Health Financial Systems SBORO AREA

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1332 Peri od: Worksheet S From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023

Date/Time Prepared: 11/20/2023 2:02 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/20/2023 Ti me: 2: 02 pm Manually prepared cost report use only]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. Contractor

[1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. use only

(3) Settled with Audit (4) Reopened

number of times reopened = 0-9.

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HILLSBORO AREA HOSPITAL (14-1332) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	ANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1				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				2
3	Signatory Title	CF0			3
4	Date				4

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
P	PART III - SETTLEMENT SUMMARY						
1.00 H	HOSPI TAL	0	85, 054	71, 231	0	0	1.00
2.00 S	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00 S	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00 S	SWING BED - SNF	0	84, 568	0		0	5.00
6.00 S	SWING BED - NF	0				0	6.00
200. 00 T	TOTAL	0	169, 622	71, 231	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1332 Peri od:

In Lieu of Form CMS-2552-10

Worksheet S-2

From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1200 E. TREMONT 1.00 PO Box: 1.00 2.00 City: HILLSBORO State: IL Zip Code: 62049 County: MONTGOMERY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type V 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HILLSBORO AREA HOSPITAL 141332 99914 09/06/1975 Ν 0 0 3.00 Hospi tal Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF HILLSBORO AREA HOSPITAL 147332 99914 04/01/2004 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17.10 17. 20 Hospital - Based (OPT) I 17.20 17.30 Hospital -Based (00T) I 17.30 17. 40 Hospital -Based (OSP) I 17.40 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) 07/01/2022 06/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 3.00 1.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 Ν disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for ves or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no Ν 22.01 Ν for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be 22.02 22. 02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 7, "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 Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 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.

Health Financial Systems
HILLSBORO
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-2 | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: | Provider CCN: 14-1332

				10 06/3	0/2023		2023 2:	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medicai HMO day	d 0 /s Med	ther di cai d days	J. Pill
leave	1.00	2. 00	3.00	4. 00	5. 00	_	5. 00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in colum 4, Medicaid HMO paid and eligible but unpaid days i column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state						0	0	24.00
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	te				hural C		Coogn	
				1. (Rural S	<u>2.</u>		
26.00 Enter your standard geographic classification (not cost reporting period. Enter "1" for urban or "2" 127.00 Enter your standard geographic classification (not	for rural.			the	2			26. 00 27. 00
reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclassi	or "2" for in	rural. If a column 2.	ippl i cabl e,		0			
35.00 If this is a sole community hospital (SCH), enter effect in the cost reporting period.	the number of	perrous s	Status I	Begi nı	ni ng:	Endi		35.00
24 00 Enter applicable beginning and	ctatus Cul	contrat !!	24 for	1.0	00	2.	00	26.00
36.00 Enter applicable beginning and ending dates of SCH of periods in excess of one and enter subsequent data 37.00 If this is a Medicare dependent hospital (MDH), en	ates.	·			0			36.00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"								37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending dargreater than 1, subscript this line for the number enter subsequent dates.								38. 00
1				Υ/		Υ/		
39.00 Does this facility qualify for the inpatient hospit hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or in the contraction of the cont	(i), (ii), ou t the mileage	r (iii)? En e requireme	nter in colu ents in	ımn		2. ·		39.00
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reducti "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October	tober 1. Ente	er "Y" for			ı	N	I	40.00
no thi cordini 2, for discharges on or arter october	1. (366 1113	ti uc ti ons)			V	XVIII	XIX	
December 1 of 1 (COO) of 1 in					1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payr	ment for dis	proportiona	ite share in	accordance	e N	l N	l N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete WIPt. III.	ception for	extraordi n	nary circums	stances	N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital payme	•		,		N N	N N	N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.						56.00		
For cost reporting periods beginning prior to Decer is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, is beginning on or after December 27, 2020, under 42 (which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete.	mber 27, 2020 ch residents in column 1. s cost repor- ete Workshee f applicable CFR 413.77(e re on duty, i	in approve If column ting period t E-4. If ce E. For cost)(1)(iv) a if the resp	ed GME progr 1 1 is "Y", d? Enter "Y column 2 is 1 reporting and (v), reconse to lir	rams trained did /" for yes on "N", periods pardless of the second secon	or			57.00

Health Financial Systems HILLSBORO
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1332

				To	o 06/30/		Date/Ti 11/20/2	023 2:	
						1. OC	XVIII 2. 00	XI X 3. 00	
	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	comple	te Wkst. D-5.		as	N N	2100	0.00	58. 00 59. 00
34.00	ALE COSTS CLAIMED ON TIME TOO OF WOLKSHEET A: TI yes	s, comp	Tete WKSt. D-2	NAHE 413. 85 Y/N	Workshee Li ne	t A	Pass-Th Qualifi Crite Coo	cation rion	34.00
(0.00		(1)(1)(5)		1. 00	2. 00		3. C	00	(0.00
	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 colis "Y", are you impacted by CR 11642 (or subsequent (adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHI	see If column 1	N					60.00
		Y/N	I ME	Direct GME	IME		Di rect	GME	
		1.00	2. 00	3. 00	4. 00		5. C		
	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	61.00
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. 01
	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)								61.02
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)								61.03
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).								61. 04
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)								61.05
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)								61.06
		Pro	ogram Name	Program Code	Unweigh		Unweig Direct FTE C	GME	
(1.10	06 the FTF- in line (1 0Fif)		1. 00	2. 00	3. 00		4.0		(1.10
	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 FTE unweighted count.					0.00		0.00	61. 10
	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, the direct GME FTE unweighted count.					0. 00		0. 00	61. 20
							1. 0	00	
	ACA Provisions Affecting the Health Resources and Sel Enter the number of FTE residents that your hospital				iod for wh	ni ch		0. 00	62. 00
62. 01	your hospital received HRSA PCRE funding (see instructions) and the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming period	ctions) a Teachi	ing Health Cen	iter (THC) into					62. 01
	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Sett ettings	ings during this c	cost reporting		nter	N		63. 00

Health Financial Systems HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1332 Peri od: Worksheet S-2 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Unwei ghted Unwei ghted Ratio (col 1/ (col. 1 + FTEs FTEs in col. 2)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/ (col. 3 + Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 65.00 Enter in column 1, if line 63 0.00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTES Nonprovi der Hospi tal Si te 1. 00 2. 00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 0.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +Nonprovi der Hospi tal col. 4)) Si te 1.00 2.00 3.00 4.00 5.00 67.00 Enter in column 1, the program 0 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column

4)). (see instructions)

Health Financial Systems
HILLSBORO
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1332

In Lieu of Form CMS-2552-10
Worksheet S-2
Part I
30/2023 Date/Time Prepared:
11/20/2023 2:02 pm Peri od: From 07/01/2022 To 06/30/2023

					11/20/20	023 2:	02 pm
				-	1. 0	0	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490	072 (August 10	, 2022)		1.0		
68. 00	For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	otain permissi	on from yo		N		68. 00
				1. 00	2.00	3. 00	
70. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	ain an IPF sub	provi der?	N			70. 00
71. 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachin	ng program in	the most			0	71. 00
	recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye Column 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	es or "N" for o in a new teacl es or "N" for o	no. (see hi ng no.				
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it cosubprovider? Enter "Y" for yes and "N" for no.	ontain an IRF		N			75. 00
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teachin recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If	"Y" for yes of in accordance column 2 is Y	r "N" for with 42			0	76.00
	indicate which program year began during this cost reporting period. (see	instructions)					
	Long Term Care Hospital PPS				1. 0	0	
80. 00 81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for r Is this a LTCH co-located within another hospital for part or all of the c "Y" for yes and "N" for no. TEFRA Providers		period? E	Enter	N N		80. 00 81. 00
85. 00 86. 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N		85. 00 86. 00
87. 00	Is this hospital an extended neoplastic disease care hospital classified unlassified unlas	under section			N		87. 00
			Approved Permane Adjustm (Y/N) 1.00	ent	Number Appro Permar Adjustm 2.0	ved nent nents	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFR amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co. 89. (see instructions)		1.00		2.0	0	88.00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	Effecti	ve	Appro	ved	
		No.	Date		Permar Adjusti Amount Discha	nent ment Per arge	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1. 00	2. 00		3. 0		89. 00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.						
			V 1. 00		XI X		
	Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column.		N		N		90.00
91. 00 92. 00	Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N N		91. 00 92. 00
93. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and		N		N N		93.00
94. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no		N		N		94. 00
95. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column		0. 00		0. 0	0	95. 00
96. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.		N		N		96. 00
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable column	١.	0. 00		0. 0	0	97. 00

Heal th Fi nancial Systems HILLSBORO AREA HOSPITAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DENTIFICATION DATA Provider CCN: 14-1332 Period:

Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:02 pm V 1. 00 2.00 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 Υ 98.00 column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 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 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) Ν 98.03 Ν 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 98.04 N Ν 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 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 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? 105.00 106.00|If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Ν 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) 108.00 ls this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 108.00 Ν Physi cal Occupati onal Speech Respi ratory 3.00 1.00 2.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109.00 Ν Ν therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 110.00 Ν Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1. 00 2.00 111.00 of this facility qualifies as a CAH, did it participate in the Frontier Community N 111 00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 112.00 Did this hospital participate in the Pennsylvania Rural Health Model 112.00 (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no Ν 0115.00 in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or 116.00 "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 117.00 Υ 118.00|s the malpractice insurance a claims-made or occurrence policy? Enter 1 118.00 if the policy is claim-made. Enter 2 if the policy is occurrence.

In Lieu of Form CMS-2552-10

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1332 Peri od: Worksheet S-2 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Premi ums Losses Insurance 1.00 2.00 3.00 118.01 List amounts of malpractice premiums and paid losses: 0118.01 158, 092 1.00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119.00 120.00|Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "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 column 2, "Y" for yes or "N" for no. 00

121.00 Did this facility incur and report costs for high cost implantable devices charged to	N	İ	121.00
patients? Enter "Y" for yes or "N" for no.		İ	
122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the	Υ	5. 01	122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2		İ	
the Worksheet A line number where these taxes are included.		İ	
123.00Did the facility and/or its subproviders (if applicable) purchase professional		İ	123. 00
services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or		İ	
management/consulting services, from an unrelated organization? In column 1, enter "Y"		İ	
for yes or "N" for no.		İ	
If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total		İ	
professional services expenses, for services purchased from unrelated organizations		İ	
located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or		İ	
"N" for no.		İ	
Conti Si ad Turanal ant Contan Information			

certified fransplant center information		
125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes	N	125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		
126.00 If this is a Medicare-certified kidney transplant program, enter the certification date		126. 00
in column 1 and termination date, if applicable, in column 2.		
127.00 If this is a Medicare-certified heart transplant program, enter the certification date		127. 00
in column 1 and termination date, if applicable, in column 2.		
128.00 f this is a Medicare-certified liver transplant program, enter the certification date		128. 00
in column 1 and termination date, if applicable, in column 2.		
129.00 f this is a Medicare-certified lung transplant program, enter the certification date		129. 00
in column 1 and termination date, if applicable, in column 2.		
130.00 f this is a Medicare-certified pancreas transplant program, enter the certification		130. 00
date in column 1 and termination date, if applicable, in column 2.		

date in column 1 and termination date, if applicable, in column 2.	
131.00 f this is a Medicare-certified intestinal transplant program, enter the certification	131.00
date in column 1 and termination date, if applicable, in column 2.	
132.00 If this is a Medicare-certified islet transplant program, enter the certification date	132.00
in column 1 and termination date, if applicable, in column 2.	
133.00 Removed and reserved	133.00
134.00 f this is a hospital-based organ procurement organization (0P0), enter the 0P0 number	134.00
in column 1 and termination date, if applicable, in column 2.	

