2. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non physic	sian anasth	notict and	48, 237	1
3.00	medical education costs (line 49 minus line		iteu, non-physic	ciali allesti	ietist, and	1, 238, 916	33.0
	TARGET AMOUNT AND LIMIT COMPUTATION					0	]
4. 00 5. 00	Program discharges Target amount per discharge						54. 55.
6. 00	Target amount (line 54 x line 55)		0	1			
7. 00 8. 00							57. 58.
9. 00							58. 59.
	market basket						
0.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	1
71.00	which operating costs (line 53) are less that	an expected costs				0	01.0
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.0
3. 00		ment (see instruct	tions)			0	
4 00	PROGRAM INPATIENT ROUTINE SWING BED COST		04 6 11			0	
4. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decemb	per 31 of the co	ost reporti	ng period (See	0	64. 0
5. 00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the cost	t reporting	period (See	0	65.0
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 64	1 nlus line 65)	(title XVII	Lonly) For	0	66. (
	CAH (see instructions)						
7. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through [	December 31 of 1	the cost re	eporting period	0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routing	ne costs after Dec	cember 31 of the	e cost repo	orting period	0	68. 0
0.00	(line 13 x line 20)		/7 1: //	2)		0	/
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.0
0. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID routi	ne service cost		ı		70. C
'1. 00 '2. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line 2)				71. 0
3. 00	Medically necessary private room cost applic	•	(line 14 x line	35)			73.0
4. 00	Total Program general inpatient routine serv	•					74. (
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service of	costs (from Work	ksheet B, F	art II, column		75.0
6. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 0
7.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. (
9. 00			ovi der records)				79.
0.00	,		st limitation (I	ine 78 mir	nus line 79)		80.
1.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 82.
3. 00	Reasonable inpatient routine service costs (		)				83. (
84.00	Program inpatient ancillary services (see in		-)				84.
35. 00 36. 00	Utilization review - physician compensation Total Program inpatient operating costs (sun						85. 86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	g 00 <i>)</i>				
37. 00 38. 00	Total observation bed days (see instructions		ino 2)			0	
	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	urem (iiile z/ ÷ l	111 <del>0</del> 2)			0.00	88. 89.

Health Financial Systems	RIVERSIDE MED	I CAL CENTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 14-S186	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 10:3	
		Title	: XVIII	Subprovi der  - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	70, 759	2, 294, 591	0. 03083	37 0	0	90. 00
91.00 Nursing Program cost	0	2, 294, 591	0.00000	00	0	91. 00
92.00 Allied health cost	0	2, 294, 591	0.00000	00	0	92. 00
93.00 All other Medical Education	0	2, 294, 591	0. 00000	00	ol	93. 00

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0186	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 14-T186	To 12/31/2021	Date/Time Prepared: 5/26/2022 10:37 am
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			8, 505	1.00
2.00	Inpatient days (including private room days, excluding swing-			8, 505	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		8, 505	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
4 00	reporting period	om doug) often December 3	11 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	6, 142	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	o	11. 00
	December 31 of the cost reporting period (if calendar year, er		om dayo, arron	Ĭ	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			٥	13.00
14. 00	Medically necessary private room days applicable to the Progra	•	, i	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period	Ü			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	g			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		7, 398, 284	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
	7 x line 19)	•			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 398, 284	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	irges)	0	28. 00 29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		.1 0.13)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	7, 398, 284	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		869. 87	
39. 00	Program general inpatient routine service cost (line 9 x line			5, 342, 742	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 5, 342, 742	40. 00 41. 00
<del>-</del> 1. 00	Trocal Trogram general Impatrent routine service cost (IIIIe 37		ı	5, 542, 142	<del>-</del> 1. 00

OMPUT	Financial Systems FATION OF INPATIENT OPERATING COST	RIVERSIDE MEDIC	Provider CO	CN: 14-0186	Peri od: From 01/01/2021	worksheet D-1	
			Component (	CCN: 14-T186	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
			Title	XVIII	Subprovi der -	PPS	
	Cost Center Description	Total Inpatient Costlr	Total npatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4. 00 00 0	5. 00 0	42.0
	Intensive Care Type Inpatient Hospital Units						
3. 00		0	0	0. 0.			
5. 00			O <sub>1</sub>	0.	00		45.0
6. 00							46.0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			3, 588, 576	48.0
9. 00	, ,	41 through 48)(se	ee instructio	ns)		8, 931, 318	49.0
0. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	nationt routing so	rvices (from	Wket D en	m of Darts I and	485, 832	50.0
0.00		battent routine se	ervices (IIOIII	WKSt. D, Su	iii Oi Faits i aliu	405, 632	30.0
1. 00	Pass through costs applicable to Program inp	oatient ancillary	services (fr	om Wkst. D,	sum of Parts II	349, 882	51.0
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				835, 714	52. (
3. 00	Total Program inpatient operating cost exclusion		ated non-phy	sician anest	hetist and	8, 095, 604	1
	medical education costs (line 49 minus line					0,070,001	]
	TARGET AMOUNT AND LIMIT COMPUTATION						
5.00	Program discharges Target amount per discharge	0 00	54. (				
6. 00		0.00	1				
7. 00	, , ,	0					
8. 00	Bonus payment (see instructions)	0					
9. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period ei	iding 1996, u	paatea ana c	ompounded by the	0.00	59. (
0.00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the m	arket basket		0.00	60.0
1. 00	If line 53/54 is less than the lower of line					0	61.0
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% o	f the target		
2. 00		111311 4011 0113)				О	62.0
3. 00		ment (see instruc	tions)			0	63. C
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						64. 0
14.00	instructions) (title XVIII only)	sts through becenii	ber 31 of the	cost report	ing perrou (see	0	04.0
5. 00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the c	ost reportin	g period (See	0	65.0
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	1 nlus line 6	5)(+i+l_ Y\/I	II only) For	0	66.0
0.00	CAH (see instructions)	The Costs (Title o	prus rine o	5)(title XVI	ii oniy). Toi		00.0
7. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through [	December 31 o	f the cost r	eporting period	0	67. C
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	na costs after Neo	cember 31 of	the cost ren	orting period	0	68. 0
0.00	(line 13 x line 20)	ie costs arter bed	cember 51 Of	the cost rep	or tring period		00.0
9. 00	Total title V or XIX swing-bed NF inpatient					0	69.0
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				<u> </u>		70. 0
1.00	Adjusted general inpatient routine service of				)		71. 0
2. 00				,			72.0
3.00	Medically necessary private room cost applic	9	•	ne 35)			73.0
4. 00 5. 00		•		orksheet R	Part II column		74.0
5. 00	26, line 45)	Toutine Service (	20313 (110111 11	or Rancet B,	rart II, corumii		/5. 0
6. 00	,	,					76.0
7.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. (
9. 00			ovi der record	s)			79. (
0.00	Total Program routine service costs for comp	parison to the cos			nus line 79)		80.0
1.00	1 '						81. (
32. 00 33. 00	1 '		)				82. (
3. 00	Program inpatient ancillary services (see in	•					84. (
5. 00	Utilization review - physician compensation	(see instructions					85. (
86. 00	Total Program inpatient operating costs (sun		ough 85)				86.0
37. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					0	87. 0
88.00	Adjusted general inpatient routine cost per		ine 2)			l e	88.0
	Observation bed cost (line 87 x line 88) (se					l 0	89.

Health Financial Systems	RIVERSIDE MED	I CAL CENTER		In Lieu of Form CMS-2			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1		
		Component (		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:		
		Title	XVIII	Subprovi der -	PPS		
				I RF			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital -related cost	672, 734	7, 398, 284	0. 09093	1 0	0	90.00	
91.00 Nursing Program cost	0	7, 398, 284	0. 00000	0 0	0	91.00	
92.00 Allied health cost	0	7, 398, 284	0.00000	0 0	0	92.00	
93.00 All other Medical Education	0	7, 398, 284	0. 00000	0 0	0	93. 00	

	DIVERSIDE MEDICAL	OFNITED			6.5. 046.6	2550 40
Health Financial Systems	RIVERSIDE MEDICAL	CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Pı	rovi der CO		Peri od: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Prep 5/26/2022 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges		Program Costs	
				Charges	(col 1 v col	

				To 12/31/2021	Date/lime Pre 5/26/2022 10:	
		Title	e XVIII	Hospi tal	PPS	or an
	Cost Center Description		Ratio of Cos		Inpati ent	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				Ť	2)	
			1.00	2. 00	3. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			11, 924, 566		30.00
	03100 INTENSIVE CARE UNIT			2, 817, 676		31.00
4	03200 CORONARY CARE UNIT			0		32. 00
	04000 SUBPROVI DER – I PF			0		40. 00
	04100 SUBPROVI DER – I RF			0		41. 00
1	04200 SUBPROVI DER			0		42. 00
	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS				T	
	D5000 OPERATING ROOM		0. 18203			1
	D5100 RECOVERY ROOM		0. 49462			
	D5200 DELIVERY ROOM & LABOR ROOM		3. 65448	· ·		1
	D5300 ANESTHESI OLOGY		0.00000		0	
	D5400 RADI OLOGY-DI AGNOSTI C		0. 14695			1
	D5401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 11259	-	71, 580	
	D5404 ULTRASOUND		0. 12446			1
	D5500 RADI OLOGY-THERAPEUTI C		0. 12059	· ·		1
	D5700 CT SCAN		0. 03771			1
	D5800 MRI		0.05246			1
	D5900 CARDI AC CATHETERI ZATI ON		0. 18067			1
	D6000 LABORATORY		0. 10213			1
	06001 BLOOD LABORATORY		0.00000		0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	
	06400 I NTRAVENOUS THERAPY		9. 67684			64.00
	06500 RESPI RATORY THERAPY		0. 20763			1
4	06600 PHYSI CAL THERAPY		0. 25057			1
	06900 ELECTROCARDI OLOGY		0. 12921			1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 28473			1
4	D7200 IMPL. DEV. CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS		0. 21065 0. 16025			1
			0. 77548			
	03955 RENAL DIALYSIS (IP) 03956 CARDIAC REHAB		0. 56651			1
	03950 OP PSY/CDU		0. 54246			
	03957 RIMMS		0. 66922			1
	03951 GENETIC/OAK PLAZA CLINICS		0.00000			1
	03952 PAIN CLINIC		0.00000			1
	03953 DI ABETES		0. 79096			76. 05
4	07698 HYPERBARI C OXYGEN THERAPY		0. 30626	-		1
	OUTPATIENT SERVICE COST CENTERS		0.30020	333, 100	103, 270	70.70
	D8800 RURAL HEALTH CLINIC		0.00000	in l	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
	09100 EMERGENCY		0. 18298		1	91.00
1	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 13945			92. 00
1	09202 OBSERVATION BEDS (DISTINCT PART)		0.00000		0	
	04951   NFUSI ON		0. 04455		146	
	04950 COMMUNITY HEALTH CENTERS		0. 14961	· ·		1
-	OTHER REIMBURSABLE COST CENTERS		2			1
	09500 AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			132, 517, 578	21, 757, 684	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)	,		132, 517, 578		202. 00
	• • • • • • • • • • • • • • • • • • • •		•	•	•	•

	DE MEDICAL CENTER			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 14-0186	Peri od: From 01/01/2021	Worksheet D-3	
	Component	CCN: 14-S186	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Title	xVIII	Subprovider -	PPS	<u> </u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00   03200   CORONARY CARE UNIT					32.00
40. 00   04000   SUBPROVI DER - 1 PF			1, 895, 107		40.00
41. 00   04100   SUBPROVI DER - I RF					41.00
42. 00   04200   SUBPROVI DER					42.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00 OPERATI NG ROOM		0. 18203	31 0	0	50.00
51. 00   05100   RECOVERY   ROOM		0. 49462		22, 007	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		3. 65448		0	1
53. 00   05300   ANESTHESI OLOGY		0. 00000		Ö	1
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 14695		2, 767	
54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C		0. 11259		0	54. 01
54. 02 05404 ULTRASOUND		0. 12446		1, 376	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12059	0	0	55.00
57. 00   05700   CT   SCAN		0. 0377	6 108, 091	4, 077	57.00
58. 00   05800   MRI		0.05246	34, 565	1, 813	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 18067	75 0	0	59.00
60. 00   06000   LABORATORY		0. 10213		49, 069	1
60. 01   06001   BLOOD LABORATORY		0.00000		0	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	62. 00
64. 00   06400   I NTRAVENOUS THERAPY		9. 67684		0	64.00
65. 00   06500   RESPI RATORY THERAPY		0. 20763		4, 228	1
66. 00   06600 PHYSI CAL THERAPY		0. 25057		19, 504	
69. 00  06900 ELECTROCARDIOLOGY 71. 00  07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 12921 0. 28473		6, 297 0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21065		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 16025		-	
75. 01 03955 RENAL DIALYSIS (IP)		0. 77548		0	75. 01
76. 00   03956   CARDI AC   REHAB		0. 5665		Ö	76. 00
76. 01   03950   OP PSY/CDU		0. 54246		2, 333	
76. 02   03957 RI MMS		0. 66922		0	1
76. 03 03951 GENETIC/OAK PLAZA CLINICS		0. 00000		0	
76. 04   03952   PAIN CLINIC		0.00000		0	76. 04
76. 05   03953 DI ABETES		0. 79096		0	76. 05
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 30626	28, 732	8, 799	76. 98
OUTPATIENT SERVICE COST CENTERS			20	-	00.00
88. 00   08800   RURAL HEALTH CLINIC		0.00000		0	
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0 22, 500	
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART		0. 18298		22, 500	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 13945 0. 00000		0	
93. 00   04951   I NFUSI ON		0.04455		0	1
93. 01   04950   COMMUNI TY HEALTH CENTERS		0. 1496		0	1
OTHER REI MBURSABLE COST CENTERS			-1		1

1, 245, 261

1, 245, 261

184, 009 200. 00 201. 00 202. 00

95.00

95. 00 OTHER REIMBURSABLE COST CENTERS
95. 00 O9500 AMBULANCE SERVICES

Net charges (line 200 minus line 201)

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

200. 00 201. 00

202.00

Health Financial Systems RIVERSIDE MEDI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	worksheet D-3	
	Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Title	e XVIII	Subprovider - IRF	PPS	<u> </u>
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
				2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00   03100   I NTENSI VE CARE UNI T					31.00
32. 00   03200   CORONARY CARE UNI T					32. 0
40. 00   04000   SUBPROVI DER - I PF					40. 0
41. 00   04100   SUBPROVI DER -   RF			5, 892, 306		41.00
42. 00   04200   SUBPROVI DER					42.0
43. 00 O4300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS 50. 00   05000   0PERATING ROOM		0. 18203	814, 734	148, 307	50.0
51. 00   05100   RECOVERY ROOM		0. 49462			1
52. 00   05200   DELIVERY ROOM & LABOR ROOM		3. 65448		0	1
53. 00   05300   ANESTHESI OLOGY		0.00000		Ō	53. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14695		33, 294	54.0
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 11259	16, 069	1, 809	54.0
54. 02   05404   ULTRASOUND		0. 12446	170, 701	21, 246	
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 12059		0	55. 0
57. 00   05700   CT SCAN		0. 03771		23, 613	
58. 00   05800   MRI		0.05246			
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY		0. 18067 0. 10213		14, 589 156, 788	
60. 01   06001   BLOOD LABORATORY		0. 00000		150, 766	60.0
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		Ö	62.0
64. 00   06400   I NTRAVENOUS THERAPY		9. 67684		47, 436	1
65. 00 06500 RESPI RATORY THERAPY		0. 20763		129, 716	
66. 00 06600 PHYSI CAL THERAPY		0. 25057	9, 520, 214	2, 385, 528	66.0
69. 00   06900   ELECTROCARDI OLOGY		0. 12921			
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 28473		886	
72. 00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 21065			
73.00  07300 DRUGS CHARGED TO PATIENTS 75.01  03955 RENAL DIALYSIS (IP)		0. 16025			
75. 01  03955 RENAL DIALYSIS (IP) 76. 00  03956 CARDIAC REHAB		0. 77548 0. 56651		94, 683	76.0
76. 01   03950   OP PSY/CDU		0. 54246		0	
76. 02   03957   RI MMS		0. 66922		0	1
76. 03   03951   GENETI C/OAK PLAZA CLINICS		0.00000		Ō	
76. 04 03952 PAIN CLINIC		0.00000		0	76.0
76. 05   03953   DI ABETES		0. 79096	0	0	76. 0
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 30626	209, 733	64, 233	76. 9
OUTPATIENT SERVICE COST CENTERS				_	
88.00  08800 RURAL HEALTH CLINIC 89.00  08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
		0.00000		10 146	89.0
91.00   09100   EMERGENCY 92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART		0. 18298 0. 13945		10, 146 0	1
92. 01   09200   0BSERVATION BEDS (NON-DISTINCT PART)		0. 00000		0	1
93. 00   04951   I NFUSI ON		0. 04455		l .	1
93. 01   04950   COMMUNITY HEALTH CENTERS		0. 14961		<b>l</b>	
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95. 0
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	16, 835, 758	3, 588, 576	200.00

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)

202. 00

3, 588, 576 200. 00 201. 00

16, 835, 758 0

16, 835, 758

200. 00 201. 00

202.00

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 10:37 am		

			10 12/31/2021	5/26/2022 10:	
		Title XVIII	Hospi tal	PPS	
	DADT A LABOUT FAIT HOOD TALL OF DIVIDED ADDO			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	prior to October 1 (s	see	0 27, 023, 898	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring	on or after October 1	(see	8, 895, 298	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for d	0	1. 03		
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring o	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2.01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions	)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see	instructions)		135, 268	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (	see instructions)		49, 132	2. 04
3.00	Managed Care Simulated Payments			15, 465, 978	3. 00
4. 00	Bed days available divided by number of days in the cost reportin	g period (see instrud	ctions)	248. 85	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most re	cent cost reporting p	period ending on	0.00	5. 00
	or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs that meet the c new programs in accordance with 42 CFR 413.79(e)		.	18. 42	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified unde			0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.	,,,,,		0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots	under § 5503 of the A	ACA. If the cost	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots	from a closed teachin	ng hospital	1. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (	8, 8,01 and 8,02) (s	see	19. 42	9. 00
10. 00	instructions) FTE count for allopathic and osteopathic programs in the current			21. 33	
11.00	FTE count for residents in dental and podiatric programs.	3		0.00	11. 00
12.00	Current year allowable FTE (see instructions)			19. 42	12. 00
13.00	Total allowable FTE count for the prior year.			19. 42	13.00
14. 00	Total allowable FTE count for the penultimate year if that year e	nded on or after Sept	ember 30, 1997,	19. 42	14. 00
45.00	otherwise enter zero.			40.40	45.00
15. 00	Sum of lines 12 through 14 divided by 3.				15.00
16.00	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count			19. 42	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 078039	
	Prior year resident to bed ratio (see instructions)			0. 077330	
	Enter the lesser of lines 19 or 20 (see instructions)			0.077330	21. 00
22.00	IME payment adjustment (see instructions)			1, 485, 079	
22. 01	IME payment adjustment - Managed Care (see instructions)			639, 441	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident		R 412. 105	0.00	23. 00
24. 00	<pre>(f)(1)(iv)(C ). IME FTE Resident Count Over Cap (see instructions)</pre>			1. 91	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lowe	r of line 23 or line	24 (see	0.00	
	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
27. 00 28. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00 28. 00
28. 00	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			1, 485, 079	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		639, 441		
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patie	nt days (see instruct	ions)	5. 38	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	in days (see mistruc	.1 5.13)	31. 89	
32. 00	Sum of lines 30 and 31			37. 27	
	Allowable disproportionate share percentage (see instructions)				33. 00
	Di sproporti onate share adjustment (see instructions)			1, 792, 368	
	• • • •				•

	Financial Systems RIVERSIDE MEDICATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Date/Time Prep 5/26/2022 10:3	pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
ш	ncompensated Care Adjustment		1. 00	2. 00	
	Total uncompensated care amount (see instructions)		0	0	35.00
	Factor 3 (see instructions)		0. 000000000	0. 000000000	
02   F	Hospital uncompensated care payment (If line 34 is zero, ente	r zero on this line) (se	e 1, 534, 650	1, 410, 638	35. 02
1	nstructions)				
- 1	Pro rata share of the hospital uncompensated care payment amo		1, 147, 834	355, 558	
	otal uncompensated care (sum of columns 1 and 2 on line 35.0 dditional payment for high percentage of ESRD beneficiary di:		1, 503, 392		36.00
	Total Medicare discharges (see instructions)	scharges (Titles 40 till ou	0		40.00
	Total ESRD Medicare discharges (see instructions)		0		41. 0
- 1	Total ESRD Medicare covered and paid discharges (see instruct	ions)	0		41.0
1	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.00
T 00	Total Medicare ESRD inpatient days (see instructions)		0		43.0
	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.0
	days)	`	0.00		45.0
1	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41	•	0.00		45. 00 46. 00
1	Subtotal (see instructions)	.01)	40, 884, 435		47. 0
	Hospital specific payments (to be completed by SCH and MDH, s	mall rural hospitals	40, 004, 433		48. 0
	only. (see instructions)	marriarar moopi taro			
				Amount	
				1. 00	
	Total payment for inpatient operating costs (see instructions			41, 523, 876	
1	Payment for inpatient program capital (from Wkst. L. Pt. I and			3, 104, 290	ı
	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0 479, 699	51. 0 52. 0
	Jursing and Allied Health Managed Care payment	THE 47 SEE THISTI UCTIONS).		8, 606	ı
	Special add-on payments for new technologies			215, 710	
	slet isolation add-on payment			0	54.0
00   1	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55. C
1	Cost of physicians' services in a teaching hospital (see intr			0	56.0
1	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	126, 574	1
- 1	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		2, 115	
1	Total (sum of amounts on lines 49 through 58) Primary payer payments			45, 460, 870 38, 635	1
	Total amount payable for program beneficiaries (line 59 minus	line 60)		45, 422, 235	
	Deductibles billed to program beneficiaries	11116 66)		3, 426, 140	
	Coinsurance billed to program beneficiaries			61, 529	1
	Allowable bad debts (see instructions)			882, 291	64. (
00   A	Adjusted reimbursable bad debts (see instructions)			573, 489	65. 0
1	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		699, 794	•
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			42, 508, 055	
	Credits received from manufacturers for replaced devices for			0	
	Outlier payments reconciliation (sum of lines 93, 95 and 96).  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(For SCH See Instruction	S)	0	
1	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70. 5
	Demonstration payment adjustment amount before sequestration	ration) adjustment (see	i iisti deti olisj	Ö	70. 8
1	SCH or MDH volume decrease adjustment (contractor use only)			Ö	70. 8
- 1	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70.8
90   F	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 9
	HSP bonus payment HRR adjustment amount (see instructions)			0	
1	Bundled Model 1 discount amount (see instructions)			0	70. 9
93   F	HVBP payment adjustment amount (see instructions)			-16, 109	•
94 H	HRR adjustment amount (see instructions)			-747, 111	

	Financial Systems RIVERSIDE MEDICA				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Peri od:	Worksheet E	
				From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	nared:
				10 12/31/2021	5/26/2022 10:	
		Title	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			41, 744, 835	71. 00
71. 01	Sequestration adjustment (see instructions)				0	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				41, 336, 336	72. 00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0273)	2, 72, and			408, 499	74. 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			5, 739, 238	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum (	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93. 00
94.00	The rate used to calculate the time value of money (see instr	uctions)			0.00	94. 00
95.00	Time value of money for operating expenses (see instructions)				0	95. 00
96.00	Time value of money for capital related expenses (see instruc	tions)			0	96. 00
					On/After 10/1	
				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					
	HVBP adjustment factor (see instructions)	_		0. 0000000000	0. 0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					4
	HRR adjustment factor (see instructions)			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 Demonstr					
200.00	Is this the first year of the current 5-year demonstration pe	riod under t	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					-
	Cost Reimbursement					ļ
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 00

74.01	Balance due provider/program-PARHM (see instructions)				74. 01
75.00	Protested amounts (nonallowable cost report items) in accordance with			5, 739, 238	75. 00
	CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				1
90.00				0	90.00
	plus 2.04 (see instructions)				
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)			0	
93. 00	Capital outlier reconciliation adjustment amount (see instructions)			o o	
94. 00				1	94.00
				0.00	
				1	
96. 00	Time value of money for capital related expenses (see instructions)		TD 1 1 40/4	0	96. 00
			Prior to 10/1		
			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				1
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
	HRR adjustment amount for HSP bonus payment (see instructions)		0	l .	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment		<u> </u>		1.000
200 00	Is this the first year of the current 5-year demonstration period under the 21st				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
					1
201 00	Cost Reimbursement		T		201 00
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201. 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	: 5-year demonst	ration	
	peri od)				
	Medicare target amount				204.00
	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				1
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
	Adjustment to Medicare IPPS payments (see instructions)				209. 00
	Reserved for future use				210. 00
	Total adjustment to Medicare IPPS payments (see instructions)				211. 00
211.00	Comparision of PPS versus Cost Reimbursement				1211.00
212 00			T		212 00
	Total adjustment to Medicare Part A IPPS payments (from line 211)				212. 00
	Low-volume adjustment (see instructions)			i	213. 00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimburseme	nτ)		1	218. 00
	(line 212 minus line 213) (see instructions)			l	