140.00	Are there any related organization or	home office costs as defined in CMS Pub). 15-1,	Υ		140. 00
	chapter 10? Enter "Y" for yes or "N" f	or no in column 1. If yes, and home off	ice costs			
	are claimed, enter in column 2 the hom	e office chain number. (see instruction	ıs)			
	1. 00	2. 00		3. 00		
	If this facility is part of a chain or	ganization, enter on lines 141 through	143 the na	me and address	of the home	
	-66:66:					1

office and enter the home office contra	actor name and contractor number.		
141. 00 Name:	Contractor's Name:	Contractor's Number:	141.00
142.00 Street:	PO Box:		142.00
143. 00 Ci ty:	State:	Zi p Code:	143.00
	-		

		1. 00	
144.00 Are provider based physicians' costs included in Worksheet A?		Υ	144.00
	1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for			145.00
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is			
no, does the dialysis facility include Medicare utilization for this cost reporting			
period? Enter "Y" for yes or "N" for no in column 2.			
146.00 Has the cost allocation methodology changed from the previously filed cost report?	N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If			
yes, enter the approval date (mm/dd/yyyy) in column 2.			

All Providers

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1332 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:02 pm 1. 00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 147.00 N 148. 00 Ν Ν 149. 00 Part A Part B Title V Title XIX 1.00 2. 00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155. 00 Hospi tal 155. 00 156.00 Subprovi der - IPF Ν Ν N Ν 156. 00 157.00 Subprovi der - IRF Ν Ν Ν Ν 157.00 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν N Ν 161.00 CMHC Ν Ν Ν 161. 00 161. 10 CORF Ν Ν Ν 161. 10 161. 20 OUTPATIENT PHYSICAL THERAPY 161. 20 Ν Ν Ν 161. 30 OUTPATIENT OCCUPATIONAL THERAPY 161. 30 Ν Ν Ν 161. 40 OUTPATIENT SPEECH PATHOLOGY Ν Ν Ν 161. 40

Multicampus		1
165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.		l

1.00

	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each						0. 00	166.00
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							

	1. 00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the		168.00
reasonable cost incurred for the HIT assets (see instructions)		
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the	0.00	169. 00
transition factor (see instructions)		

It alls then ractor. (see ristructions)			
	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			170.00
period respectively (mm/dd/yyyy)			
	1 00	2 00	

	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	0	171.00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

Heal th Fi nanci al Systems HILLSBORO
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE

Provider CCN: 14-1332

In Lieu of Form CMS-2552-10
Worksheet S-2
Part II
30/2023 Date/Time Prepared:
11/20/2023 2: 02 pm Peri od: From 07/01/2022 To 06/30/2023

					11/20/2023 2:	UZ pm
				Y/N	Date	
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMEN			.11 1.1	T. L.	-
	General Instruction: Enter Y for all YES responses. Enter N for	or all NO re	esponses. Enter	all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					1
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the be	ainning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in colu			IN		1.00
	Troporting period. Tr yes, effect the date of the change in our	2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Prod	gram? If	N			2.00
	yes, enter in column 2 the date of termination and in column 3	Š, "V" for				
	voluntary or "I" for involuntary.					
3.00	Is the provider involved in business transactions, including m		Υ			3.00
	contracts, with individuals or entities (e.g., chain home offi					
	or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of t					
	of directors through ownership, control, or family and other s					
	relationships? (see instructions)	or iiir r ar				
	To detroit of the tractions,		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certifi		Υ	Α	10/02/2023	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for					
	or "R" for Reviewed. Submit complete copy or enter date availa	able in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differer	at from	Υ			5.00
5.00	those on the filed financial statements? If yes, submit recond		Ţ			3.00
	those of the fired financial statements. If yes, submit reconc	or ration.		Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column 2:	If yes, is	s the provider	N		6.00
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see instr			N		7.00
8. 00	Were nursing programs and/or allied health programs approved a	and/or rene	wed during the	N		8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gra	aduato modi	cal oducation	N		9.00
7. 00	program in the current cost report? If yes, see instructions.	iddate medit	car education	IN		7.00
10.00	Was an approved Intern and Resident GME program initiated or r	enewed in	the current	N		10.00
	cost reporting period? If yes, see instructions.					
11.00	Are GME cost directly assigned to cost centers other than I &	R in an App	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1. 00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes, s	see instruc	tions		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection poli			t reporting	, N	13.00
	period? If yes, submit copy.	oy onango .	au g t o o o o	r ropor rring		10.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance	e amounts wa	aived? If yes,	see	N	14.00
	instructions.					
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporting			uctions.	L N	15.00
			t A		rt B	
	_	Y/N 1.00	Date	Y/N	Date	
	PS&R Data	1. 00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16.00
	If either column 1 or 3 is yes, enter the paid-through					10.00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
	Was the cost report prepared using the PS&R Report for	Υ	11/02/2023	Υ	11/02/2023	17.00
17. 00	totals and the provider's records for allocation? If					
17. 00						
17. 00	either column 1 or 3 is yes, enter the paid-through date					1
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		18 00
17. 00 18. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		18. 00
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N N		N N		18.00
18. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					

Heal th Fi nanci al Systems

HOSPI TAL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE

Provi der CCN: 14-1332 | Peri od:

Worksheet S-2 From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/20/2023 2:02 pm Description Y/N 1.00 3.00 20.00 | If line 16 or 17 is yes, were adjustments made to PS&R N Ν 20.00 Report data for Other? Describe the other adjustments: Y/N Date Y/N Date 3.00 1.00 2.00 4.00 21.00 Was the cost report prepared only using the provider's 21 00 N N records? If yes, see instructions. 1. 00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23 00 reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 24.00 If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 i nstructi ons. Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 26,00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31 00 <u>i nstructi ons</u> Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Ν 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 Ν 33.00 no, see instructions. Provi der-Based Physi ci ans Were services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If ves see instructions If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35 00 physicians during the cost reporting period? If yes, see instructions. Date 1. 00 2.00 Home Office Costs 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 prepared by the home office? 37.00 Ν If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 38.00 Ν 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 see instructions. 40 00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position DAVI D GOODMAN 41.00 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 Enter the employer/company name of the cost report WIPFLI LLP 42.00 preparer. Enter the telephone number and email address of the cost 6082702962 DGOODMAN@WI PFLI . COM 43.00

In Lieu of Form CMS-2552-10

report preparer in columns 1 and 2, respectively.

Health Financial Systems HILLSBORO
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

In Lieu of Form CMS-2552-10

Peri od: Worksheet S-2
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 11/20/2023 2: 02 pm Provider CCN: 14-1332

		3.00	
	Cost Report Preparer Contact Information		
		CPA	41.00
	held by the cost report preparer in columns 1, 2, and 3,		
	respecti vel y.		
42.00	Enter the employer/company name of the cost report		42.00
	preparer.		
43.00	Enter the telephone number and email address of the cost		43.00
	report preparer in columns 1 and 2, respectively.		

Health Financial Systems HILLSB
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2552-10

Peri od: Worksheet S-3
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Provider CCN: 14-1332

						11/20/2023 2:	02 pm_
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	comporter t	Li ne No.		Avai I abl e	0,11,711,211,110,011,0		
		1. 00	2. 00	3.00	4.00	5. 00	
	PART I - STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	25	9, 125	20, 616. 00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	20	7, 120	20,010.00		1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2 00							2 00
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		25	9, 125	20, 616. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)		25	9, 125	20, 616. 00	0	14. 00
15. 00	CAH visits		20	7, 120	20,010.00	0	15.00
15. 10	REH hours and visits					Ŭ	15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
							20.00
20.00	NURSING FACILITY						
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25. 00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	99. 10				0	25. 10
25. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	99. 20				0	25. 20
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99. 30				0	25. 30
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99. 40				0	25. 40
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 25
27.00	Total (sum of lines 14-26)		25	5			27.00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		(ol c			32.00
32. 01	Total ancillary labor & delivery room			1			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30.00	(n	34.00
5 00	1	1 55.00		-1	П	١	300

Health Financial Systems HILLSB
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1332

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/20/2023 2: 02 pm

I/P Days / O/P Visits / Trips Fu		qui val ents	02 pm
17. Says 7 67. Visites 7 in ps	II IIIIC E	qui vai cires	
		Employees On	
	si dents	Payrol I	
	0. 00	10. 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 398 11 859			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) 108 0			2.00
3.00 HMO IPF Subprovider 0 0 0 4.00 HMO IRF Subprovider 0 0			3.00
4.00 HMO LRF Subprovider 0 0 5.00 Hospital Adults & Peds. Swing Bed SNF 511 0 671			4. 00 5. 00
6.00 Hospital Adults & Peds. Swing Bed NF			6.00
7.00 Total Adults and Peds. (exclude observation 909 11 1,530			7.00
beds) (see instructions)			
8.00 INTENSIVE CARE UNIT			8. 00
9.00 CORONARY CARE UNIT			9. 00
10.00 BURN INTENSIVE CARE UNIT			10.00
11. 00 SURGICAL INTENSIVE CARE UNIT			11.00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY			12. 00 13. 00
14.00 Total (see instructions) 909 11 1,530	0. 00	154. 57	14.00
15. 00 CAH visits 0 0 0	0.00	134. 37	15.00
15.10 REH hours and visits			15. 10
16. 00 SUBPROVI DER - I PF			16.00
17. 00 SUBPROVI DER - I RF			17.00
18. 00 SUBPROVI DER			18. 00
19.00 SKILLED NURSING FACILITY			19.00
20. 00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY			21. 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 0 0	0. 00	0. 00	
25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 0 0 0	0. 00	0. 00	
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 0 0 0	0.00	0. 00	
25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 0 0	0. 00	0. 00	
26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0	0. 00	0. 00	26. 00 26. 25
27.00 Total (sum of lines 14-26)	0.00	154. 57	27.00
28. 00 Observation Bed Days 0 524	0.00	154. 57	28.00
29. 00 Ambul ance Trips 0			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 0 0			32.00
32.01 Total ancillary labor & delivery room 0			32. 01
outpatient days (see instructions) 33.00 LTCH non-covered days			33.00
33.00 LTCH hon-covered days 33.01 LTCH si te neutral days and discharges			33.00
34.00 Temporary Expansion COVID-19 PHE Acute Care 0 0 0			34.00