Provider CCN: 14-0186

				Title	XVIII	Hospi tal	5/26/2022 10: PPS	37 am
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		5.00	1.0
	payments			]				
1.01	DRG amounts other than outlier	1. 01	27, 023, 898	0	27, 023, 898		27, 023, 898	1. 0
	payments for discharges occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	8, 895, 298	o		8, 895, 298	8, 895, 298	1. 0.
	payments for discharges		2, 212, 213	]		2, 212, 213	2, 212, 212	
	occurring on or after October							
1 00	1 DDC for Fodorel file	1.00		0	0		0	1
1. 03	DRG for Federal specific operating payment for Model 4	1. 03	0	U	0		0	1.0
	BPCI occurring prior to							
	October 1							
1. 04	DRG for Federal specific	1. 04	0	0		0	0	1.0
	operating payment for Model 4 BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 0
	discharges (see instructions)							
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 0
2. 02	Outlier payments for	2. 03	135, 268	0	135, 268		135, 268	2.0
	discharges occurring prior to			]	,			
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	49, 132	0		49, 132	49, 132	2.0
	discharges occurring on or after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	o	0	0	0	3. 0
4 00	reconciliation	0.00	45 475 070		44 540 007	0.050.450	45 4/5 070	
4. 00	Managed care simulated payments	3. 00	15, 465, 978	0	11, 512, 326	3, 953, 652	15, 465, 978	4.0
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 077330	0. 077330	0. 077330	0. 077330		5.0
	A, line 21 (see instructions)	22.00	1 405 070		1 117 202	2/7 77/	1 405 070	, ,
6. 00	IME payment adjustment (see instructions)	22. 00	1, 485, 079	0	1, 117, 303	367, 776	1, 485, 079	6.0
6. 01	IME payment adjustment for	22. 01	639, 441	o	475, 977	163, 464	639, 441	6.0
	managed care (see							
	instructions) Indirect Medical Education Adju	istment for the	Add on for Co	otion 100 of th	a a MMA			
7. 00	IME payment adjustment factor	27.00	0. 000000	0.000000	0.000000	0. 000000		7.0
	(see instructions)							
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 0
0 01	instructions)	28. 01	0	0	0	0	0	
8. 01	IME payment adjustment add on for managed care (see	20.01	U	o o	U	U	0	8. 0
	instructions)							
9.00	Total IME payment (sum of	29. 00	1, 485, 079	0	1, 117, 303	367, 776	1, 485, 079	9. 0
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	639, 441	0	475, 977	163, 464	639, 441	9.0
9.01	care (sum of lines 6.01 and	29.01	037, 441	o o	4/3, 9//	103, 404	037, 441	7.0
	8. 01)							
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1996	0. 1996	0. 1996	0. 1996		10. 0
	instructions)							
11.00	Di sproporti onate share	34.00	1, 792, 368	О	1, 348, 493	443, 875	1, 792, 368	11. 0
	adjustment (see instructions)			_				
11. 01	Uncompensated care payments  Additional payment for high per	36.00	1, 503, 392	0	1, 147, 834	355, 558	1, 503, 392	11. 0 
12. 00	Total ESRD additional payment	46. 00		ui schar ges 0	0	0	0	12. 0
50	(see instructions)			Ĭ	Ö			3
13. 00	Subtotal (see instructions)	47. 00	40, 884, 435	0	30, 772, 796	10, 111, 639	40, 884, 435	
14. 00	Hospital specific payments	48. 00	0	0	0	0	0	14. 0
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	41, 523, 876	0	31, 248, 773	10, 275, 103	41, 523, 876	15.0
	operating costs (see							
14 00	instructions)	EO 00	2 104 200		0 051 000	750 250	2 104 200	1, ^
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	3, 104, 290	0	2, 351, 932	752, 358	3, 104, 290	16.0
	100p. car (110m mot. L, 11. 1,		1					I
	if applicable)			l				

						rom 01/01/2021 o 12/31/2021	Part A Exhibi Date/Time Pre 5/26/2022 10:	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for	54.00	215, 710	0	116, 806	98, 904	215, 710	17. 00
	new technologies							
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	o	0	l c	0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	o	0		0	0	18. 00
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	33, 717, 511	11, 126, 365	44, 843, 876	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	2, 741, 809	0	2, 076, 099	665, 710	2, 741, 809	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	26, 061	0	21, 096	4, 965	26, 061	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	O	0	l c	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0443	0. 0443	0. 0443	0. 0443		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	121, 462	0	91, 971	29, 491	121, 462	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0784	0. 0784	0. 0784	0. 0784		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11.00	214, 958	0	162, 766	52, 192	214, 958	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12.00	3, 104, 290	0	2, 351, 932	752, 358	3, 104, 290	26. 00
	payments (see instructions)							
		· ·	(Amounts to E,					
		line	Part A)					
	1	0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 000000			27. 00
28. 00	Low volume adjustment	70. 96			C	)	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
400	Pt. A, line)							
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.							I

From 01/01/2021 Part A Exhibit 5 Date/Time Prepared: 12/31/2021 5/26/2022 10:37 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 27, 023, 898 27, 023, 898 27, 023, 898 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 8, 895, 298 8, 895, 298 8, 895, 298 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 135, 268 2 02 Outlier payments for discharges occurring 2 03 135, 268 135, 268 2 02 prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring on 2.04 49, 132 49, 132 49, 132 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 15, 465, 978 11, 512, 326 3. 953. 652 15, 465, 978 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.077330 0.077330 0.077330 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 1, 485, 079 1, 117, 303 367, 776 1, 485, 079 6.00 IME payment adjustment for managed care (see 639, 441 6.01 22.01 639, 441 475, 977 163, 464 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 1, 485, 079 1, 117, 303 367, 776 1, 485, 079 9.00 Total IME payment for managed care (sum of 9.01 29.01 639, 441 475, 977 163, 464 639, 441 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1996 0.1996 0.1996 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1, 792, 368 1.348.493 443.875 1, 792, 368 11.00 instructions) 11.01 1,503,392 Uncompensated care payments 36, 00 1, 147, 834 355, 558 1,503,392 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 40, 884, 435 30, 772, 796 10, 111, 639 Subtotal (see instructions) 40, 884, 435 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 41, 523, 876 31, 248, 773 10, 275, 103 41, 523, 876 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 3, 104, 290 2, 351, 932 752, 358 3, 104, 290 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 215, 710 116, 806 98, 904 215, 710 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 C 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 C 0 18.00 amount (see instructions) 33, 717, 511 19.00 SUBTOTAL 11, 126, 365 44, 843, 876 19.00

Health Financial Systems	RIVERSIDE MEDIC	AL CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CC	N: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/26/2022 10:3	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				

				-	To 12/31/2021	Date/Time Pre 5/26/2022 10:	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	2, 741, 809	2, 076, 09	9 665, 710	2, 741, 809	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	26, 061	21, 09	4, 965	26, 061	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	5. 00	0. 0443	0. 0443	0. 0443		22. 00
00.00	instructions)		404 440	04.07	1 00 404	404 4/0	00.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	121, 462	91, 97	29, 491	121, 462	23. 00
24. 00	Allowable disproportionate share percentage	10. 00	0. 0784	0. 078	0. 0784		24. 00
	(see instructions)						
25. 00	Disproportionate share adjustment (see	11. 00	214, 958	162, 76	52, 192	214, 958	25. 00
26. 00	instructions) Total prospective capital payments (see	12.00	3, 104, 290	2, 351, 93:	752, 358	3, 104, 290	26. 00
20.00	instructions)	12.00	3, 104, 290	2, 331, 43.	2 752, 556	3, 104, 290	20.00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2. 00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0		O	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-16, 109	-16, 10	9 0	-16, 109	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0		0	0	30. 01
	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-747, 111	-564, 52	-182, 583	-747, 111	
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	(	0	0	31. 01
	instructions)					(A+ +- WI+	
						(Amt. to Wkst. E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0	0	32. 00
100 00	Transfer HAC Reduction Program adjustment to		N				100. 00
100.00	Wkst. E, Pt. A.		14				1.50.00
	1			1	1	ı	1

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared:

		5/26/2022 10:	37 am_
	Title XVIII Hospital	PPS	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	1, 840	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	43, 030, 993	2. 00
3. 00	OPPS payments	39, 817, 557	3. 00
4.00	Outlier payment (see instructions)	9, 125	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions)	0.000	4. 01 5. 00
6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	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 from Wkst. D, Pt. IV, col. 13, line 200	3, 476	9. 00
10.00	Organ acqui si ti ons	0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	1, 840	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12. 00	Reasonable charges Ancillary service charges	12, 135	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	12, 133	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	12, 135	
	Customary charges		
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)	0 000000	47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	
19. 00	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	12, 135 10, 295	
17.00	instructions)	10, 273	17.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
	instructions)		
	Lesser of cost or charges (see instructions)	1, 840	
	Interns and residents (see instructions)	0	22. 00
	Cost of physicians' services in a teaching hospital (see instructions)	20, 020, 150	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  COMPUTATION OF REIMBURSEMENT SETTLEMENT	39, 830, 158	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6, 818, 205	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	33, 013, 793	27. 00
	instructions)		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	457, 574	
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30.00	Subtotal (sum of lines 27 through 29) Primary payer payments	33, 471, 367 3, 462	
	Subtotal (line 30 minus line 31)	33, 467, 905	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
	Allowable bad debts (see instructions)	853, 479	
	Adjusted reimbursable bad debts (see instructions)	554, 761	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	656, 404	
37. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	34, 022, 666 -404	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-404	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions)	34, 023, 070	
40. 01	Sequestration adjustment (see instructions)	0	
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
	Sequestration adjustment-PARHM pass-throughs  Interim payments	34, 129, 832	40. 03 41. 00
	Interim payments  Interim payments-PARHM	34, 129, 032	41.00
42. 00	Tentative settlement (for contractors use only)	0	42. 00
	Tentative settlement-PARHM (for contractor use only)		42. 01
43.00	Balance due provider/program (see instructions)	-106, 762	
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	735, 798	44. 00
	\$115. 2		
90. 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)	1 0	90. 00
	Outlier reconciliation adjustment amount (see instructions)	0	1
92. 00	The rate used to calculate the Time Value of Money	0.00	
93. 00		0	1
94. 00	Total (sum of lines 91 and 93)	0	94. 00

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0186		Worksheet E
		From 01/01/2021	Part B
	Component CCN: 14-S186	To 12/31/2021	Date/Time Prepared:
	·		5/26/2022 10:37 am
	Title XVIII	Subprovi der -	PPS
		LDE	

	litle XVIII Subprovider -	PPS	
	DADT D. HEDLON, AND OTHER HEALTH CERMINES	1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)	0	1. 00
2.00	Medical and other services (see First detrois)  Medical and other services reimbursed under OPPS (see instructions)	1, 079	
3. 00	OPPS payments	734	
4.00	Outlier payment (see instructions)	0	•
4.01	Outlier reconciliation amount (see instructions)	0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	
6.00	Line 2 times line 5	0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0. 00 0	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9. 00
10. 00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12 00	Reasonable charges	0	12.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	0	
	Customary charges	-	
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18. 00	Total customary charges (see instructions)	0.000000	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19. 00
	instructions)		l
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21 00	instructions)	0	21. 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)	0	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	734	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	147 587	
27.00	instructions)	567	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30.00	Subtotal (sum of lines 27 through 29)	587	30.00
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)	0 587	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	567	32.00
33. 00		0	33. 00
34.00	Allowable bad debts (see instructions)	0	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)	0	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	587	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)	587 0	40. 00 40. 01
40. 01	Demonstration adjustment amount after sequestration	0	•
40. 03	Sequestration adjustment-PARHM pass-throughs	_	40. 03
41.00	Interim payments	587	41. 00
41. 01	Interim payments-PARHM	_	41. 01
42.00	Tentative settlement (for contractors use only)	0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	0	42. 01 43. 00
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
	§115. 2		l
00.00	TO BE COMPLETED BY CONTRACTOR		00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0	
91.00	The rate used to calculate the Time Value of Money		91.00
93. 00	Time Value of Money (see instructions)	0.00	
94. 00	Total (sum of lines 91 and 93)	0	94. 00

Health Financial Systems RIV
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-0186

			'	12, 01, 2021	5/26/2022 10: 3	37 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		41, 336, 336	5	34, 129, 832	1. 00
2.00	Interim payments payable on individual bills, either		(		o	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(	1	0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER					3. 01
3. 02						3. 02
3. 04						3. 04
3. 05						3. 04
3.03	Provider to Program			7	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51	7.65 CO TIME TO THOUSAND				0	3. 51
3. 52					l ol	3. 52
3. 53					l ol	3. 53
3.54			Ċ		o	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		Ċ		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		41, 336, 336	5	34, 129, 832	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			T		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 01	Program to Provider TENTATIVE TO PROVIDER			<u></u>	0	E 01
5. 01 5. 02	TENTATIVE TO PROVIDER		(			5. 01 5. 02
5. 02						5. 02
5.03	Provider to Program			<u>/ </u>	U	5.03
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51	TENTATI VE TO TROGITAM					5. 51
5. 52					l ől	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				Ö	5. 99
	5. 50-5. 98)		]			
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		408, 499		0	6. 01
6.02	SETTLEMENT TO PROGRAM		(		106, 762	6. 02
7.00	Total Medicare program liability (see instructions)		41, 744, 835	5	34, 023, 070	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Provider CCN: 14-0186 Component CCN: 14-S186 Title XVIII

		Title	XVIII	Subprovi der - I PF	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 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 315, 872 0		587 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3.05
	Provider to Program			1		
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	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 appropriate) TO BE COMPLETED BY CONTRACTOR		1, 315, 872		587	4. 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
5. 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 01	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
5. 05	Provider to Program		· · · · · ·			5. 05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		o	5. 51
5. 52			0		o	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 the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		33, 657		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 349, 529		587	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor			l		8. 00

Provider CCN: 14-0186 Component CCN: 14-T186 Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I=	1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		11, 423, 310 0		0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0	)	0	3. 02
3.03			0	)	0	3. 03
3.04			0	)	0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	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 appropriate) TO BE COMPLETED BY CONTRACTOR		11, 423, 310		0	4. 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
E 04	Program to Provider					E 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0			5. 02 5. 03
5.03	Provider to Program				0	3.03
5. 50	TENTATI VE TO PROGRAM		0	1	0	5. 50
5. 51	TENTALL TO TROOTOUM		0		0	5. 51
5. 52			Ö			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 the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		17, 162		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		Ö	6. 02
7. 00	Total Medicare program liability (see instructions)		11, 440, 472		Ö	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems RIVERSIDE MEDICA	AL CENTER	Inlie	u of Form CMS-:	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 14-0186  Peri od: From 01/01/2021 To 12/31/2021 55				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	-			1. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				3. 00
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
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 l				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10. 00		(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	ine 31) (see instruction	s)		32. 00

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0186	Peri od:	Worksheet E-3
		From 01/01/2021	
	Component CCN: 14-S186	To 12/31/2021	
			5/26/2022 10:37 am
	Title XVIII	Subprovi der -	PPS
		I PF	

		. I PF		
			1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1, 419, 604	1.00
2.00	Net IPF PPS Outlier Payments		8, 641	2. 00
3.00	Net IPF PPS ECT Payments		4, 560	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or bef	ore November	0.00	4. 00
	15, 2004. (see instructions)			
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were		0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustme	nt under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			
5. 00	New Teaching program adjustment. (see instructions)		0.00	
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth per	iod of a "new	0. 00	6. 00
7 00	teaching program" (see instuctions)		0.00	7 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth per	rod or a new	0.00	7. 00
8. 00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8. 00
9. 00	Average Daily Census (see instructions)		8. 542466	
10. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		0. 000000	1
11. 00	Teaching Adjustment (line 1 multiplied by line 10).		0.000000	ı
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1, 432, 805	
13. 00	Nursing and Allied Health Managed Care payment (see instruction)		1, 432, 663	1
14. 00	Organ acqui si ti on (DO NOT USE THIS LINE)			14. 00
	Cost of physicians' services in a teaching hospital (see instructions)		0	ı
16. 00	Subtotal (see instructions)		1, 432, 805	
17. 00	Primary payer payments		0	1
18. 00			1, 432, 805	1
	Deducti bl es		100, 608	
20.00			1, 332, 197	
21. 00	Coinsurance		16, 324	1
22. 00			1, 315, 873	1
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		51, 778	1
24.00	Adjusted reimbursable bad debts (see instructions)		33, 656	24. 00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		44, 869	25. 00
26.00	Subtotal (sum of lines 22 and 24)		1, 349, 529	26. 00
27.00	Direct graduate medical education payments (see instructions)		0	27. 00
28.00	Other pass through costs (see instructions)		0	28. 00
29.00	Outlier payments reconciliation		0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30. 50
30. 98	Recovery of accelerated depreciation.		0	30. 98
30. 99	Demonstration payment adjustment amount before sequestration		0	
	Total amount payable to the provider (see instructions)		1, 349, 529	1
31. 01	Sequestration adjustment (see instructions)		0	
31. 02	Demonstration payment adjustment amount after sequestration		0	
	Interim payments		1, 315, 872	1
33. 00	, , , , , , , , , , , , , , , , , , , ,		0	
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		33, 657	
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, ch	apter 1,	4, 375	35. 00
	§115. 2			
F0 00	TO BE COMPLETED BY CONTRACTOR		0 (11	F0 00
	Original outlier amount from Worksheet E-3, Part II, line 2		8, 641	
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	•
53. 00	Time Value of Money (see instructions)	OF THE COVED 10	0	53. 00
99. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE ENDI- Teaching Adjustment Factor for the cost reporting period immediately preceding February		0. 000000	99. 00
	Calculated Teaching Adjustment Factor for the cost reporting period immediately preceding February	∠7, ∠U∠U.	0. 000000	1
99. U I	positionated resolving Adjustillent ractor for the current year. (see instructions)	l	0.000000	J 99. U I

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0186	Peri od:	Worksheet E-3
		From 01/01/2021	Part III
	Component CCN: 14-T186	To 12/31/2021	Date/Time Prepared:
	·		5/26/2022 10:37 am
	Title XVIII	Subprovi der -	PPS
		IRF	

	. I RF		
		1 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1. 00	
1.00	Net Federal PPS Payment (see instructions)	10, 986, 136	1. 00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0148	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	236, 202	3. 00
4.00	Outlier Payments	347, 879	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were 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	0.00	7. 00
8.00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
0.00	teaching program" (see instructions)	0.00	0.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10. 00 11. 00	Average Daily Census (see instructions) Teaching Adjustment Factor (see instructions)	23. 301370 0. 000000	10. 00 11. 00
12. 00	Teaching Adjustment (see instructions)	0.000000	12. 00
13. 00	Total PPS Payment (see instructions)	11, 570, 217	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00
15. 00	Organ acqui si ti on (DO NOT USE THIS LINE)	_	15. 00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	11, 570, 217	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	11, 570, 217	19. 00
20. 00	Deducti bl es	143, 644	
21. 00	Subtotal (line 19 minus line 20)	11, 426, 573	
22. 00	Coi nsurance	5, 565	
23. 00	Subtotal (line 21 minus line 22)	11, 421, 008	
24. 00 25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29, 945 19, 464	24. 00 25. 00
26. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	21, 509	
27. 00	Subtotal (sum of lines 23 and 25)	11, 440, 472	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	11, 440, 472	28. 00
29. 00	Other pass through costs (see instructions)	Ö	29. 00
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	Demonstration payment adjustment amount before sequestration	0	31. 9
32. 00	Total amount payable to the provider (see instructions)	11, 440, 472	32.00
32. 01	Sequestration adjustment (see instructions)	0	32. 0
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 0
33. 00	Interim payments	11, 423, 310	33.00
34.00	Tentative settlement (for contractor use only)	17 1/2	34. 00 35. 00
35. 00 36. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	17, 162 2, 097	36. 00
30.00	§115. 2	2,071	30. 00
50. 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4	347, 879	50 00
51. 00	Outlier reconciliation adjustment amount (see instructions)	347, 879	50. 00 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)	0.00	53. 00
55. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19		55.00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	99. 00
99. 01		0. 000000	
		•	

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT LL EDUCATION COSTS	Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Preps/26/2022 10:3	pared:
		Title	e XVIII	Hospi tal	PPS	57 dili
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	0. 00	1.00
00 00	Unweighted FTE resident cap add-on for new programs per 42 CFI Amount of reduction to Direct GME cap under section 422 of MM.		1) (see instr	uctions)	18. 42 0. 00	2. 0 3. 0
01	Direct GME cap reduction amount under ACA §5503 in accordance		8 §413.79 (m).	(see	0.00	3.0
00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0.00	4. 0
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0. 00	4. 0
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot:	s (see inst	ructions for	cost reporting	1. 00	4. 0
. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	us or minus	line 4 plus l	ines 4.01 and	19. 42	5. 00
. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	21. 33	6. 00
. 00	records (see instructions) Enter the lesser of line 5 or line 6				19. 42	7. 0
			Primary Care		Total	
.00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2. 00	3. 00 18. 13	8. 0
	program for the current year.					
.00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount 6.		13.5	8 2.92	16. 50	9. 0
0. 00	Weighted dental and podiatric resident FTE count for the curre			0.00		10.0
0. 01 1. 00	Unweighted dental and podiatric resident FTE count for the cultotal weighted FTE count	rrent year	13.5	0.00		10. 0 11. 0
2. 00	Total weighted FIE count Total weighted resident FTE count for the prior cost reporting instructions)	g year (see	13. 3			12. 0
3. 00	Total weighted resident FTE count for the penultimate cost relyear (see instructions)	porti ng	13. 2	9 3. 98		13. 0
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	13. 4			14. 0
5. 00	Adjustment for residents in initial years of new programs		0.0			15.0
5. 01	Unweighted adjustment for residents in initial years of new p		0.0			15.0
6. 00	Adjustment for residents displaced by program or hospital close		0.0			16.0
6. 01	Unweighted adjustment for residents displaced by program or help closure	ospi tai	0.0	0.00		16. 0
7.00	Adjusted rolling average FTE count Per resident amount		13.4			17. 0 18. 0
8. 00 9. 00	Approved amount for resident costs		111, 627. 6 1, 498, 04	·	1, 902, 135	
0.00	Additional unweighted allopathic and osteopathic direct GME F	TE rosidont	can slots roc	oi vod under 42	1. 00	20. 0
0.00	Sec. 413.79(c)(4)	ie resident	cap siots rec	erved under 42	0.00	20.0
		ctions)			1. 91	
	Direct GME FTE unweighted resident count over cap (see instru					
2. 00	Allowable additional direct GME FTE Resident Count (see instru	uctions)			0. 00	
2. 00 3. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident au	uctions)	nstructions)		0. 00	23. 0
2. 00 3. 00 4. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident au Multiply line 22 time line 23	uctions)	nstructions)		0. 00 0	23. 0 24. 0
2. 00 3. 00 4. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident au Multiply line 22 time line 23	uctions)	Inpatient Par	t Managed Care	0. 00	23. 00 24. 00
2. 00 3. 00 4. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident au Multiply line 22 time line 23	uctions)		t Managed Care	0. 00 0 1, 902, 135	23. 00 24. 00
2. 00 3. 00 4. 00 5. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident and Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)  COMPUTATION OF PROGRAM PATIENT LOAD	uctions) mount (see i	Inpatient Par A 1.00	2.00	0. 00 0 1, 902, 135 Total	23. 0 24. 0 25. 0
2. 00 3. 00 4. 00 5. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident au Multiply line 22 time line 23  Total direct GME amount (sum of lines 19 and 24)	uctions) mount (see i	Inpatient Par A	2.00	0. 00 0 1, 902, 135 Total	23. 0 24. 0 25. 0
2. 00 3. 00 4. 00 5. 00 6. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident and Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)  COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part II 3.02, column 2) Total Inpatient Days (see instructions)	uctions) mount (see i	Inpati ent Par A 1.00 21,75 57,84	2. 00 0 7, 037 0 57, 840	0. 00 0 1, 902, 135 Total	23. 0 24. 0 25. 0 26. 0 27. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident and Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)  COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part II 3.02, column 2) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days	uctions) mount (see i	Inpati ent Par A 1.00 21,75 57,84 0.37603	2. 00 7, 037 0 57, 840 7 0. 121663	0. 00 0 1, 902, 135 Total 3. 00	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident and Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)  COMPUTATION OF PROGRAM PATIENT LOAD  Inpatient Days (see instructions) (Title XIX - see S-2 Part II 3.02, column 2) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount	uctions) mount (see i	Inpati ent Par A 1.00 21,75 57,84	2.00 0 7,037 0 57,840 7 0.121663 3 231,419	0. 00 0 1, 902, 135 Total	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 01	Allowable additional direct GME FTE Resident Count (see instruenter the locality adjustment national average per resident and Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)  COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part II 3.02, column 2) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days	uctions) mount (see i	Inpati ent Par A 1.00 21,75 57,84 0.37603	2. 00 7, 037 0 57, 840 7 0. 121663	0. 00 0 1, 902, 135 Total 3. 00	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 0

	Financial Systems RIVERSIDE MEDIC			u of Form CMS-2			
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 14-0186	Peri od: From 01/01/2021	Worksheet E-4			
MEDI CA	AL EDUCATION COSTS		To 12/31/2021	Date/Time Pre 5/26/2022 10:			
		Title XVIII	Hospi tal	PPS			
				1. 00			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONLY (NURSING PR	OGRAM AND PARAMED	OI CAL			
32.00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00		
	and 94)						
33. 00			74 and 94)	0			
	Ratio of direct medical education costs to total charges (lin	ne 32 ÷ line 33)		0.000000			
	Medicare outpatient ESRD charges (see instructions)			0			
36. 00	Medicare outpatient ESRD direct medical education costs (line		0	36.00			
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY					
	Part A Reasonable Cost						
37. 00	1 ( (			45, 172, 887			
38. 00				0	38. 00		
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00		
	Primary payer payments (see instructions)			38, 635	1		
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	ıs line 40)		45, 134, 252	41.00		
	Part B Reasonable Cost						
	Reasonable cost (see instructions)			43, 055, 976			
43.00				3, 462			
44.00				43, 052, 514			
	Total reasonable cost (sum of lines 41 and 44)			88, 186, 766			
	Ratio of Part A reasonable cost to total reasonable cost (lin			0. 511803			
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 488197	47. 00		
40.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	KI R		027 070	40.00		
	Total program GME payment (line 31)			937, 273			
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			479, 699			
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)	l	457, 574	50.00		