Health Financial Systems

In Lieu of Form CMS-2552-10

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 14-1332

Peri od: Worksheet S-3 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023

11/20/2023 2:02 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12. 00 13.00 14. 00 15.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 250 1.00 117 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) 25 2.00 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4 00 0 4 00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7 00 beds) (see instructions) 8 00 INTENSIVE CARE UNIT 8 00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 NURSERY 13.00 13.00 Total (see instructions) 250 14.00 0.00 0 117 14.00 3 15.00 CAH visits 15.00 15.10 REH hours and visits 15.10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 SUBPROVI DER 18.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 HOSPICE (non-distinct part) 24.10 24.10 25.00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0.00 25.10 CMHC - OUTPATIENT PHYSICAL THERAPY 25 20 0 00 25 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25.30 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 25. 40 0.00 25.40 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26 25 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 29.00 Ambul ance Trips Employee discount days (see instruction) 30.00 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions)
Total ancillary labor & delivery room 32.00 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care

Heal th Financial Systems

HILLSBORO AREA HOSPITAL

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1332

Period:
From 07/01/2022
To 06/30/2023

Date/Time Prepared:

Discomposated and indisent care cost consustrion 1.00				00/30/2023	11/20/2023 2:	
Uncompensated and indigent care cost computation 0.0 0.00					1 00	
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		Uncompensated and indigent care cost computation			1.00	
Medicaid (see Instructions for each line)	1. 00		ine 202 column	8)	0. 410119	1. 00
3.00 Old you receive DSH or supplemental payments from Medical d? Y 3.00 0.00 1 1 1 1 1 1 1 1 1			202 001 0	<u> </u>	0. 1.01.17	
If Ine 3 is yes, does Ine 2 include all DSH and/or supplemental payments from Medicaid?	2.00	Net revenue from Medicaid			6, 786, 252	2.00
	3.00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3.00
Medicaid charges	4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen	ts from Medicai	d?	Υ	4.00
Medical d cost (line 1 times line 6) 6.809, 226 7.00			i d			
0.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 22,974 8.00 22,974 8.00 20,00						
A care of their enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line) 9.00						
Children's Health Insurance Program (CHIP) (see instructions for each line) 0,00 0.00	8.00	1 9 \	nus sum of line	s 2 and 5; if	22, 974	8. 00
9.00 Net revenue from stand-alone CHIP 0,00 0		,	no)			
10.00 Stand-allone CHIP cost (line 1 times line 10) 0.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) 0 the state or local government indigent care program (see instructions for each line) 1.00 Early 1.00 Ear	0 00		ne)		0	0.00
11.00 Stand-al one CHIP cost (line 1 times line 10) 0 11.00 0 12.00 0 0 12.00 0 0 12.00 0 0 0 12.00 0 0 0 12.00 0 0 0 0 0 0 0 0 0					-	
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) Dither state or local government indigent care program (see instructions for each line) Other state or local indigent care program (Not included on lines 2, 5 or 9) Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other state or local indigent care program (Not included in lines 6 or 0 Other lines (See Instructions) Other state or local indigent care programs (See Instructions) Other state or local indigent care program (See Instructions) Other state or local indigent care program (See Instructions) Other state or local indigent care program (See Instructions) Other state or local indigent care pro					-	
Interest Content Con			inus line 9: if	< zero then		
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 15.00 13; if < zero then enter zero) Grants, donations and total unrelmbursed cost for Medicald, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 19.00 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 22, 974 19.00 19.00 State and 16) 20.00 Charity care charges and uninsured discounts for the entire facility 288,899			,			
14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15. 00 State or local indigent care program cost (line 1 times line 14) 0 15. 00 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 22, 974 19. 00 19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 22, 974 19. 00 19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 22, 974 19. 00 19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 22, 974 19. 00 19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 22, 974 19. 00 19. 00 Total unreimbursed cost for Medicaid or the entire facility 288, 899 0 2.00 19. 00 Total unreimbursed cost for Medicaid scounts for the entire facility 288, 899 0 2.00 19. 00 Total unreimbursed discounts for the entire facility 288, 899 0 288, 899 0.00 19. 00 Total unreimbursed discounts for the entire facility 288, 899 0 288, 899 0.00 19. 00 Total cost of patients approved for charity care and uninsured discounts (see 118, 483 0 118, 483 21. 00 19. 00 Total cost of patients approved for charity care and uninsured discounts (see 118, 483 0 118, 483 21. 00 19. 00 Total cost of patients approved for manufacturing the form patients and unreimbursed cost of patients and unreimbursed cost of patients and unreimbursed cost of patients and unreimbursed cos		Other state or local government indigent care program (see instructions	for each line)			
10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 19. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 19. 00 19. 00 Charity care charges and uninsured discounts for the entire facility 10. 00 2. 00 3. 00 Uncompensated Care (see instructions for each line) 20. 00 Charity care charges and uninsured discounts for the entire facility 288, 899 0 288, 899 20. 00 21. 00 Cost of patients approved for charity care and uninsured discounts (see 118, 483 0 118, 483 21. 00 22. 00 Payments received from patients for amounts previously written off as 0 0 0 22. 00 23. 00 Cost of Charity care (line 21 minus line 22) 118, 483 0 118, 483 23. 00 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 1 N 24. 00 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 1 N 24. 00 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 2, 450, 543 26. 00 27. 00 Medicare allowable bad debts for the entire hospital complex (see instructions) 2, 154, 594 28. 00 28. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 1, 1, 105, 705 30. 00 29. 00 Cost of non-Medicare area (line 23 column 3 plus line 29) 1, 1, 105, 705 30. 00						
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 evernment grants, appropriations or transfers for support of hospital operations 0 18.00 government grants, appropriations or transfers for support of hospital operations 0 18.00 evernment grants, appropriations or transfers for support of hospital operations 19.00 evernment grants, appropriations or transfers for support of hospital operations 19.00 evernment grants, appropriations or transfers for support of hospital operations 19.00 evernment grants, appropriations or transfers for support of hospital operations 19.00 evernment grants, appropriations or transfers for support of hospital operations 19.00 evernment grants patients patients 19.00 evernment grants patients 19.00 evernment grants patients 19.00 evernment grants patients 19.00 evernment grants patients 19.00 evernment grants patients 19.00 evernment grants patients 19.00 evernment grants patients 19.00 evernment grants patients 19.00 evernment grants patients ever grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 evernment grants every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every grants 19.00 every	14.00	Charges for patients covered under state or local indigent care program	(Not included i	n lines 6 or	0	14.00
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) Grants, donations and total unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 19.00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 8, 12 and 16) 17.00 Private grants, appropriations or transfers for support of hospital operations 18.00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 8, 12 and 16) 18.00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 8, 12 and 16) 19.00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 8, 12 and 16) 19.00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 8, 12 and 16) 19.00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 9, 19.00 18.					_	
13: if < zero then enter zero) Grants, donations and total unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17:00 Private grants, donations, or endowment income restricted to funding charity care 0 17:00 18:00 18:00 18:00 18:00 18:00 19:00 19:00 19:00 10:00			41.1	45 1 11	-	
Crants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 19	16.00	· · · · · · · · · · · · · · · · · · ·	e program (line	15 minus line	0	16.00
instructions for each line) Private grants, donations, or endowment income restricted to funding charity care 8. 00 Government grants, appropriations or transfers for support of hospital operations 9. 00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 974 19.00 2.90 19.00 2.90 2.90 2.90 2.90 2.90 2.90 2.90			to/Local indigo	nt caro progra	nme (eoo	
17.00 Private grants, donations, or endowment income restricted to funding charity care Sovernment grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 22, 971 19.00 2.00 3.00 19.00 2.00 3.00 19.00 2.00 3.00 19			te/Tocal Thurge	iit care progra	iiis (see	
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 22, 974 19.00	17. 00		rity care		0	17. 00
Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Insured patients Hold (col. 1 + col. 2)			9		-	
Uninsured patients patients Total (col. 1 patients patients Four Patients Four Patients Pat	19.00			(sum of lines	22, 974	19. 00
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as ocharity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit willimit li		8, 12 and 16)				
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20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cast of uncompensated care (line 23 column 3 plus line 29)			1.00	2. 00	3.00	
(see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 21.00 Interview of the set instructions on the patient of the entire hospital complex (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 21.00 Interview of the set instructions on the patient of the entire hospital complex (see instructions) 22.450 Jan. 28.00 Interview of the entire hospital complex (see instructions) 23.00 Cost of uncompensated care (line 23 column 3 plus line 29) 24.00 Interview of the patient of the patient of the patient days beyond a length of stay limit of the patient days beyond a length of stay limit of the patient days beyond a length of stay limit of the patient days beyond a length of stay limit of the patient days beyond a length of stay limit of the patient days beyond a length of stay limit of the patient days beyond a length of stay limit of the patient days beyond a length of the patient days beyond a length of the patient days beyond a length of the patient days beyond a length of the patient days beyond a length of the patient days beyond a length of the patient days beyond a length of the patient days beyond a length o	20.00		200 000		200 000	20.00
21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 118, 483 0 118, 483 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 192, 367 27.00 Medicare lallowable bad debts for the entire hospital complex (see instructions) 295, 949 27.01 Medicare bad debt expense (see instructions) 295, 949 27.01 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 297, 222 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 105, 705 30.00	20.00		200, 099	U	200, 099	20.00
instructions) Payments received from patients for amounts previously written off as Cost of charity care 23.00 Cost of charity care (line 21 minus line 22) 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 100 118, 483 118, 48	21 00		118 483	0	118 483	21 00
charity care Cost of charity care (line 21 minus line 22) 118, 483 0 118, 483 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 118, 483 23.00 1.00 1.00 24.00 1.00 24.00 25.00 25.00 27.01 29.00 29.00 20	211.00		110,100	· ·	1.07.100	21.00
23.00 Cost of charity care (line 21 minus line 22) 118, 483 1.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 295, 949 27.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 296, 900 297, 000 2987, 222 299, 000 3000 Cost of uncompensated care (line 23 column 3 plus line 29) 1000 118, 483 118, 483 100 1.00 1.00 24.00 25.00 25.00 26.00 27.00 29, 9450, 543 26.00 29, 949 27.00 29, 949 27.00 295, 949 27.00 295, 949 27.00 295, 949 27.00 297, 949 27.00 2987, 222 29.00 30.00	22. 00		O	0	0	22.00
24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 29. 00 Non-Medicare bad debt expense (see instructions) 20. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 10. 00 Instructions 20. 00 Instructions 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29)		chari ty care				
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 29.00 Non-Medicare bad debt expense (see instructions) 20.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)	23.00	Cost of charity care (line 21 minus line 22)	118, 483	0	118, 483	23.00
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 29.00 Non-Medicare bad debt expense (see instructions) 20.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)						
imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 26.00 27.00 27.01 Medicare program's length of 0 25.00 29.450,543 26.00 192,367 27.00 295,949 27.01 295,949 27.01 297,949 28.00 2987,222 29.00 1,105,705 30.00	0.4.00	December 20 and		6 . 1 1		0.4.00
25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 20.	24.00		yond a rength o	r stay limit	N	24.00
stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 24. 450, 543 26. 00 29. 57. 00 29. 57. 00 29. 57. 00 29. 57. 00 29. 154, 594 29. 00 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 10. 10. 10. 10. 10. 10. 10. 10. 10. 10.	25 00		t care program'	s Lanath of	0	25 00
26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 29.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 2, 450, 543 26.00 2, 27.00 2, 29.00 2, 10.00 2, 154, 594 28.00 2,	23.00		t care program	3 rength of	0	23.00
27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 192,367 27.00 295,949 27.01 2,154,594 28.00 2,154,594 28.00 1,105,705 30.00	26. 00	, ,)		2, 450, 543	26. 00
27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 29.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 27.01 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00						
28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 29.00 1,105,705 30.00						
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,105,705 30.00		Non-Medicare bad debt expense (see instructions)	•		2, 154, 594	28. 00
			instructions)		· ·	
31 OO Total unreimbursed and uncompensated care cost (line 19 plus line 30)						
1, 120, 077 31.00	31. 00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1, 128, 679	31.00