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

Provider CCN: 14-0186 Period From 0

oni y)				10 12/01/2021	5/26/2022 10:	37 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	131, 910, 792		0	0	
2. 00 3. 00	Temporary investments				0	
4. 00	Notes recei vabl e Accounts recei vabl e	29, 772, 688	1	1		
5. 00	Other recei vable	2, 569, 588			ا	
6. 00	Allowances for uncollectible notes and accounts receivable	0		o o	Ō	
7.00	Inventory	8, 566, 076		0	0	
8.00	Prepai d expenses	6, 377, 304	. (	0	0	
9.00	Other current assets	000000000000000000000000000000000000000		0	0	
10.00	Due from other funds Total current assets (sum of lines 1-10)	32, 025, 682		0	0	1
11. 00	FIXED ASSETS	211, 222, 130	1	<u>)</u>		11. 00
12. 00	Land	8, 108, 094	. (	0	0	12. 00
13. 00	Land improvements	7, 012, 527		o o		
14.00	Accumulated depreciation	-2, 474, 924	1	0	0	14. 00
15. 00	Bui I di ngs	298, 823, 800	1	0	0	
16. 00	Accumulated depreciation	-140, 437, 264	1	0	0	
17. 00	Leasehold improvements	7, 992, 529	1	1	0	
18. 00 19. 00	Accumulated depreciation			1	0	
20. 00	Fixed equipment Accumulated depreciation					
21. 00	Automobiles and trucks				Ö	
22. 00	Accumulated depreciation			o o	0	
23.00	Maj or movable equipment	202, 641, 840	) (	0	0	23. 00
24. 00	Accumulated depreciation	-134, 169, 995	5 (	0	0	
25.00	Mi nor equi pment depreci abl e	0	) (	0	0	
26. 00	Accumulated depreciation	0		0	0	
27. 00	HIT designated Assets			0	0	
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable		1			
30. 00	Total fixed assets (sum of lines 12-29)	247, 496, 607	1			
00.00	OTHER ASSETS	21171707001	`	<u>,                                      </u>		- 00.00
31.00	Investments	355, 999, 071	(	0	0	31.00
32.00	Deposits on Leases	0	) (	0	-	
33. 00	Due from owners/officers	0	)	1	0	1
34. 00	Other assets	13, 586, 001		1	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	369, 585, 072 828, 303, 809	1		0	
30.00	CURRENT LIABILITIES	020, 303, 007		<u> </u>		30.00
37. 00	Accounts payable	4, 723, 381		0	0	37. 00
38. 00	Salaries, wages, and fees payable	32, 683, 023		0	0	38. 00
39. 00	Payroll taxes payable	C	1	0	0	
40.00	Notes and Loans payable (short term)	6, 080, 330	) (	0	0	
41.00	Deferred income	0		0	0	
42. 00 43. 00	Accel erated payments Due to other funds				0	42.00
44. 00	Other current liabilities	63, 870, 198				
45. 00	Total current liabilities (sum of lines 37 thru 44)	107, 356, 932	1			
	LONG TERM LIABILITIES			-		1
46.00	Mortgage payable	0	) (	0	0	46. 00
47.00	Notes payable	128, 083, 588	3	0		
48. 00	Unsecured Loans	0		0	-	
49. 00	Other long term liabilities	46, 776, 382		0	1	
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	174, 859, 970		0		
31.00	CAPITAL ACCOUNTS	282, 216, 902	:	<u>)</u>		31.00
52.00	General fund balance	546, 086, 907	1			52. 00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56. 00	Governing body created - endowment fund balance			0	_	56. 00
57. 00	Plant fund balance - invested in plant		1		0	1
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion		1		0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	546, 086, 907	,	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	828, 303, 809		o o	Ö	
	59)					

Provi der CCN: 14-0186

| Period: | Worksheet G-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					То	12/31/2021	Date/Time Prep 5/26/2022 10:3	oared: 37 am
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) INCREASE IN NET ASSETS WITHOUT RESTR INCREASE IN PERMANENTLY RESTRICTED N	351, 844 427, 875 0 0	498, 052, 536 47, 254, 652 545, 307, 188		0 0 0	C	0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0	779, 719 546, 086, 907		0 0 0 0 0 0	C	0 0 0 0	13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 546, 086, 907		0	C	0	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) INCREASE IN NET ASSETS WITHOUT RESTR INCREASE IN PERMANENTLY RESTRICTED N	0	0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	0 0 0 0 0		0 0			9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0186

			Γο 12/31/2021	Date/Time Pre 5/26/2022 10:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	<b>'</b>	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				1
1.00	Hospi tal	47, 204, 129	9	47, 204, 129	1.00
2.00	SUBPROVI DER - I PF	3, 940, 340	)	3, 940, 340	2. 00
3.00	SUBPROVI DER - I RF	7, 694, 14:	3	7, 694, 143	3. 00
4.00	SUBPROVI DER		o	0	4. 00
5.00	Swi ng bed - SNF	(	o	0	5. 00
6.00	Swing bed - NF		O	0	6.00
7.00	SKILLED NURSING FACILITY				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)	58, 838, 61	2	58, 838, 612	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	7, 947, 50	9	7, 947, 509	11. 00
12.00	CORONARY CARE UNIT		D	0	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	7, 947, 50	9	7, 947, 509	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	66, 786, 12		66, 786, 121	17. 00
18. 00	Ancillary services	331, 373, 18			18. 00
19. 00	Outpati ent servi ces	21, 452, 210			
20. 00	RURAL HEALTH CLINIC		387, 825	387, 825	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		4, 612, 367	4, 612, 367	22. 00
23. 00	AMBULANCE SERVICES	116, 63	7 10, 164, 224	10, 280, 861	
24. 00	CMHC				24. 00
24. 10	CORF		0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PHYSI CI AN REVENUE		105, 823, 135		27. 00
27. 01	JOINT VENTURE REVENUE & CARE-A-VAN		13, 153, 335		27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 419, 728, 15	1, 040, 511, 836	1, 460, 239, 989	28. 00
	G-3, line 1)				
00.00	PART II - OPERATING EXPENSES		204 404 047		00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)	0.004.70	394, 184, 067		29. 00
30.00	MI SCELLANEOUS	3, 224, 78			30.00
31.00					31.00
32. 00					32.00
33. 00					33.00
34. 00			1		34.00
35. 00	Total additions (sum of lines 20 25)		2 224 705		35.00
36.00	Total additions (sum of lines 30-35)	1	3, 224, 785		36.00
37. 00 38. 00	DEDUCT (SPECI FY)				37. 00 38. 00
38.00					38.00
40. 00					40.00
					40.00
41. 00 42. 00	Total deductions (sum of lines 37-41)	'	<u></u>		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(training expenses)	efor	397, 408, 852		42.00
43.00	to Wkst. G-3, line 4)	121 61	371, 408, 852		43.00
	10 ms. 0 0, 1116 4)	I	1	ı	I

Heal th	Financial Systems RIVER	RSIDE MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 14-0186	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 10:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, col	umn 3 line 28)		1, 460, 239, 989	1. 00
2.00	Less contractual allowances and discounts on patier			1, 064, 173, 657	2. 00
3.00	Net patient revenues (line 1 minus line 2)	TES GOODANTES		396, 066, 332	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part	t II line 43)		397, 408, 852	
5. 00	Net income from service to patients (line 3 minus I			-1, 342, 520	
	OTHER I NCOME			., , , , , , , ,	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous com	nmunication services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies	to other than patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18. 00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and cant	teen		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 REVENUE			4, 021, 515	24.00
	NON OPERATING INCOME			35, 969, 013	24. 01
	FINANCE RECLASS			2, 611	
24. 50	COVI D-19 PHE Fundi ng			8, 604, 014	
25 00	Total ather income (sum of lines 4 24)	40 507 152	25 00		

8, 604, 014 24. 50 48, 597, 153 25. 00

47, 254, 633 26. 00 -19 27. 00 -19 28. 00

47, 254, 652 29. 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 ROUNDING

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)

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

43, 706

0

3, 370, 963

O

0

3, 370, 963

23 00

23.50

24.00

0

0

All Others (specify)

24.00 Total (sum of lines 1-23)

Tel emedi ci ne

23.00

23. 50

Heal th	Financial Systems		RIVERSIDE MEDI	CAL CENTER		In Lie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 14-0186	Peri od: From 01/01/2021	Worksheet H-1 Part I	
				HHA CCN:	14-7400	To 12/31/2021	Date/Time Pre	pared:
						Home Health	5/26/2022 10: PPS	37 am
			C: +-  D- -		1	Agency I		
			Capital Rela	itea Costs				
		Net Expenses	Bl dgs &	Movabl e	Plant	Transportati on	Subtotal	
		for Cost Allocation	Fi xtures	Equi pment	Operation 8 Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		col . 10) 0	1. 00	2. 00	3.00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable	0		0			0	2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3. 00
4.00	Transportati on	Ö	O	Ö		0 0		4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	1, 155, 434	0	0		0 0	1, 155, 434	5.00
6. 00	Skilled Nursing Care	1, 045, 778	0	0		0 0	1, 045, 778	6. 00
7.00	Physi cal Therapy	864, 456		0	1	0 0	864, 456	
8. 00 9. 00	Occupational Therapy Speech Pathology	140, 797 4, 084	0	0		0 0	140, 797 4, 084	1
10. 00	Medical Social Services	35, 179	0	0		0 0	35, 179	1
11. 00 12. 00	Home Health Aide Supplies (see instructions)	27, 895 93, 669		0		0 0		11. 00 12. 00
13. 00	Drugs	3, 671	0	0		0	3, 671	1
14. 00	DME	0	0	0		0 0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0		0 0	0	16. 00
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19. 00	Health Promotion Activities	Ö	Ö	Ö		0 0	Ö	1
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0	1	0 0	0	
22. 00	Homemaker Service	0	0	0	1	0 0	0	1
23. 00	All Others (specify)	0	0	0		0 0	0	
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	3, 370, 963	0	0	1	0 0	0 3, 370, 963	
		Admi ni strati ve						
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2. 00
3. 00	Equipment Plant Operation & Maintenance							3. 00
4. 00	Transportation							4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	1, 155, 434						5.00
6.00	Skilled Nursing Care	545, 390						6. 00
7. 00 8. 00	Physical Therapy Occupational Therapy	450, 828						7. 00 8. 00
9.00	Speech Pathology	73, 428 2, 130						9. 00
10.00	Medical Social Services	18, 346	53, 525					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	14, 548 48, 850						11. 00 12. 00
13. 00	Drugs	1, 914						13. 00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14. 00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16.00	Respiratory Therapy	0						16.00
17. 00 18. 00	Private Duty Nursing Clinic	0	0					17. 00 18. 00
19. 00	Health Promotion Activities	0	0					19. 00
20.00	Day Care Program Home Delivered Meals Program	0	0					20. 00 21. 00
21.00	Homemaker Service	0	0					21.00
23. 00	All Others (specify)	0	0					23. 00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	0	0 3, 370, 963					23. 50 24. 00
		'						

	Financial Systems		RI VERSI DE MED				u of Form CMS-2	
COST A	LLOCATION - HHA STATISTICAL BAS	TS		Provi der C	CN: 14-0186	Peri od: From 01/01/2021	Worksheet H-1 Part II	
				HHA CCN:	14-7400	To 12/31/2021	Date/Time Pre	pared:
						Home Health	5/26/2022 10: PPS	37 am_
						Agency I	113	
		Capital Rel	ated Costs			.,		
		BI dgs &	Movabl e	Pl ant	  Transportatio	onReconciliation	Administrative	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance	_ `		(ACCUM. COST)	
				(SQUARE FEET)				
	CENEDAL CEDVICE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &	0			1	0		1. 00
1.00	Fixtures					0		1.00
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0		0		3. 00
4.00	Transportation (see	0	0	0	)	0		4. 00
5. 00	instructions)	0	0			0 -1. 155. 434	2 215 520	F 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES			0		0 -1, 155, 434	2, 215, 529	5. 00
6.00	Skilled Nursing Care	0	0	0		0 0	1, 045, 778	6.00
7. 00	Physical Therapy	o	0		1		864, 456	1
8.00	Occupational Therapy	0	0	0	1	0 0	140, 797	
9.00	Speech Pathology	0	0	0	)	0	4, 084	9. 00
10.00	Medical Social Services	0	0	0	1	0	35, 179	
11. 00	Home Health Aide	0	0	0		0	27, 895	•
12.00	Supplies (see instructions)	0	0	0		0	93, 669	1
13. 00 14. 00	Drugs DME	0	0	0	l .	0 0	3, 671 0	1
14.00	HHA NONREIMBURSABLE SERVICES	0				0 0		14.00
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	Ö	0	Ö	1	0 0	o	
17.00	Private Duty Nursing	0	0	0	)	0 0	0	17. 00
18.00	Clinic	0	0	0	)	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0		0	0	
20. 00	Day Care Program	0	0	0	l .	0	0	
21. 00	Home Delivered Meals Program	0	0	0	1	0	0	
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0	1	0 0	0	
23. 50	Telemedicine				1	0 0		23. 50
24. 00	Total (sum of lines 1-23)	1 0	0	0		0 -1, 155, 434	2, 215, 529	
25. 00	Cost To Be Allocated (per	0	0	Ö		0	1, 155, 434	
	Worksheet H-1, Part I)	_						
24 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	00	0. 521516	26 00

							5/26/2022 10:3	3/ am
						Home Health	PPS	
			CAPITAL REL	ATED COSTS		Agency I		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	DATA PROCESSI NG	
		0	1. 00	2. 00	4. 00	5. 01	5. 02	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0 1, 591, 168 1, 315, 284 214, 225 6, 214 53, 525 42, 443 142, 519 5, 585 0 0 0 0 0 0 0 0	96, 837 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 318 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	736, 456		489, 312 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.  Cost Center Description	PURCHASI NG	BUSI NESS OFFI CE	Subtotal	GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	
		5. 03	5. 05	5A. 05	5. 06	6. 00	7. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	10, 097 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41, 839 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 397, 543 1, 591, 168 1, 315, 284 214, 225 6, 214 53, 525 42, 443 142, 519 5, 585 0 0 0 0 0 0 0 4, 768, 506 0. 000000	175, 279 28, 548 828 7, 133 5, 656 18, 993 744 0 0 0 0 0 0		82, 209 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 19. 00 19. 00 19. 00 20. 00 21. 00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Homemaker Service All Others (specify) 0 0 19.00 19.00 0 0 0 0 19.50 Tel emedi ci ne 19.50 20.00 20.00 Total (sum of lines 1-19) (2) 13, 731 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

0

0

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14.00

15.00

16.00

17.00

18.00

0

0

0

14.00

15.00

16.00

17.00

18.00

Clinic

Day Care Program

Health Promotion Activities

Home Delivered Meals Program

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 14-0186 Peri od: Worksheet H-2 From 01/01/2021 Part I HHA CCN: 14-7400 12/31/2021 Date/Time Prepared: To 5/26/2022 10:37 am Home Health PPS Agency I Total HHA Cost Center Description Subtotal Intern & Subtotal Allocated HHA Residents Cost A&G (see Part Costs & Post II) Stepdown Adjustments 24. 00 25. 00 26.00 27. 00 28. 00 1.00 Administrative and General 1, 740, 583 1, 740, 583 1.00 1, 803, 211 0 1, 803, 211 821, 593 2, 624, 804 2 00 2 00 Skilled Nursing Care 3.00 Physical Therapy 1, 490, 563 0 1, 490, 563 679, 142 2, 169, 705 3.00 4.00 Occupational Therapy 242, 773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 242, 773 110, 614 353, 387 4.00 Speech Pathology 7, 042 3, 209 10, 251 5 00 7,042 5 00 88, 295 60,658 27, 637 6.00 Medical Social Services 60,658 6.00 7.00 Home Heal th Aide 48, 099 48, 099 21, 915 70, 014 7.00 8.00 Supplies (see instructions) 161, 512 161, 512 73, 589 235, 101 8.00 9.00 6, 329 6, 329 2,884 9, 213 9 00 Drugs 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 0 0 11.00 11.00 0 Respiratory Therapy 0 0 12.00 12.00 0 0 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 0 14.00 Health Promotion Activities 15.00 0 0 15.00 Day Care Program 0 0 0 0 0 0 0 16.00 16, 00 17.00 Home Delivered Meals Program 0 17 00 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 0 0 0 19.00 Tel emedi ci ne 19.50 19.50 0 0 0 Total (sum of lines 1-19) (2) 5, 560, 770 5, 560, 770 1, 740, 583 20.00 5, 560, 770 20.00 Unit Cost Multiplier: column 0.455628 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

			HHA CCN:	14-7400 T	o 12/31/2021	Date/Time Prep 5/26/2022 10:	pared: 37 am
					Home Health Agency I	PPS	
	CAPI TAL REI	ATED COSTS					
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (ACTUAL BEN EFITS)	COMMUNI CATI ONS (PHONES)	DATA PROCESSING (DEVICES)	PURCHASI NG (REQS)	
	1.00	2.00	4.00	5. 01	5. 02	5. 03	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	2, 848 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 274 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	481, 018 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19 19 10 10 10 10 10 10 10 10 10 10	35 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118, 652 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00
	CHARGES)	54.06	5.06	6.00	7 00	LAUNDRY)	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	5. 05 4, 612, 367 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 06 1, 397, 543 1, 591, 168 1, 315, 284 214, 225 6, 214 53, 525 42, 443 142, 519 5, 585 0 0 0 0 0 0 0 4, 768, 506 635, 465 0. 133263		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 00 20. 00 21. 00

Cost Center Description					HHA CCN:	14-7400 10	) 12/31/2021	5/26/2022 10:3	
Cost Center Description   Hauserspin (SQUARE FEET)   MEALS SERVED)   CASETERIA   CHORNES   ADMINISTRATION   CASETERIA   CHORNES   ADMINISTRATION   CASETERIA   CHORNES   COSTOR   COSTOR   COSTOR   CASETERIA   CHORNES   COSTOR   CASETERIA   CHORNES   COSTOR   CASETERIA   CHORNES   CASETERIA   CASETE							Home Health		
COURT FETT   CHAIRS SERVED   CHOURS)   ADMINISTRATION   SERVICES   COSTED   REQUIS   COSTED   REQUIS			HOUGEVEENING	DI ETIDY	045575014	I wilborno		DUARMA OV	
1.00		Cost Center Description							
1.00			(SQUARE FEET)	(MEALS SERVED)	(HUUKS)	ADMINISTRATION		,	
1.00   Administrative and General   2,848   0   10.00   11.00   13.00   14.00   15.00   1.0						(DI DECT NDS		REQUIS.)	
1.00   Administrative and General   2,848   0   0   0   0   0   0   0   0   0						,			
1.00   Admin instrative and General   2.848   0   0   0   0   0   0   0   0   0			9, 00	10.00	11, 00			15. 00	
Physical Therapy	1.00	Administrative and General	2, 848	0					1. 00
4.00	2.00	Skilled Nursing Care	0	0	0	0	0	0	2. 00
Speech Pathology	3.00	Physi cal Therapy	0	0	0	0	0	0	3. 00
Medical Social Services	4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
Nome   Heal th Aide   0		1	0	0	0	0	0	0	
8.00   0		1	0	0			0	0	
0.00   Drugs		II .	0	0	0	0	0	0	
10.00   DME		1 ,	0	0	0	0	0	0	
11.00   Home Dialysis Aide Services   0   0   0   0   0   0   0   11.00		•	0	0		1	0	0	
12.00   Respiratory Therapy   0   0   0   0   0   0   12.00			0	0		1 1	0	0	
13.00   Private Duty Nursing   0   0   0   0   0   0   13.00				0	_	1	0	0	
14.00   Clinic   15.00   Health Promotion Activities   0   0   0   0   0   0   0   0   15.00				0	_	1	0	0	
15. 00   Heal th Promotion Activities   0   0   0   0   0   0   0   0   0			0	0			0		
16.00   Day Care Program			0	0	_	1	0	-	
17. 00   Home Deli vered Meals Program   0   0   0   0   0   0   0   0   0			0	0	Ö	o	0	0	
19.00   All Others (specify)   0   0   0   0   0   0   0   0   0			0	0	O	o	0	0	
19.50   Telemedicine	18.00	Homemaker Service	0	0	0	0	0	0	18. 00
20.00   Total (sum of lines 1-19)   2,848   0   0   0   0   0   0   0   21.00	19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
1.00		Tel emedi ci ne	0	0	0	0	0	0	19. 50
Cost Center Description   MEDICAL RECORDS & LIBRARY (GROSS CHARGES)   TIME)   TIME)		1 .		0	0	0	0	0	
Cost Center Description   MEDICAL RECORDS & LIBRARY (GROSS CHARGES)   LIBRARY (ASSIGNED TIME)   LIBRARY (ASSIGNED TIME)		1		0	0	0	0		
Cost Center Description	22.00	Junit cost muitiplier	20. 526334	0. 000000			0.000000	0. 000000	22.00
RECORDS & LIBRARY (GROSS CHARGES)   Y & FRINGES APPRV (ASSIGNED TIME)   PROGRAM (ASSIGNED TIME)   PROGRAM (ASSIGNED TIME)					TIVILKINS &	KLSTDLNTS			
RECORDS & LIBRARY (GROSS CHARGES)   Y & FRINGES APPRV (ASSIGNED TIME)   PROGRAM (ASSIGNED TIME)   PROGRAM (ASSIGNED TIME)		Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED		
CHARGES         CHARGES         (ASSIGNED TIME)         (ASSIGNED TIME)         (ASSIGNED TIME)         CHARGES         TIME)         TIME         TIME)         TIME)         TIME         TIME)         TIME         TIME)         TIME         TIME)         TIME         TIME         TIME         TIME         TIME <th< td=""><td></td><td>·</td><td></td><td></td><td></td><td></td><td>EDUCATI ON</td><td></td><td></td></th<>		·					EDUCATI ON		
CHARGES   TIME   TIME   TIME   TIME     TIME     TIME     TIME       TIME				(TIME SPENT)					
16.00									
1.00         Administrative and General         4,612,367         0				17 00					
2.00         Skilled Nursing Care         0         0         0         0         0         0         2.00           3.00         Physical Therapy         0 <td>1 00</td> <td>Administrative and General</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1 00</td>	1 00	Administrative and General							1 00
3.00   Physical Therapy		d .		0					
4.00       Occupational Therapy       0       0       0       0       0       4.00         5.00       Speech Pathology       0       0       0       0       0       0       0       0       5.00         6.00       Medical Social Services       0<		Ü		0		1	0		
6.00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0		4. 00
7.00 Home Health Aide	5.00	Speech Pathology	0	0	0	0	0		5. 00
8.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00	Medical Social Services	0	0	0	0	0		6. 00
9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0	0	0		
10.00 DME       0       0       0       0       0       0       10.00         11.00 Home Dialysis Aide Services       0       0       0       0       0       0       0       0       11.00         12.00 Respiratory Therapy       0       0       0       0       0       0       0       0       12.00         13.00 Pri vate Duty Nursing       0       0       0       0       0       0       0       0       0       0       0       0       0       0       13.00       14.00       0       0       0       0       0       0       0       0       0       0       14.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       14.00       0 <td></td> <td></td> <td>0</td> <td>0</td> <td>_</td> <td>1</td> <td>0</td> <td></td> <td></td>			0	0	_	1	0		
11.00       Home Dialysis Aide Services       0       0       0       0       0       11.00         12.00       Respiratory Therapy       0       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0       0       0       0       0       0       0       0       13.00         14.00       Clinic       0       0       0       0       0       0       0       14.00         15.00       Heal th Promotion Activities       0       0       0       0       0       0       0       0       15.00         16.00       Day Care Program       0       0       0       0       0       0       0       0       16.00         17.00       Home Delivered Meals Program       0       0       0       0       0       0       17.00       0       0       17.00       0       17.00       0       17.00       0       18.00       19.00       19.00       19.00       19.00       19.00       19.50       0       0       0       0       0       0       0        0       19.50       0       0       0       0       0       <		0	0	0		1 1	0		
12.00       Respiratory Therapy       0       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0       0       0       0       0       0       0       13.00         14.00       Clinic       0       0       0       0       0       0       0       14.00         15.00       Health Promotion Activities       0       0       0       0       0       0       0       0       15.00         16.00       Day Care Program       0       0       0       0       0       0       0       0       16.00         17.00       Home Delivered Meals Program       0       0       0       0       0       0       0       17.00         18.00       Homemaker Service       0       0       0       0       0       0       17.00         19.00       All Others (specify)       0       0       0       0       0       0       0       19.50         20.00       Total (sum of lines 1-19)       4,612,367       0       0       0       0       0       0       20.00         21.00       Total cost to be allocated       13		1		0		1	-		
13.00     Private Duty Nursing     0     0     0     0     0     0     13.00       14.00     Clinic     0     0     0     0     0     0     14.00       15.00     Heal th Promotion Activities     0     0     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     17.00       19.00     All Others (specify)     0     0     0     0     0     19.00       19.50     Tel emedicine     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     4,612,367     0     0     0     0     0     0     20.00       21.00     Total cost to be allocated     13,731     0     0     0     0     0     0		1		0			ŭ		
14.00     Clinic     0     0     0     0     0     14.00       15.00     Heal th Promotion Activities     0     0     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     19.00       19.50     Tel emedicine     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     4,612,367     0     0     0     0     0     20.00       21.00     Total cost to be allocated     13,731     0     0     0     0     0     21.00			l ő	0		.1	ŭ		
16.00     Day Care Program     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     19.50       19.50     Telemedicine     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     4,612,367     0     0     0     0     0     20.00       21.00     Total cost to be allocated     13,731     0     0     0     0     0     21.00			0	0	O		0		
17. 00     Home Delivered Meals Program     0     0     0     0     0     17. 00       18. 00     Homemaker Service     0     0     0     0     0     0     18. 00       19. 00     All Others (specify)     0     0     0     0     0     0     19. 00       19. 50     Tel emedicine     0     0     0     0     0     19. 50       20. 00     Total (sum of lines 1-19)     4, 612, 367     0     0     0     0     0     20. 00       21. 00     Total cost to be allocated     13, 731     0     0     0     0     0     21. 00	15.00	Health Promotion Activities	0	0	0	0	0		15. 00
18.00     Homemaker Service     0     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     0     19.00       19.50     Tel emedicine     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     4,612,367     0     0     0     0     0     20.00       21.00     Total cost to be allocated     13,731     0     0     0     0     21.00	16. 00	Day Care Program	0	0	0	0	0		16. 00
19.00     All Others (specify)     0     0     0     0     0     19.00       19.50     Tel emedicine     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     4,612,367     0     0     0     0     0     0     20.00       21.00     Total cost to be allocated     13,731     0     0     0     0     0     21.00		S S	0	0	_	1	-		
19.50     Tel emedicine     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     4,612,367     0     0     0     0     0     0     20.00       21.00     Total cost to be allocated     13,731     0     0     0     0     0     21.00		1	0	0	_	1	ŭ		
20.00 Total (sum of lines 1-19)			0	0		1	0		
21.00 Total cost to be allocated 13,731 0 0 0 0 21.00			1 412 247	0	0		0		
				0	0		0	-	
				0 000000	0 000000	0 000000	0 000000		
	00	1	1.002,77		1.000000	1 2.000000	2. 000000	·	00