eal th Financial Systems STATE HILLSBORD AREA HOSPITAL

Heal th Financial Systems HILLSBORO AREA HOSPITA In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 14-1332 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				T	06/30/2023	Date/Time Pre 11/20/2023 2:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	OZ PIII
	·			+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
		1. 00	2.00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		675, 132	675, 132	-108, 502	566, 630	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		711, 094		40, 760		2.00
3.00	00300 OTHER CAP REL COSTS	440.040	0	_	0	-	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	148, 042	3, 477, 917		-37, 423 -95, 379		4.00
5. 01 6. 00	00592 ADMINISTRATION & GENERAL 00600 MAINTENANCE & REPAIRS	1, 533, 834	3, 543, 406	5, 077, 240	-95, 379 0	4, 981, 861 0	5. 01 6. 00
7. 00	00700 OPERATION OF PLANT	280, 527	500, 488	781, 015	0	781, 015	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	34, 302	113, 255		0	147, 557	8.00
9. 00	00900 HOUSEKEEPI NG	196, 677	35, 109		0	231, 786	9.00
10.00	01000 DI ETARY	222, 743	182, 425	405, 168	0	405, 168	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	199, 047	328, 317	527, 364	0	527, 364	13.00
14. 00 14. 01	01400 CENTRAL SERVICES & SUPPLY 01401 PURCHASING	0	0	0	0	0	14. 00 14. 01
14. 01	01401 PURCHASTING 01402 CENTRAL SERVICES & SUPPLY	67, 811	5, 363	73, 174	0	73, 174	14.01
15. 00	01500 PHARMACY	07, 011	1, 030, 039		-602, 630		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	229, 502	225, 849		0	455, 351	16. 00
17.00	01700 SOCI AL SERVI CE	0	475		0	475	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	O	0	0	0	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 504, 762	639, 324	2, 144, 086	415, 685	2, 559, 771	30. 00
00.00	ANCILLARY SERVICE COST CENTERS	1,001,702	007,021	2,111,000	110,000	2,007,771	00.00
50.00	05000 OPERATING ROOM	791, 272	548, 539	1, 339, 811	39, 168	1, 378, 979	50.00
53.00	05300 ANESTHESI OLOGY	0	233, 111		-61, 215		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	652, 008	354, 506		0	1, 006, 514	54.00
54. 01	03040 ULTRA SOUND	74 040	256, 849		0	256, 849	54. 01
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	74, 242 904, 846	376, 049 1, 736, 214		0	450, 291 2, 641, 060	56. 00 60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	904, 640	1, 730, 214		0	2, 641, 060	62. 30
65. 00	06500 RESPIRATORY THERAPY	213, 851	52, 004	·	-25, 480	_	65.00
65. 50	06501 SLEEP LAB	20, 567	91, 995		0	112, 562	65. 50
66.00	06600 PHYSI CAL THERAPY	1, 322, 787	117, 281	1, 440, 068	0	1, 440, 068	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	274, 024	10, 333	284, 357	0	284, 357	67. 00
69. 00	06900 ELECTROCARDI OLOGY	0	72, 459		0	72, 459	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	30, 570		55, 367	85, 937	71.00
73. 00 76. 97	O7300 DRUGS CHARGED TO PATIENTS O7697 CARDIAC REHABILITATION	0	0	0	595, 595 0	595, 595 0	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0		76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0		76. 99
	OUTPATIENT SERVICE COST CENTERS	-1					
90.00	09000 CLI NI C	717, 228	696, 159		37, 423		90.00
91. 00	09100 EMERGENCY	1, 030, 194	2, 912, 825	3, 943, 019	-416, 490	3, 526, 529	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
99. 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0	0	0	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	Ö	0		0		99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	ő	0		0		99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
118.00		10, 418, 266	18, 957, 087	29, 375, 353	-163, 121	29, 212, 232	118. 00
102 00	NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0		0		192. 00
	19201 ASSISTED LIVING	815, 400	619, 352	_	163, 121	1, 597, 873	
200.00		11, 233, 666	19, 576, 439			l I	
	- · · · · · · · · · · · · · · · · · · ·	·					

Health Financial Systems HILLSBORO
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

In Lieu of Form CMS-2552-10
Worksheet A

Provider CCN: 14-1332

Peri od: Worksheet A From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2.02 pm

				11/20/2023 2:	
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-146, 429	l '	i e e e e e e e e e e e e e e e e e e e	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-11, 854	740, 000		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 588, 536	l e e e e e e e e e e e e e e e e e e e	4.00
5. 01	00592 ADMINISTRATION & GENERAL	-866, 105	1	l .	5. 01
6.00	00600 MAINTENANCE & REPAIRS	0	0	l .	6.00
7. 00	00700 OPERATION OF PLANT	0	781, 015		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	147, 557		8. 00
9. 00	00900 HOUSEKEEPI NG	0	231, 786		9.00
10.00	01000 DI ETARY	-47, 006			10.00
11.00	01100 CAFETERI A	0	0	l .	11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	l .	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	527, 364		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	l control of the cont	14.00
14. 01	01401 PURCHASI NG	0	0	•	14. 01
14. 02	01402 CENTRAL SERVICES & SUPPLY	0	73, 174		14. 02
15.00	01500 PHARMACY	0 540	427, 409		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-3, 548			16.00
17. 00	01700 SOCIAL SERVICE	0	475	·	17.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	1	19.00
20.00	02000 NURSI NG PROGRAM	0	0	·	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES A	0	0	•	21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS A	0	0		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	U	0		23.00
30.00	03000 ADULTS & PEDIATRICS	-324, 774	2, 234, 997	•	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	-324, 774	2, 234, 771		30.00
50.00	05000 OPERATING ROOM	0	1, 378, 979		50.00
53. 00	05300 ANESTHESI OLOGY	-148, 327	,	l e e e e e e e e e e e e e e e e e e e	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-100	1	l e e e e e e e e e e e e e e e e e e e	54.00
54. 01	03040 ULTRA SOUND	0		l e e e e e e e e e e e e e e e e e e e	54. 01
56. 00	05600 RADI OI SOTOPE	0	450, 291		56.00
60.00	06000 LABORATORY	-57, 818			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500 RESPIRATORY THERAPY	0	240, 375		65.00
65.50	06501 SLEEP LAB	-19, 200			65. 50
66.00	06600 PHYSI CAL THERAPY	-3, 783	1, 436, 285		66.00
67.00	06700 OCCUPATI ONAL THERAPY	-1, 631	282, 726		67.00
69.00	06900 ELECTROCARDI OLOGY	-36, 144	36, 315		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	-174	85, 763		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	595, 595		73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
76. 99	07699 LI THOTRI PSY	0	0		76. 99
	OUTPATIENT SERVICE COST CENTERS				4
	09000 CLI NI C	-793, 497	657, 313		90.00
	09100 EMERGENCY	-893, 609	2, 632, 920		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT				92.00
	OTHER REIMBURSABLE COST CENTERS				4
99. 10	09910 CORF	0			99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	i e e e e e e e e e e e e e e e e e e e	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		99. 40
440 5	SPECIAL PURPOSE COST CENTERS	0.050.055	05 050 555	J	4.40.00
118.00		-3, 353, 999	25, 858, 233		118. 00
100.00	NONREI MBURSABLE COST CENTERS	^	_	J	100.00
	19200 PHYSICIANS' PRIVATE OFFICES 19203 PHYSICIANS' PRIVATE OFFICES	0			192. 00 192. 01
	19203 PHYSICIANS PRIVATE OFFICES 219201 ASSISTED LIVING	0	1	1	192.01
200.00		-3, 353, 999	1, 597, 873 27, 456, 106		200.00
∠00. UC	TOTAL (SUM OF LINES 110 LITTOUGH 199)	-3, 303, 499	27,430,100	'I	1200.00

ems STATE HILLSBORO AREA HOSPI TAL

Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

RECLASSI FI CATI ONS

Provi der CCN: 14-1332 | Peri od: | Worksheet A-6

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Increases Cost Center 0ther Li ne # Sal ary 2.00 3.00 4.00 5.00 A - TO RECLASS DRUG COST FROM PHARMACY 1.00 DRUGS CHARGED TO PATIENTS 73.00 595, 595 1.00 595, 595 B - TO RECLASS MED SUPPLY FROM PHARMACY 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 1, 417 1.00 PAT TOTALS 1, 417 0 C - TO RECLASS MED SUPPLY FROM OR MEDICAL SUPPLIES CHARGED TO 1.00 71.00 0 20,002 1.00 0 20,002 D - TO RECLASS OXGEN FROM RT TO MED SUP 1.00 MEDICAL SUPPLIES CHARGED TO 1.00 71.00 0 25, 480 PAT 25, 480 E - TO RECLASS INSURANCE CAP REL COSTS-BLDG & FIXT 1.00 1.00 0 37, 198 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 58, 181 2.00 95, 379 F - TO RECLASS DEPRECIATION 1.00 ASSISTED LIVING 192. 02 0 163, 121 1.00 2.00 0.00 2.00 ō 163, 121 G - TO RECLASS ONCALL EXPENSE OPERATING ROOM 1.00 50.00 61, 050 1.00 61, 050 H - TO RECLASS IV THERAPY TO MED SUP MEDICAL SUPPLIES CHARGED TO 1.00 71.00 0 8.468 1.00 2.00 0.00 0 0 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 4.00 0 5.00 0.00 0 5.00 TOTALS o 8, 468 I - TO RECLASS CLINIC PHYSICIAN BENEFITS CLINIC 1.00 37, 423 1.00 90.00 TOTALS 37, 423 J - TO RECLASS MIDLEVEL PROVIDERS 415, 957 1.00 ADULTS & PEDIATRICS 30.00 1.00

0

415, 957

500.00

1, 423, 892

TOTALS

500.00 Grand Total: Increases

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 14-1332

In Lieu of Form CMS-2552-10
Worksheet A-6 Period: Worksheet A-6
From 07/01/2022
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm

						11/20/2023 2: 02 pm
		Decreases				
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - TO RECLASS DRUG COST FROM	M PHARMACY				
1.00	PHARMACY	15. 00	0	595, 595	0	1.0
	TOTALS		0	595, 595		
	B - TO RECLASS MED SUPPLY FRO	OM PHARMACY				
1.00	PHARMACY	15. 00	0	1, 417	0	1. 0
	TOTALS		0	1, 417		
	C - TO RECLASS MED SUPPLY FRO	OM OR				
1.00	OPERATING ROOM	50.00	0	20, 002	0	1.0
	TOTALS			20, 002		
	D - TO RECLASS OXGEN FROM RT	TO MED SUP	•	,		
1.00	RESPI RATORY THERAPY	65. 00	0	25, 480	0	1.0
	TOTALS			25, 480		
	E - TO RECLASS INSURANCE				'	
1.00	ADMINISTRATION & GENERAL	5. 01	0	95, 379	12	1.0
2. 00		0.00	O	0	12	2.0
	TOTALS			95, 379		
	F - TO RECLASS DEPRECIATION	<u> </u>				
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	145, 700	9	1.0
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	O	17, 421	9	2.0
	TOTALS			163, 121		
	G - TO RECLASS ONCALL EXPENSI		-			
1. 00	ANESTHESI OLOGY	53.00	0	61, 050	0	1.0
	TOTALS			61, 050		
	H - TO RECLASS IV THERAPY TO	MED SUP	<u> </u>	0.,000		
1. 00	PHARMACY	15. 00	0	5, 618	0	1.0
2. 00	ADULTS & PEDIATRICS	30.00	0	272	0	2.0
3. 00	OPERATING ROOM	50.00	0	1, 880	0	3.0
4. 00	ANESTHESI OLOGY	53. 00	0	165	0	4.0
5. 00	EMERGENCY	91. 00	0	533		5.0
0.00	TOTALS		— — — 			0.0
	I - TO RECLASS CLINIC PHYSIC	AN RENEFITS	9	0, 100		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37, 423	0	1.0
1.00	TOTALS		— — ў	37, 423	— — "	1.0
	J - TO RECLASS MIDLEVEL PROVI	DERS	<u> </u>	37, 423		
1. 00	EMERGENCY	91.00	nl	415. 957	0	1.0
1.00	TOTALS		— — — ў	41 <u>5, 4</u> 57 415, 957		1.0
500.00	Grand Total: Decreases		0	1, 423, 892		500.0
300.00	Jordina Total. Decleases	l l	Ч	1, 423, 072		500. 0

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1332

						11/20/2023 2: (U2 pm
				Acquisitions			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	355, 860	0	0	0	25, 000	1.00
2.00	Land Improvements	1, 814, 732	13, 477		13, 477	0	2.00
3.00	Buildings and Fixtures	17, 955, 388	129, 874	0	129, 874	14, 420	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	164, 333	0	0	0	0	5.00
6.00	Movable Equipment	16, 043, 958	1, 108, 476	0	1, 108, 476	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36, 334, 271	1, 251, 827	0	1, 251, 827	39, 420	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36, 334, 271	1, 251, 827	0	1, 251, 827	39, 420	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	330, 860	0				1.00
2.00	Land Improvements	1, 828, 209	0				2.00
3.00	Buildings and Fixtures	18, 070, 842	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	164, 333	0				5.00
6.00	Movable Equipment	17, 152, 434	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	37, 546, 678	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	37, 546, 678	0				10.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

In Lieu of Form CMS-2552-10

Period: Worksheet A-7

From 07/01/2022 Part II

To 06/30/2023 Date/Time Prepared:
11/20/2023 2:02 pm Provider CCN: 14-1332

						11/20/2023 2:	02 pm_
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	675, 132	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	711, 094	0		0	0	2.00
3.00	Total (sum of lines 1-2)	1, 386, 226	0		0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	675, 132				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	711, 094				2.00
3.00	Total (sum of lines 1-2)	o	1, 386, 226				3.00

Health Financial Systems

In Lieu of Form CMS-2552-10 RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 14-1332 Peri od: Worksheet A-7

From 07/01/2022 Part III 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL Cost Center Description Gross Assets Capi tal i zed Gross Assets Ratio (see Insurance for Ratio instructions) Leases (col. 1 col. 2) 1.00 2.00 3.00 4.00 5.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 20 1.00 20, 063, 383 20, 063, 383 0.539109 1.00 0 CAP REL COSTS-MVBLE EQUIP 2.00 17, 152, 434 17, 152, 434 0.460891 0 2.00 3.00 Total (sum of lines 1-2) 37, 215, 817 37, 215, 817 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes 0ther Total (sum of Depreciation Lease Capi tal -Rel at cols. 5 ed Costs through 7) 10.00 6.00 7.00 9.00 8.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS CAP REL COSTS-BLDG & FIXT 0 383, 003 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 681, 819 0 2.00 Total (sum of lines 1-2) 0 0 1,064,822 0 3.00 3.00 SUMMARY OF CAPITAL Other Total (2) Capital-Relat (sum of cols. Cost Center Description Interest Insurance Taxes (see instructions) (see instructions) ed Costs (see 9 through 14) instructions) 11.00 12.00 13.00 14.00 15.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 1.00 0 37, 198 420, 201 1.00 0 CAP REL COSTS-MVBLE EQUIP 0 58, 181 0 2 00 740, 000 2.00

0

95, 379

0

1, 160, 201

3.00

3.00

Total (sum of lines 1-2)

n Fi nanci al Systems

Health Financial Systems

ADJUSTMENTS TO EXPENSES

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 14-1332

Period:
From 07/01/2022

06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -136, 241 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) -4, 818 ADMINISTRATION & GENERAL 4.00 Trade, quantity, and time В 5.01 4.00 discounts (chapter 8) 5.00 Refunds and rebates of -19,842 ADMINISTRATION & GENERAL 5.01 5.00 B expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 -415 ADMINISTRATION & GENERAL 5. 01 7.00 Α stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 0 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -1, 952, 923 10.00 Provi der-based physici an 10.00 A - 8 - 2adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -43, 611 DI ETARY 10.00 14.00 В 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than В -174 MEDICAL SUPPLIES CHARGED TO 71.00 17.00 pati ents PAT Sale of medical records and -3,548 MEDICAL RECORDS & LIBRARY 18.00 18.00 R 16.00 abstracts 19.00 Nursing and allied health 0.00 19.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22 00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 *** Cost Center Deleted *** 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19.00 28.00 Physicians' assistant 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

Health Financial Systems ADJUSTMENTS TO EXPENSES

In Lieu of Form CMS-2552-10

Provider CCN: 14-1332

Worksheet A-8 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

5.01

0 47.08

50.00

				To	06/30/2023	Date/Time Pre 11/20/2023 2:	pared: 02 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	•	(2)				Ref.	
		1. 00	2. 00	3.00	4.00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	A	-11, 854	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32.00
	Depreciation and Interest		,				
33.00	NUTRI TI ONAL SERVI CES	Α	-3, 395	DI ETARY	10. 00	0	33.00
34.00	CRNA	A		ANESTHESI OLOGY	53. 00	0	34.00
35. 00	LOBBYING PORTION OF DUES	A	· ·	ADMINISTRATION & GENERAL	5. 01	0	35.00
36. 00	MARKETING COSTS	A		ADMINISTRATION & GENERAL	5. 01	0	36.00
40. 00	ACCRETION COSTS	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	40.00
41. 00	OTHER ADJUSTMENTS (SPECIFY)	, ,	1, 1, 0	l KEE GOOTO BEBO WITKI	0.00	0	1
41.00	(3)				0.00	O	11.00
42.00	OTHER MI SCELLANEOUS	В	_100	RADI OLOGY-DI AGNOSTI C	54. 00	0	42.00
43. 00	OTHER ADJUSTMENTS (SPECIFY)	, B	100	INDIOLOGI DI AGNOSTI C	0.00	0	1
43.00	(3)				0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	44.00
44.00	(3)		0		0.00	0	44.00
45. 00	DAYCARE REIMBURSEMENT	В	-7 010	ADMINISTRATION & GENERAL	5. 01	0	45.00
45. 00	AMBULANCE REIMBURSEMENT	В	· ·	ADMINISTRATION & GENERAL	5. 01	0	
45. 05	MEDICALD TAX ASSESSMENT	A		ADMINISTRATION & GENERAL	5. 01	0	45.05
45. 06	RETIREMENT OBLIGATION	Ä		CAP REL COSTS-BLDG & FIXT	1. 00	9	•
45. 07	DONATIONS	A		ADMINISTRATION & GENERAL	5. 01	7	45.00
45. 48	di di di di di di di di di di di di di d	A	-1,4/3	ADMINISTRATION & GENERAL	0.00	0	
45. 48			0		0.00	Ü	45.48
45. 49	(3) PHYSI CI AN RECRUI TMENT	_	0.400	ADMINISTRATION & GENERAL	5. 01	0	45. 49
45. 49	LAND RENTAL TO HILLSBORO AREA	A	· ·	ADMINISTRATION & GENERAL ADMINISTRATION & GENERAL	5. 01 5. 01	0	
45. 50	HEALTH	A	-41	ADMINISTRATION & GENERAL	5. 01	Ü	45.50
47. 00	BEHAVIORAL HEALTH OTHER	В	-55, 539	CLINIC	90. 00	0	47.00
47.00	REVENUE	В	-55, 539	CLINIC	90.00	Ü	47.00
47 01		D	2 702	DUVELCAL TUEDADY	44 00	0	47.01
47. 01	PHYSICAL THERAPY STAFF REVENUE			PHYSI CAL THERAPY	66.00	-	
47. 02		В	-1,631	OCCUPATI ONAL THERAPY	67. 00	0	47. 02
47.00	REVENUE		21 000	ADMINISTRATION O CENEDAL	F 01	0	47.00
47. 03		В	-31,080	ADMINISTRATION & GENERAL	5. 01	0	47. 03
47.04	REI MBURSEMENT	^	4 022	CAD DEL COSTS DIDO 8 FLVT	1 00	9	47.04
47. 04		A	-4, 023	CAP REL COSTS-BLDG & FIXT	1. 00	9	47.04
47 05	SPACE DT	В	11/ 500	CLINIC	00.00	^	47. 05
47.05	PODI ATRY OTHER REVENUE	Ь	-116, 580	CLINIC	90.00	0	
47. 06	OTHER ADJUSTMENTS (SPECIFY)				0. 00	Ü	47. 06
47. 07	(3)		140 172	ADMINISTRATION & CENERAL	E 01	0	47. 07
47.07	OTHER COMMUNITY SERVICE EXPENSES	A	- 140, 1/3	ADMINISTRATION & GENERAL	5. 01	Ü	47.07
47 OO	LUCCULTAL DILEC		20	ADMINISTRATION & CENERAL	5.01	0	47 NO