	Financial Systems    ONMENT OF PATIENT SERVICE COST	·c	RIVERSIDE MED		CN: 14-0186	Period:	u of Form CMS-2 Worksheet H-3	
PPURTI	TONMENT OF PATTENT SERVICE COST	5		HHA CCN:	14-7400	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	pared
				Titl€	e XVIII	Home Health	5/26/2022 10: PPS	37 am
	Cost Contor Decemintion	From Wko+	Facility Coata	Chanad	Total IIIIA	Agency I	Avenage Coet	
	Cost Center Description	From, Wkst. H-2, Part I,	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Visits	Average Cost Per Visit	
		col. 28, line		Costs (from	+ 2)	'	(col. 3 ÷ col.	
		20, 11110	11 2, 141 ( 1)	Part II)	' 2)		4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
- 1	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF TH	E PROGRAM LIN	IITATION COST, OF	2	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
	Skilled Nursing Care	2. 00	2, 624, 804		2, 624, 80	9, 344	280. 91	1. (
00	Physical Therapy	3. 00		C	1		273. 33	
00	Occupational Therapy	4. 00		C			338. 82	
00	Speech Pathology	5. 00		C	10, 25		186. 38	
	Medical Social Services	6. 00			88, 29		3, 678. 96	
00	Home Health Aide	7. 00			70, 01			1
00	Total (sum of lines 1-6)		5, 316, 456	C	1			7.
			.,		Program Visit			
					Pa	art B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1	o Subject to		
					Deducti bl es			
					Coi nsurance			
	Limitation Cost Computation	0	1.00	2. 00	3. 00	4. 00	5. 00	
	Skilled Nursing Care		16984	C	51	11		8.
01	Skilled Nursing Care		28100	C	1			8.
02	Skilled Nursing Care		99914	C	53			8.
	Physical Therapy		16984	C	45			9.
	Physi cal Therapy		28100	C	3, 91			9.
	Physical Therapy		99914	C	42			9.
	Occupational Therapy		16984	C	$\epsilon$	50		10.
	Occupational Therapy		28100	C	47	70		10.
1	Occupational Therapy		99914	C	) 7	72		10.
	Speech Pathology		16984	C		6		11.
. 01	Speech Pathology		28100	C	) 4	12		11.
. 02	Speech Pathology		99914	C		0		11.
	Medical Social Services		16984	C		2		12.
	Medical Social Services		28100	C	) 1	11		12.
. 02	Medical Social Services		99914	C		1		12.
. 00	Home Health Aide		16984	C	) <del>,</del>	78		13.
. 01	Home Health Aide		28100	C	62	20		13.
. 02	Home Health Aide		99914	C	$\epsilon$	53		13.
. 00	Total (sum of lines 8-13)			C	11, 43			14.
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Charges	,	
		Part I, col.	(from Wkst.		Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	Part II) 2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies	8. 00		C			0. 000000	1
. 00	Cost of Drugs	9. 00	9, 213 Program Vi si ts	C	9, 21 Cost of	13 0	0. 000000	16.
			110gram VISITS		Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &		
		4.00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	6.00 OF AGGREGATE F	7.00 PROGRAM COST, A	8.00 GGREGATE OF TH	9.00 E PROGRAM LIN	10.00 ILTATION COST, OF	11. 00	
	BENEFICIARY COST LIMITATION							1
	Cost Per Visit Computation							
	Skilled Nursing Care	0	5, 219			0 1, 466, 069		1.
00	Physical Therapy	0	4, 788			0 1, 308, 704		2.
	Occupational Therapy	0	602			0 203, 970		3.
00	Speech Pathology	0	48			0 8, 946		4.
	Medical Social Services	0	14			0 51, 505		5.
00	Home Health Aide	0	761			0 51, 428		6. 7.
00	Total (sum of lines 1-6)	1 0	11, 432			0 3, 090, 622		

APP0R7	Financial Systems		RIVERSIDE MED	ICAL CENTER		In Lie	u of Form CMS	2552-10
	TIONMENT OF PATIENT SERVICE COST	-S		Provider CO	CN: 14-0186 14-7400	Period: From 01/01/2021 To 12/31/2021	Worksheet H-3 Part I Date/Time Pre	pared:
				Title	XVIII	Home Health	5/26/2022 10: PPS	37 alli
	Cost Center Description					Agency I		
	cost center bescription	6. 00	7.00	8. 00	9. 00	10.00	11.00	
	Limitation Cost Computation	T						
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 00 11. 01 11. 02 12. 00 12. 01 13. 00 13. 01 13. 02	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 02 11. 00 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02
14. 00	Total (sum of lines 8-13)	_						14. 00
		Prog	ram Covered Cha	ırges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
15. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	14, 447	0		0 0	0	15. 00
	Cost of Drugs		0			0	0	
	Cost Center Description	Total Program Cost (sum of cols. 9-10)						-
	PART I - COMPUTATION OF LESSER	12.00 OF AGGREGATE F	PROGRAM COST A	GGREGATE OF TH	F PROGRAM II	MITATION COST OF	?	
	BENEFICIARY COST LIMITATION	- Noonzonie					•	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1, 466, 069						1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	1, 308, 704 203, 970						2.00
4. 00	Speech Pathology	8, 946						4. 00
5.00	Medical Social Services	51, 505						5. 00
6.00	Home Health Aide	51, 428						6. 00
7. 00	Total (sum of lines 1-6)	3, 090, 622						7. 00
	Cost Center Description	12. 00						1
	Limitation Cost Computation	12.00						
0 00	Skilled Nursing Care							8.00
8.00	Skilled Nursing Care							8. 01
8. 01	_							1
8. 01 8. 02	Skilled Nursing Care							8. 02
8. 01 8. 02 9. 00	Skilled Nursing Care Physical Therapy							8. 02 9. 00
8. 01 8. 02 9. 00 9. 01	Skilled Nursing Care Physical Therapy Physical Therapy							8. 02 9. 00 9. 01
8. 01 8. 02 9. 00	Skilled Nursing Care Physical Therapy							8. 02 9. 00 9. 01 9. 02
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 11. 02
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 11. 02	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 11. 02 12. 00
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02
8. 01 8. 02 9. 00 9. 01 10. 00 10. 01 10. 02 11. 00 11. 01 12. 00 12. 01 12. 02 13. 00	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 12. 02 12. 00 12. 01 12. 02 13. 00 13. 01
8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02	Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00

Heal th	Financial Systems		RIVERSIDE MED	I CAL CENTER		In Lie	u of Form CMS-2	2552-10
APPOR	FIONMENT OF PATIENT SERVICE COST	S		Provi der Co		Peri od:	Worksheet H-3	
				HHA CCN:	14-7400	From 01/01/2021 To 12/31/2021	Part II Date/Time Prep 5/26/2022 10:3	
				Title	xVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 250575	0		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 284730	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 160258	0		0 col. 2, line 1	6. 00	5. 00

	Financial Systems RIVERSIDE MEDICA ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CO	`N: 14_0186	Peri od:	eu of Form CMS-2 Worksheet H-4	
ALCUL	ATTON OF THE REINDORSEMENT SETTLEMENT	HHA CCN:	14-7400	From 01/01/2021 To 12/31/2021	Part I-II	pare
		Title	XVIII	Home Health Agency I	PPS	07 0
			D 1 4		rt B	
			Part A	Not Subject to Deductibles & Coinsurance		
			1.00	2. 00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	MARY CHARGES	S			
0 0	Reasonable cost of services (see instructions) Total charges			0 0	l .	1 2
	Customary Charges					
0	Amount actually collected from patients liable for payment for on a charge basis (from your records)	servi ces		0	0	3
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a			0	0	4
0	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 00000	0. 000000	
0	Total customary charges (see instructions)		3. 3300	0 0	0	1
0	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	(complete		0	0	-
0	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	8
0	Primary payer amounts			0 Part A	Part B	(
				Servi ces	Servi ces	
	DADT II COMBUTATION OF HUA DEIMBURGEMENT CETTLEMENT			1. 00	2. 00	
00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)				0	1
00	Total PPS Reimbursement - Full Episodes without Outliers				1	
	Total PPS Reimbursement - Full Episodes with Outliers			(	102, 102	
00	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				39, 426 2, 975	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				42, 992	
00	Total PPS Outlier Reimbursement - PEP Episodes				0	
00	Total Other Payments				o o	1
00	DME Payments					18
00	Oxygen Payments				0	10
00	Prosthetic and Orthotic Payments			(	0	20
00	Part B deductibles billed to Medicare patients (exclude coinsu	ırance)			0	2
00	Subtotal (sum of lines 10 thru 20 minus line 21)			(	2, 518, 862	2:
00	Excess reasonable cost (from line 8)			(	0	23
00	Subtotal (line 22 minus line 23)			(	2, 518, 862	
00	Coinsurance billed to program patients (from your records)				0	2
00	Net cost (line 24 minus line 25)				_, -, ,	
	Reimbursable bad debts (from your records)			(		
	Reimbursable bad debts for dual eligible beneficiaries (see in					28
	Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	27)				
00 50	Pioneer ACO demonstration payment adjustment (see instructions	:)			1	
99	Demonstration payment adjustment amount before sequestration	• /			1	1
00	Subtotal (see instructions)				1	
01	Sequestration adjustment (see instructions)				0	
02	Demonstration payment adjustment amount after sequestration					
75	Sequestration adjustment for non-claims based amounts (see ins	structions)			1	
	Interim payments (see instructions)				1	
	Tentative settlement (for contractor use only)				0	
	•			1	1	
. 00	Balance due provider/program (line 31 minus lines 31.01, 32, a	and 33)		(	)  -1	34

In Lieu of Form CMS-2552-10

Health Financial Systems RIVERSIDE MEDICAL CENTER
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED Provider
TO PROGRAM BENEFICIARIES Provider CCN: 14-0186 Peri od: From 01/01/2021 To 12/31/2021 Worksheet H-5 Date/Time Prepared: 5/26/2022 10:37 am HHA CCN: 14-7400

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2, 518, 863 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0	3. 03 3. 04
3. 05				0		3. 05
0.00	Provider to Program			<u> </u>	J.	0.00
3.50				0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 54 3. 99
3. 77	3. 50-3. 98)		'	9		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		ı	0	2, 518, 863	4. 00
	TO BE COMPLETED BY CONTRACTOR					
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				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.05	Provider to Program		<u>'</u>	<u> </u>	0	5. 05
5. 50	Trevitati te Tregitani			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 the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	2 510 0/2	6. 02
7. 00	Total Medicare program liability (see instructions)			O Contractor	2, 518, 862 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems RIVERSIDE MEDI	CAL CENTER	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provider CCN: 14-0186	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/26/2022 10:	pared:
		Title XVIII	Hospi tal	PPS	
	DART I FULLY PROCRECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			2, 741, 809	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			2, 741, 007	1. 01
2.00	Capital DRG outlier payments			26, 061	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	126. 62	3. 00
4.00	Number of interns & residents (see instructions)		,	19. 42	4.00
5.00	Indirect medical education percentage (see instructions)			4. 43	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)	ne sum of lines 1 and 1.01	, columns 1 and	121, 462	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)		, part A line	5. 38	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		31. 89	8. 00
9.00	Sum of lines 7 and 8			37. 27	9. 00
10.00	Allowable disproportionate share percentage (see instruction	ns)		7. 84	10.00
11.00	Disproporti onate share adjustment (see instructions)			214, 958	11.00
12. 00	Total prospective capital payments (see instructions)			3, 104, 290	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			2	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstar	noon (coo i netructions)		0	1. 00 2. 00
3.00	Net program inpatient capital costs for extraordinary circumstar line program inpatient capital costs (line 1 minus line 2)	ices (see mstructions)		0	3. 00
4. 00	Applicable exception percentage (see instructions)			0.00	4. 00
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5. 00
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0. 00	6. 00
7. 00	Adjustment to capital minimum payment level for extraordinar		(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)	`	,	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to	capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)		,	0	11. 00
12.00	Net comparison of capital minimum payment level to capital p			0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)		following period	0	14. 00
15. 00		nstructions)		0	15. 00
	Current year operating and capital costs (see instructions)			0	16. 00
17 00	Current year exception offset amount (see instructions)			0	17. 00