-3, 353, 999

-30 ADMINISTRATION & GENERAL

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

47. 08 HOSPITAL DUES

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems Provider CCN: 14-1332

In Lieu of Form CMS-2552-10

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Peri od: Worksheet A-8-1 From 07/01/2022 06/30/2023 Date/Time Prepared:

11/20/2023 2:02 pm Li ne No. Cost Center Expense Items Amount of Amount Allowable Cost Included in Wks. A, column 1.00 2.00 3.00 4 00 5.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 66.00 PHYSI CAL THERAPY RENT 40, 663 40, 663 1.00 2.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT WELLNESS BENEFIT 125,000 2.00 125,000 3.00 0.00 0 3.00 4.00 0.00 0 4.00 TOTALS (sum of lines 1-4). 5.00 5.00 165, 663 165, 663 Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.

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

				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

i ci ilibai	Schicit ander true Aviii.					
6.00	G	HILLSBORO HEALTH SERVICES	0.00	HILLSBORO HEALTH SERVICES	0.00	6.00
7. 00	G	HILLSBORO HEALTH SERVICES	0.00	HILLSBORO HEALTH SERVICES	0.00	7.00
8. 00			0.00		0.00	8.00
9. 00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

Health Financial Systems

In Lieu of Form CMS-2552-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 14-1332 Peri od: Worksheet A-8-1

From 07/01/2022 OFFICE COSTS 06/30/2023

Date/Time Prepared: 11/20/2023 2:02 pm

	Net	Wkst.	A-7 Ref.																
	Adjustments																		
	(col. 4 minus																		
	col. 5)*																		
	6. 00		7.00																
	A. COSTS INCUR	RED A	ND ADJUSTI	MENTS	REQUI RED	AS A	RESULT	0F	TRANSACTI	ONS	WI TH	RELATED	ORGANI ZA	TI ONS	OR	CLAI MED	HOME		
	OFFICE COSTS:																		
1.00	0)	0] 1	1. 00
2.00	0)	0															2	2.00
3.00	0)	0															3	3.00
4.00	0	o]	0															4	4. 00
5.00	0	ol .																	5. 00

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

nas not	been posted to worksheet A,	COI UIIIIIS	i and/or	۷,	the allount	arrowabre	Silouiu	be Thui Cateu	TH COLUMN 4 OF	tilis pai t.	
	Related Organization(s)										
	and/or Home Office										
	Type of Business										
	Type of Business										
	6. 00										
	0. 00										
	B. INTERRELATIONSHIP TO RELA	TED ORGAN	IZATION(S)	AND/OR HOME	OFFICE:					

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

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

	Comonit under the Arrive		
6. 00	HEALTH RELATED SERVICES	6.	5. 00
7. 00	HEALTH RELATED SERVICES	7.	7. 00
8. 00		8.	3. 00
9.00		9.	9. 00
10.00		10.	0.00
100.00		100.	0.00

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

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

In Lieu of Form CMS-2552-10

Provider CCN: 14-1332

Peri od: Worksheet A-8-2 From 07/01/2022 06/30/2023 Date/Time Prepared:

1, 952, 923

200.00

11/20/2023 2:02 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5.00 7. 00 6 00 60. 00 LABORATORY 1.00 103, 154 57,818 45, 336 1.00 0 2.00 69. 00 ELECTROCARDI OLOGY 36, 144 36, 144 0 2.00 91. 00 EMERGENCY 3.00 1,885,648 893, 609 992, 039 0 0 0 3.00 19, 200 0 4.00 65. 50 SLEEP LAB 19, 200 4.00 5.00 90. 00 CLI NI C 966, 584 621, 378 345, 206 0 5.00 6.00 30. 00 ADULTS & PEDIATRICS 324, 774 324, 774 6.00 0 0 7.00 0.00 0 0 7.00 0 0.00 8.00 0 8.00 0 0 0 0 9.00 0.00 0 0 9.00 10.00 0.00 0 10.00 1, 952, 923 3, 335, 504 1, 382, 581 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col Insurance Education 12.00 1.00 2.00 8. 00 9.00 13.00 14. 00 1.00 60. 00 LABORATORY 0 0 1.00 2.00 69. 00 ELECTROCARDI OLOGY 0 0 0 0 2.00 91. 00 EMERGENCY 0 3.00 0 0 0 3.00 0 0 0 0 4.00 65. 50 SLEEP LAB 0 4.00 5.00 90. 00 CLI NI C 0 0 0 5.00 30. 00 ADULTS & PEDIATRICS 0 0 0 6.00 0 0 0 6.00 0 0 0 7.00 7 00 0 00 0 0 0 8.00 0.00 0 8.00 9.00 0.00 0 0 9.00 0 10.00 0.00 0 0 0 C 10.00 o 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 16. 00 1.00 2.00 15.00 17.00 18.00 1.00 60. 00 LABORATORY 0 0 0 57,818 1.00 2.00 69. 00 ELECTROCARDI OLOGY 0 0 0 36, 144 2.00 0 3.00 91. 00 EMERGENCY 0 0 893, 609 3.00 0 19, 200 65. 50 SLEEP LAB 0 4.00 4.00 5.00 90. 00 CLI NI C 0 0 0 621, 378 5.00 6.00 30. 00 ADULTS & PEDIATRICS 0 0 0 324, 774 6.00 7.00 0 0 7.00 0 00 0 0 0.00 0 0 0 8.00 0 8.00 9.00 0.00 o 0 0 9.00 0 0 10.00 0.00 0 10.00 C

200.00

leal th Financial Systems HILLSBORO AREA HOSPITAL

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HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1332
From 07/01/2022
To 06/30/2023
Date/Time Prepared:
11/20/2023 2:02 pm

					00/30/2023	11/20/2023 2:	
			CAPI TAL REI	LATED COSTS			,
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)					
		0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	420, 201	420, 201				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	740, 000		740, 000			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 588, 536	1, 282	2, 257	3, 592, 075		4.00
5. 01	00592 ADMINISTRATION & GENERAL	4, 115, 756	127, 184	223, 979	505, 963	4, 972, 882	5. 01
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7. 00	00700 OPERATION OF PLANT	781, 015	34, 062		92, 537	967, 600	7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	147, 557	12, 300		11, 315	192, 834	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	231, 786 358, 162	1, 694 18, 240		64, 878 73, 476	301, 341 481, 999	9. 00 10. 00
11. 00	01100 CAFETERI A	338, 102	10, 240	1	73, 470	401, 777	11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	527, 364	8, 846	15, 578	65, 659	617, 447	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14. 01	01401 PURCHASI NG	0	0	0	0	0	14. 01
14. 02	01402 CENTRAL SERVICES & SUPPLY	73, 174	5, 225	9, 202	22, 369	109, 970	14. 02
15.00	01500 PHARMACY	427, 409	5, 759	10, 141	0	443, 309	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	451, 803	4, 781	8, 420	75, 706	540, 710	16.00
17. 00	01700 SOCI AL SERVI CE	475	0	0	0	475	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00	02100 1&R SERVICES-SALARY & FRINGES A 02200 1&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>		23.00
30.00	03000 ADULTS & PEDIATRICS	2, 234, 997	61, 526	108, 351	496, 374	2, 901, 248	30.00
	ANCILLARY SERVICE COST CENTERS	·	·				
50.00	05000 OPERATING ROOM	1, 378, 979	35, 665	62, 809	261, 016	1, 738, 469	50.00
53.00	05300 ANESTHESI OLOGY	23, 569	346		0	24, 525	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 006, 414	18, 541		215, 077	1, 272, 683	54.00
54. 01	03040 ULTRA SOUND	256, 849	1, 276		0	260, 372	54. 01
56.00	05600 RADI OI SOTOPE	450, 291	6, 028		24, 490	491, 425	56.00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	2, 583, 242	11, 421	20, 113	298, 481 0	2, 913, 257 0	60. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	240, 375	4, 740	8, 348	70, 543	324, 006	•
65. 50	06501 SLEEP LAB	93, 362	1, 617		6, 784	104, 610	65. 50
66. 00	06600 PHYSI CAL THERAPY	1, 436, 285	26, 999		436, 346	1, 947, 177	66.00
67.00	06700 OCCUPATI ONAL THERAPY	282, 726	618		90, 392	374, 824	
69.00	06900 ELECTROCARDI OLOGY	36, 315	0	0	0	36, 315	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	85, 763	0	0	0	85, 763	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	595, 595	0	0	0	595, 595	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	657, 313	1, 126	1, 983	171, 865	832, 287	90.00
91.00	09100 EMERGENCY	2, 632, 920	30, 925		339, 829	3, 058, 135	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	2,032,920	30, 723	34, 401	337, 027	0,000,100	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
118.00		25, 858, 233	420, 201	740, 000	3, 323, 100	25, 589, 258	118. 00
100.00	NONREI MBURSABLE COST CENTERS		^				100.00
	19200 PHYSICIANS' PRIVATE OFFICES 19203 PHYSICIANS' PRIVATE OFFICES		0		0		192. 00 192. 01
	2 19201 ASSISTED LIVING	1, 597, 873	0		268, 975	1, 866, 848	
200.00		1, 377, 073	Ü		200, 7/5		200.00
201.00	, ,		0	l ol	0		201.00
202.00		27, 456, 106	420, 201	740, 000	3, 592, 075	27, 456, 106	
		,	•				•

Provider CCN: 14-1332

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:
11/20/2023 2:02 pm

				''	0 00/30/2023	11/20/2023 2:	
	Cost Center Description	ADMI NI STRATI O	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	'	N & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 01	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
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	00592 ADMINISTRATION & GENERAL	4, 972, 882					5. 01
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	214, 016	0	1, 181, 616			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	42, 651	0	56, 406	291, 891		8.00
9.00	00900 HOUSEKEEPI NG	66, 651	0	7, 767	0	375, 759	9.00
10.00	01000 DI ETARY	106, 610	0	83, 642	o	28, 126	10.00
11.00	01100 CAFETERI A	0	0	0	o	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	o	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	136, 568	0	40, 564	o	13, 640	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	o	0	14.00
14.01	01401 PURCHASI NG	o	0	0	o	0	14. 01
14. 02	01402 CENTRAL SERVICES & SUPPLY	24, 323	0	23, 962	o	8, 058	14. 02
15.00	01500 PHARMACY	98, 052	0	26, 408	o	8, 880	1
16.00	01600 MEDICAL RECORDS & LIBRARY	119, 595	0	1	o	7, 373	1
17. 00	01700 SOCIAL SERVICE	105	0	1	o	0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES A	0	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS A	0	0	Ō	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	٥,		<u> </u>	٦		20.00
30.00	03000 ADULTS & PEDI ATRI CS	641, 704	0	282, 140	291, 891	94, 875	30.00
00.00	ANCILLARY SERVICE COST CENTERS	011,701		202,110	271,071	71,070	00.00
50.00	05000 OPERATING ROOM	384, 518	0	163, 552	o	54, 997	50.00
53. 00	05300 ANESTHESI OLOGY	5, 424	0		l ől	534	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	281, 495	0		0	28, 590	•
54. 01	03040 ULTRA SOUND	57, 590	0	1	0	1, 968	
56. 00	05600 RADI OI SOTOPE	108, 694	0	1	0	9, 295	•
60.00	06000 LABORATORY	644, 360	0		0	17, 611	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	044, 300	0	1		0	62.30
65.00	06500 RESPIRATORY THERAPY	71, 664	0	1		7, 310	•
65. 50	06501 SLEEP LAB	23, 138	0	1	0	2, 493	1
66.00	06600 PHYSI CAL THERAPY	430, 681	0	1		41, 633	•
67.00	06700 OCCUPATI ONAL THERAPY	82, 904	0	1	0	953	1
69.00	06900 ELECTROCARDI OLOGY	8, 032	0	2, 633	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	18, 969	0		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	131, 735	0		0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	131, 735	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	T1	0			0	1
76. 99	07699 LI THOTRI PSY	0	0	1		0	ł
70. 99	OUTPATIENT SERVICE COST CENTERS	υĮ	U	· · · · · ·	U U	U	70.99
00 00	09000 CLINIC	184, 087	0	F 1/2	ام	1. 736	00 00
90.00	09100 EMERGENCY				0		90.00
91.00		676, 403	0	141, 813	U	47, 687	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
00 10	OTHER REIMBURSABLE COST CENTERS	ما		1 0	ام	0	00 10
99. 10	09910 CORF	0	0	l .	0	0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0	0	
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	1	0	0	1
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS			1			
118.00		4, 559, 969	0	1, 181, 616	291, 891	375, 759	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
	19203 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 01
	19201 ASSISTED LIVING	412, 913	0	0	0	0	192. 02
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 972, 882	0	1, 181, 616	291, 891	375, 759	202.00

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In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm

						11/20/2023 2:	02 pm
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
				OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		10. 00	11. 00	12.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT					I	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					I	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5. 01	00592 ADMINISTRATION & GENERAL					I	5. 01
6.00	00600 MAINTENANCE & REPAIRS					I	6.00
7.00	00700 OPERATION OF PLANT					I	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					I	8.00
9.00	00900 HOUSEKEEPI NG					I	9.00
10.00	1	700, 377				I	10.00
11.00		0	0			I	11.00
12.00		0	0	0		I	12.00
13. 00	1	o	0	Ö		I	13.00
14. 00		o	0	0		0	1
14. 01	01401 PURCHASI NG		0	0	_	0	14. 01
14. 02			0		-	Ö	14. 02
15. 00	1		0			0	15.00
16. 00	1 I	0	0			0	16.00
	1 I	0	0	0	0	_	•
17.00	1 I	0	0		U	0	17.00
19.00	1	0	0		U	0	19.00
20.00		0	0	0	0	0	20.00
21.00		0	0	0	-	0	21.00
22. 00		0	0	0		0	22.00
23. 00		0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00		700, 377	0	0	368, 470	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	1	0	0			0	
53.00	1	0	0	0	0	0	53.00
54.00	1	0	0	0	0	0	54.00
54.01	03040 ULTRA SOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	134, 394	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	0	0	31, 763	0	65.00
65.50	06501 SLEEP LAB	0	0	0	3, 055	0	65. 50
66.00	06600 PHYSI CAL THERAPY	O	0	0	o	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	О	0	67.00
69.00	06900 ELECTROCARDI OLOGY	o	0	0	o	0	69.00
71.00	l l	0	0	0	0	0	71.00
73.00	1	0	0	0	0	0	73.00
76. 97		0	0	0	o	0	76. 97
76. 98	1	ام	0	Ö	o	0	76. 98
76. 99	07699 LI THOTRI PSY	ام	0	Ö		0	76. 99
, 0, , ,	OUTPATIENT SERVICE COST CENTERS				<u> </u>		, , , , ,
90.00		0	0	0	O	0	90.00
	1		0				
	09200 OBSERVATION BEDS (NON-DISTINCT		O		155, 012	ı	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				l l		72.00
99. 10		0	0	0	ا	0	99. 10
99. 20		0	0	0		0	•
	1	0					1
99. 30	1	0	0			0	1
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	l U	0	0	U U	0	99. 40
110 00		700 277	0		000 010	0	110 00
118.00		700, 377	0	0	808, 219	0	118. 00
100.00	NONREI MBURSABLE COST CENTERS		^			_	102.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
	1 19203 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 01
	2 19201 ASSI STED LIVING	0	0	0	이	0	192. 02
200.00	1 1			_			200.00
201.00		0	0	0			201.00
202.00	0 TOTAL (sum lines 118 through 201)	700, 377	0	0	808, 219	, 0	202. 00

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				10	06/30/2023	11/20/2023 2:	
	Cost Center Description	PURCHASI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	<u> </u>
	· ·		SERVICES &		RECORDS &	SERVI CE	
			SUPPLY		LI BRARY		
	OFNEDAL OFDILLOS COOT OFNEDO	14. 01	14. 02	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						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	00592 ADMINI STRATI ON & GENERAL						5. 01
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						9.00
10.00	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVI CES & SUPPLY						14.00
14. 01	01401 PURCHASI NG	0	1// 212				14. 01
14. 02 15. 00	01402 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	166, 313 462				14. 02 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	367	577, 111 0	689, 971		16.00
17. 00	01700 SOCI AL SERVI CE	0	0	-	009, 971	580	1
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	02000 NURSI NG PROGRAM	0	0	0	0	Ö	20.00
	02100 I&R SERVICES-SALARY & FRINGES A	0	0	o	0	0	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	5, 882	2, 964	42, 691	580	30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	39, 963		61, 030	0	50.00
53.00	05300 ANESTHESI OLOGY	0	1, 034		6, 525	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03040 ULTRA SOUND	0	4, 319 3, 293		169, 426 27, 385	0	54. 00 54. 01
	05600 RADI OI SOTOPE	0	5, 293 527	36, 814	36, 418	0	56.00
60.00	06000 LABORATORY	0	93, 312	30, 014	121, 531	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0, 312	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	o	9, 058	0	65.00
65. 50	06501 SLEEP LAB	0	0	0	6, 284	0	65. 50
66.00	06600 PHYSI CAL THERAPY	0	1, 436	0	59, 661	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	225	0	6, 520	0	67.00
69. 00	06900 ELECTROCARDI OLOGY	0	18	0	8, 876	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	5, 203		17, 185	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	520, 411	25, 019	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	U	0	0	0	0	76. 99
90 00	09000 CLINIC	0	794	474	3, 363	0	90.00
	09100 EMERGENCY	0	9, 478		88, 999		
	09200 OBSERVATION BEDS (NON-DISTINCT	J	,, 170	2, 100	00, 777	Ŭ	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
118. 00		0	166, 313	577, 111	689, 971	580	118. 00
100.00	NONREI MBURSABLE COST CENTERS	-	-				100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
	19203 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 01 192. 02
192. 02 200. 00	19201 ASSISTED LIVING Cross Foot Adjustments	ا	O		U	0	200.00
200.00	,		0		0	0	200.00
201.00		0	166, 313	577, 111	689, 971		202.00
202.00	1.51/12 (54m 111105 110 till odgir 201)	ı Y	100, 313	377, 111	307, 771	300	1-02.00

Provider CCN: 14-1332

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:
11/20/2023 2:02 pm

				'	0 00/30/2023	11/20/2023 2:	
				INTERNS &	RESI DENTS		
			AULDOL NO	050111 050 041 4	050,4,050,07,45	5454455 55	
	Cost Center Description	NONPHYSI CI AN	NURSI NG		SERVI CES-OTHE	PARAMED ED	
		ANESTHETI STS	PROGRAM	RY & FRINGES	R PRGM COSTS A	PRGM	
		19. 00	20. 00	21.00	22.00	23. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 6. 00	00592 ADMINISTRATION & GENERAL 00600 MAINTENANCE & REPAIRS	-					5. 01 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						11.00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
14. 00	01400 CENTRAL SERVICES & SUFFEI						14. 00
14. 02	01402 CENTRAL SERVICES & SUPPLY						14. 02
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0					19.00
20.00	02000 NURSI NG PROGRAM		0				20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES A 02200 &R SERVICES-OTHER PRGM COSTS A			0	0		21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				U	0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u>I</u>		L			20.00
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	0	30. 00
	ANCILLARY SERVICE COST CENTERS				1		
50.00	05000 OPERATI NG ROOM	0	0	•		0	
53.00	05300 ANESTHESI OLOGY	0	0		0	0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03040 ULTRA SOUND	0	0	1	0	0	
56. 00	05600 RADI OI SOTOPE	0	0	i e		0	56.00
60.00	06000 LABORATORY	ő	0			0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	О	0	0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
65. 50	06501 SLEEP LAB	0	0	· -		0	65. 50
66.00	06600 PHYSI CAL THERAPY	0	0	0		0	66.00
67. 00 69. 00	06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY	0	0			0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0			0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	O	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	О	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS			1			00.00
	09000 CLI NI C 09100 EMERGENCY	0	0	•		0	
	09200 OBSERVATION BEDS (NON-DISTINCT	U	U	0	U	U	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	О	0	0	0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0			0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
110 00	SPECIAL PURPOSE COST CENTERS		0	1 0	٥	0	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0	0	0	0	118. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	O	0	Ιο	O	0	192. 00
	19203 PHYSICIANS' PRIVATE OFFICES	ol	0				192. 01
192. 02	19201 ASSISTED LIVING	O	0	0	o	0	192. 02
200.00	1 1	0	0	0	0		200. 00
201.00		0	0				201.00
202. 00	TOTAL (sum lines 118 through 201)	0	0	0	0	0	202. 00