Heal th	Financial Systems	RIVERSIDE MED	ICAL CENTER		In lie	eu of Form CMS-	2552_10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS	KI VERSI DE MED		CN: 14-0186	Peri od: From 01/01/2021	Worksheet M-1	
			Component	CCN: 14-3976	To 12/31/2021	Date/Time Pre 5/26/2022 10:	
					RHC I	Cost	
	·	Compensation	Other Costs	Total (col.	1 Reclassi ficati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	36, 829	C	36, 82	29 0	36, 829	1.00
2.00	Physician Assistant	0	C		0 0	0	2. 00
3.00	Nurse Practitioner	107, 489	C	107, 48	39 0	107, 489	3. 00
4.00	Visiting Nurse	0	C		0 0	0	4.00
5.00	Other Nurse	0	C		0 0	0	5.00
6.00	Clinical Psychologist	0	C		0 0	0	6.00
7.00	Clinical Social Worker	0	C		0 0	0	7.00
8.00	Laboratory Techni ci an	o	C		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	65, 027	C	65, 02	27 1, 785	66, 812	9.00
10.00	Subtotal (sum of lines 1 through 9)	209, 345	C	209, 34	1, 785		
11. 00	Physician Services Under Agreement	ol	C		0 0	0	11.00
12.00	Physician Supervision Under Agreement	ol	C		0 0	0	12.00
13. 00	Other Costs Under Agreement	ol	C		0 0	0	1
14. 00	Subtotal (sum of lines 11 through 13)	ol	C		0 0	0	14.00
15. 00	Medical Supplies	ol	2, 250	2, 25	50 0	2, 250	15. 00
16. 00	Transportation (Health Care Staff)	ol		,	0 0	0	1
17. 00	Depreciation-Medical Equipment	ol	C		0 0	0	1
18. 00	Professional Liability Insurance	ol	Ċ		0 0	0	
19. 00	Other Health Care Costs	ol	8, 128	8, 12	28 0	8, 128	19.00
20. 00	Allowable GME Costs			,			20.00
21. 00	Subtotal (sum of lines 15 through 20)	ol	10, 378	10, 37	78 0	10, 378	1
22. 00	Total Cost of Health Care Services (sum of	209, 345	·				1
	lines 10, 14, and 21)		,	],	.,		
	COSTS OTHER THAN RHC/FQHC SERVICES	'					1
23. 00	Pharmacy	0	C	)	0 0	0	23.00
24. 00	Dental	ol	C		0 0	0	24.00
25. 00	Optometry	ol	C		0 0	0	1
25. 01	Tel eheal th	ol	C		0 0	0	25. 01
25. 02	Chronic Care Management	ol	C		0 0	0	25. 02
26. 00	All other nonreimbursable costs	ol	Ċ		0 0	0	
27. 00	Nonallowable GME costs	1				_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	C		0 0	0	1
00	through 27)	l				l	
	FACILITY OVERHEAD	ll					1
29. 00	Facility Costs	0	19, 035	19, 03	-13, 500	5, 535	29. 00
30.00	Administrative Costs	Ö	31, 029			· ·	
31. 00	Total Facility Overhead (sum of lines 29 and	o	·	1			

209, 345

60, 442

269, 787

-6, 737

263, 050

32.00

32.00 Total facility costs (sum of lines 22, 28

and 31)

Health Financial Systems	RIVERSIDE MEDICAL CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-0186	Period: Worksheet M-1 From 01/01/2021
	Component CCN: 14-3976	To 12/31/2021 Date/Time Prepared: 5/26/2022 10:37 am

			Component	CCN. 14-37	70   10	12/31/2021	5/26/2022 10:	
						RHC I	Cost	
	·	Adjustments	Net Expenses					
		•	for Allocation					
			(col. 5 + col.					
			6)					
		6.00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	36, 829	1				1. 00
2.00	Physician Assistant	0	0					2. 00
3.00	Nurse Practitioner	-107, 489	0					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	0					5. 00
6.00	Clinical Psychologist	0	0					6. 00
7.00	Clinical Social Worker	0	0					7. 00
8.00	Laboratory Techni ci an	0	0	)				8. 00
9.00	Other Facility Health Care Staff Costs	0	66, 812					9. 00
10.00	Subtotal (sum of lines 1 through 9)	-107, 489	103, 641					10.00
11.00	Physician Services Under Agreement	0	0					11. 00
12.00	Physician Supervision Under Agreement	0	0					12. 00
13.00	Other Costs Under Agreement	0	0					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0					14. 00
15.00	Medical Supplies	0	2, 250					15. 00
16.00	Transportation (Health Care Staff)	0	0					16. 00
17.00	Depreciation-Medical Equipment	0	0					17. 00
18.00	Professional Liability Insurance	0	0					18. 00
19.00	Other Health Care Costs	0	8, 128					19. 00
20.00	Allowable GME Costs							20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	10, 378					21. 00
22.00	Total Cost of Health Care Services (sum of	-107, 489	114, 019					22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0					23. 00
24.00	Dental	0	0	)				24. 00
25.00	Optometry	0	0	)				25. 00
25. 01	Tel eheal th	0	0	)				25. 01
25. 02	Chronic Care Management	0	0	)				25. 02
26.00	All other nonreimbursable costs	0	0	)				26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	)				28. 00
	through 27)							]
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	5, 535					29. 00
30. 00	Administrative Costs	0	36, 007	1				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	41, 542	1				31. 00
	30)			1				
32. 00	Total facility costs (sum of lines 22, 28	-107, 489	155, 561					32. 00
	and 31)			I				1

	Financial Systems	RIVERSIDE MED				eu of Form CMS-	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2021 To 12/31/2021		nared:
			Component	CCN. 14 3770	10 12/31/2021	5/26/2022 10:	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	2.00	3) 4. 00	4 5. 00	
	VISITS AND PRODUCTIVITY	1.00	2. 00	3.00	4.00	5.00	
	Posi ti ons						1
1. 00	Physi ci an	0.00	) C	4, 20	0 0		1.00
2. 00	Physician Assistant	0. 00	<b>I</b>	1			2. 00
3. 00	Nurse Practitioner	0. 81	1			l .	3.00
4. 00	Subtotal (sum of lines 1 through 3)	0. 81			1, 701		
5.00	Visiting Nurse	0. 00		1	,	0	
5. 00	Clinical Psychologist	0.00	o c	1		0	6.00
7. 00	Clinical Social Worker	0. 00	) c			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	) C	)		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00	) C	)		0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	0. 81	1, 834			1, 834	8.00
9. 00	through 7)					0	9.00
9.00	Physician Services Under Agreements			l		0	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASE	ED RHC/FOHC SER	VICES		1.00	
10. 00						114, 019	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1					0	11.00
12. 00	Cost of all services (excluding overhead) (	sum of lines 10	and 11)			114, 019	12.00
13.00	Ratio of hospital-based RHC/FQHC services (	line 10 divided	by line 12)			1.000000	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		41, 542	
15. 00	Parent provider overhead allocated to facil	ity (see instru	ctions)			513, 889	
16. 00	Total overhead (sum of lines 14 and 15)					555, 431	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	0110 1 (11	40 11	0)		555, 431	
	Overhead applicable to hospital-based RHC/F					555, 431	
20.00	Total allowable cost of hospital-based RHC/	FUHL SERVICES (S	sum of lines 10	and 19)		669, 450	20.0C

CALCIII	Financial Systems RIVERSIDE MEDICAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0186	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (	ES	Component CCN: 14-3976	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 10:3	pared:
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			669, 450	
2.00	Cost of injections/infusions and their administration (from Wks			10, 956	
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 mir Total Visits (from Wkst. M-2, column 5, line 8)	nus i i ne 2)		658, 494 1, 834	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			1, 834	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		0-11	359.05	7. 00
			Cal cul ati on	OT LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through 03/31/2021)	through 12/31/2021)	
			1.00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	6 or your contractor)	87. 52	100.00	8. 00
9. 00	Rate for Program covered visits (see instructions)		87. 52	100.00	9. 00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from c	contractor records)	41	150	10.00
11.00	Program cost excluding costs for mental health services (line s		3, 588	15, 000	
12.00	Program covered visits for mental health services (from contrac		0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x line	e 12)	0	0	13. 00
14. 00 15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions)	1	0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a		0	18, 588	
16. 01	Total program charges (see instructions)(from contractor's reco	•		39, 493	
16. 02	Total program preventive charges (see instructions)(from provide			9, 136	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I			4, 300	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	and 18) trilles .80)		7, 871	16. 04
16. 05	Total program cost (see instructions)		0	12, 171	16. 05
17. 00	Primary payer amounts			0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 449	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instructions	s) (from contractor		5, 182	19. 00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)	// /   i mo 1/)		12, 171	
21.00	Program cost of vaccines and their administration (from Wkst. M Total reimbursable Program cost (line 20 plus line 21)	w-4, TTNe 16)		9, 122 21, 293	
23. 00	Allowable bad debts (see instructions)			70	
23. 01	Adjusted reimbursable bad debts (see instructions)			46	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		30	
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	1		0	
25. 99	Demonstration payment adjustment amount before sequestration	,		0	
26. 00	Net reimbursable amount (see instructions)			21, 339	
26. 01	Sequestration adjustment (see instructions)			0	
26. 02	Demonstration payment adjustment amount after sequestration			11 604	
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			11, 694 0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.02	2, 27, and 28)		9, 645	
30.00	Protested amounts (nonallowable cost report items) in accordance			3	

		Component CCN: 14-3976		From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/26/2022 10:37 am	
		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	103, 641	103, 6	103, 641	103, 641	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000139	0. 0003	0. 000000	0.000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	14	;	35 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	1, 073	7.	14 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1, 087	7	79 0	0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	114, 019				6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	555, 431				7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 009533			0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5, 295			0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6, 382	4, 5	74 O	0	10. 00
11. 00	Total number of injections/infusions (from your records)	9		22 0	0	11. 00
12.00	Cost per injection/infusion (line 10/line 11)	709. 11	207.	0.00	0.00	
13. 00	Number of injection/infusion administered to Program beneficiaries	7	:	20 0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4, 964	4, 1!	58 0	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		10, 9	56		15. 00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		9, 1:	22		16. 00

Health Financial Systems	Ith Financial Systems RIVERSIDE MEDICAL (			In Lieu of Form CMS-2552-10			
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 14-0186	Peri od: From 01/01/2021	Worksheet M-5			
SERVICES RENDERED TO PROGRAM BENEFICIAN	RIES	Component CCN: 14-3976		Date/Time Prepared: 5/26/2022 10:37 am			

		Component CCN: 14-3976	То	12/31/2021	Date/Time Prep 5/26/2022 10:3	
				RHC I	Cost	
				Par		
				mm/dd/yyyy	Amount	
				1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC				11, 694	1. (
00	Interim payments payable on individual bills, either submit				0	2. (
	the contractor for services rendered in the cost reporting	period. If none, write				
	"NONE" or enter a zero					_
00	List separately each retroactive lump sum adjustment amount					3.
	revision of the interim rate for the cost reporting period.	Also show date of each				
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	Program to Provider				0	2
02					0	3. 3.
					0	
03						3.
04					0	3
05	Describer to Describe				0	3
	Provider to Program				0	2
50						3
51					0	3
52					- 1	
53					0	3
54 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines 2 FO 2	00)			0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.				- 1	
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	ster to worksheet M-3, line			11, 694	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after des	sk review. Also show date of	-			5
50	each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date of				5
	Program to Provider					
01	1 Togram to 11 ovi dei		Т		0	5
)2					ő	5
03					Ö	5
	Provider to Program				0	Ŭ
50					0	5
51					Ö	5
52					Ö	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)			Ö	5
00	Determined net settlement amount (balance due) based on the				ا	6
01	SETTLEMENT TO PROVIDER				9, 645	6
02	SETTLEMENT TO PROGRAM				0	6
00	Total Medicare program liability (see instructions)				21, 339	7
	1 111 11 11 11 11 11 11 11 11 11 11 11			Contractor	NPR Date	Ė
				Number	(Mo/Day/Yr)	
		0		1. 00	2. 00	
	Name of Contractor					