Health Financial Systems

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1332 Peri od: Worksheet B From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:02 pm Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24. 00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00592 ADMINISTRATION & GENERAL 5.01 5.01 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 14.01 01401 PURCHASI NG 14.01 01402 CENTRAL SERVICES & SUPPLY 14.02 14.02 01500 PHARMACY 15 00 15 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES A 21.00 02200 I&R SERVICES-OTHER PRGM COSTS A 22.00 22.00 23 00 02300 PARAMED ED PRGM-(SPECIFY) 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 332, 822 0 5, 332, 822 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 2, 560, 611 2, 560, 611 50 00 05300 ANESTHESI OLOGY 53.00 40,620 0 40,620 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 853, 988 0 1, 853, 988 54.00 54.01 03040 ULTRA SOUND 356, 460 0 356, 460 54.01 05600 RADI OI SOTOPE 56.00 710, 816 710, 816 0 56.00 60.00 06000 LABORATORY 3, 976, 837 3, 976, 837 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 465, 539 0 465, 539 65.00 06501 SLEEP LAB 146, 994 146, 994 65.50 65.50 66.00 06600 PHYSI CAL THERAPY 2, 604, 397 2,604,397 66.00 67 00 06700 OCCUPATI ONAL THERAPY 468, 259 468, 259 67.00 06900 ELECTROCARDI OLOGY 0 53. 241 69.00 69.00 53. 241 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 127, 120 0 127, 120 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 272, 760 0 1, 272, 760 73.00 07697 CARDIAC REHABILITATION 0 76. 97 76.97 C 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 C 76.98 76. 99 07699 LI THOTRI PSY 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 1.027.904 1, 027, 904 90.00 0 09100 EMERGENCY 4, 177, 977 91.00 C 4, 177, 977 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 C 0 99.10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 C 0 99.20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 25, 176, 345 0 25, 176, 345 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19203 PHYSI CI ANS' PRI VATE OFFI CES 192.00 C 0

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2, 279, 761

27, 456, 106

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C

2, 279, 761

27, 456, 106

192.01

192.02

200.00

201 00

202.00

192. 02 19201 ASSISTED LIVING

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201 00

202.00

Heal th Fi nanci al Systems STATE HILLSBORO AREA HOSPI TAL

Health Financial Systems HILLSBORO AREA HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1332 Period: Worksheet B

From 07/01/2022

Part II

Date/Time Prepared: 06/30/2023 11/20/2023 2:02 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Di rectly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 4.00 2A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 1, 282 2, 257 3,539 3,539 4.00 0 00592 ADMINISTRATION & GENERAL 223, 979 498 5.01 127, 184 351, 163 5.01 00600 MAINTENANCE & REPAIRS 6.00 0 6.00 7.00 00700 OPERATION OF PLANT 00000000 34,062 59, 986 94, 048 91 7.00 00800 LAUNDRY & LINEN SERVICE 12, 300 21, 662 33, 962 8.00 8.00 11 00900 HOUSEKEEPI NG 2, 983 1, 694 4.677 9 00 9 00 64 10.00 01000 DI ETARY 18, 240 32, 121 50, 361 72 10.00 11.00 01100 CAFETERI A 0 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 12.00 0 01300 NURSING ADMINISTRATION 65 13.00 8,846 15, 578 24, 424 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 01401 PURCHASI NG 14.01 00000000 0 0 14.01 5, 225 01402 CENTRAL SERVICES & SUPPLY 9.202 22 14 02 14 427 14 02 15, 900 15.00 01500 PHARMACY 5, 759 10, 141 0 15.00 01600 MEDICAL RECORDS & LIBRARY 4, 781 8, 420 13, 201 75 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 0 0 01900 NONPHYSICIAN ANESTHETISTS 19 00 O 0 Ω 19 00 C 02000 NURSING PROGRAM 20.00 C 0 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES A 0 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS A 0 22.00 C 0 ol 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 108, 351 489 30.00 30.00 61, 526 169, 877 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 257 50 00 0 35, 665 62,809 98.474 53.00 05300 ANESTHESI OLOGY 0 346 610 956 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 0 18, 541 32, 651 51, 192 212 54.00 54.01 03040 ULTRA SOUND 1, 276 2, 247 3, 523 54 01 0 56.00 05600 RADI OI SOTOPE 6,028 10,616 16,644 24 56.00 06000 LABORATORY 60.00 11, 421 20, 113 31, 534 294 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 000000000 0 62.30 0 06500 RESPIRATORY THERAPY 13, 088 4,740 8.348 70 65.00 65.00 65.50 06501 SLEEP LAB 1, 617 2,847 4, 464 65.50 66.00 06600 PHYSI CAL THERAPY 26, 999 47, 547 74, 546 430 66.00 06700 OCCUPATI ONAL THERAPY 1, 088 1, 706 67.00 67.00 618 89 06900 ELECTROCARDI OLOGY 69.00 r 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT C 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0 76.97 0 0 0 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 C 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 1 983 3. 109 169 90.00 1.126 91.00 09100 EMERGENCY 0 30, 925 54, 461 85, 386 335 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 99 10 09910 CORF 0 0 0 0 99.20 09920 OUTPATIENT PHYSICAL THERAPY 0 C 0 0 0 99.20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 99.30 0 0 99.30 0 99 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 O 99.40 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 3, 274 118. 00 0 420, 201 740, 000 1, 160, 201 NONREI MBURSABLE COST CENTERS

192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 192. 00 0 0 192. 01 19203 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 192.01 0 192. 02 19201 ASSISTED LIVING 0 C 0 265 192.02 200 00 Cross Foot Adjustments 0 200 00 201.00 Negative Cost Centers 0 201.00

420, 201

740,000

1, 160, 201

3, 539 202. 00

TOTAL (sum lines 118 through 201)

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1332

				11	0 06/30/2023	11/20/2023 2:	
	Cost Center Description	ADMI NI STRATI O	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	<u> </u>
		N & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	SEMERAL OFFICE COOK OFFICE	5. 01	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-BEDG & TTXT						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00592 ADMINISTRATION & GENERAL	351, 661					5. 01
	00600 MAINTENANCE & REPAIRS	0	C			•	6.00
7. 00	00700 OPERATION OF PLANT	15, 134	C	109, 273			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 016	C	5, 216	42, 205		8. 00
	00900 HOUSEKEEPI NG	4, 713	C	718			9. 00
	01000 DI ETARY	7, 539	C	7, 735		761	10.00
	01100 CAFETERI A	0	C	0	0	0	11.00
	01200 MAI NTENANCE OF PERSONNEL	0 (57	C	0	0	0	12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	9, 657		3, 751	0	369 0	13. 00 14. 00
	01400 CENTRAL SERVICES & SUPPLY	0			_		14.00
	01402 CENTRAL SERVICES & SUPPLY	1, 720		2, 216	0	218	ł
	01500 PHARMACY	6, 934	C	2, 442	0	240	15. 00
	01600 MEDICAL RECORDS & LIBRARY	8, 457	C	2, 028	0	200	16. 00
	01700 SOCIAL SERVICE	7	C	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C	0	0	0	19.00
	02000 NURSING PROGRAM	0	C	0	0	0	20. 00
	02100 I&R SERVICES-SALARY & FRINGES A	0	C	0	0	0	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS A	0	C	_	0	0	22.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	C	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	45 270		24 002	42 205	2.540	20.00
	ANCILLARY SERVICE COST CENTERS	45, 378	C	26, 092	42, 205	2, 569	30.00
-	05000 OPERATING ROOM	27, 191	C	15, 125	0	1, 489	50.00
	05300 ANESTHESI OLOGY	384	C		0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	19, 906	C			774	54.00
54. 01	03040 ULTRA SOUND	4, 072	C	541	0	53	54. 01
	05600 RADI OI SOTOPE	7, 686	C	2, 556	0	252	56.00
	06000 LABORATORY	45, 566	C	4, 843	0	477	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0	0	0	62. 30
	06500 RESPIRATORY THERAPY	5, 068	C	2, 010	0	198	65.00
	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	1, 636		686	0		65. 50 66. 00
	06700 OCCUPATI ONAL THERAPY	30, 456 5, 863	C	11, 450 262	0	1, 127 26	67.00
	06900 ELECTROCARDI OLOGY	568		0	_	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 341	C	o o	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	9, 316	C	0	0	0	73.00
76. 97	07697 CARDIAC REHABILITATION	0	C	0	0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	C	0	0	0	76. 98
⊢	07699 LI THOTRI PSY	0	C	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	10.010				.=	
	09000 CLI NI C 09100 EMERGENCY	13, 018	C		0		90.00
	09200 OBSERVATION BEDS (NON-DISTINCT	47, 836	C	13, 115	0	1, 291	91.00 92.00
_	OTHER REIMBURSABLE COST CENTERS						92.00
	09910 CORF	O	C	0	0	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	C	1	0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	o	C		0	0	99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	O	C	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	322, 462	C	109, 273	42, 205	10, 172	118. 00
	NONREI MBURSABLE COST CENTERS				0		100.00
	19200 PHYSICIANS' PRIVATE OFFICES 19203 PHYSICIANS' PRIVATE OFFICES	0	C				192. 00 192. 01
	19203 PHYSICIANS PRIVATE OFFICES	29, 199			0		192. 01
200.00	Cross Foot Adjustments	27, 177	C		U		200.00
201.00	Negative Cost Centers	o	C	0	O	n	201.00
202. 00	TOTAL (sum lines 118 through 201)	351, 661	C	109, 273	42, 205		
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Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Provider CCN: 14-1332

Peri od: Worksheet B From 07/01/2022 Part II 06/30/2023 Date/Time Prepared:

11/20/2023 2:02 pm Cost Center Description DI ETARY CAFETERI A MAI NTENANCE NURSI NG CENTRAL ADMI NI STRATI O SERVICES & OF PERSONNEL Ν **SUPPLY** 12.00 10 00 11 00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00592 ADMINISTRATION & GENERAL 5.01 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 66, 468 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 38, 266 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 0 01401 PURCHASI NG 14.01 0 0 0 14.01 0 14.02 01402 CENTRAL SERVICES & SUPPLY 0 0 14.02 01500 PHARMACY 0 15.00 0 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 0 0 16,00 01700 SOCIAL SERVICE 0 17 00 C 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 19.00 02000 NURSING PROGRAM 0 0 0 20.00 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES A 0 21.00 C 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS A 0 C 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 17, 446 30.00 66, 468 0 0 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 5, 564 0 50.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 0 54.00 0 54.01 03040 ULTRA SOUND 0 0 0 54.01 05600 RADI OI SOTOPE 0 56.00 00000000 0 0 56.00 60 00 06000 LABORATORY 0 0 6.363 0 60 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 1,504 0 65.00 65.50 06501 SLEEP LAB 145 0 65.50 66.00 06600 PHYSI CAL THERAPY 0 66.00 Ω 0 0 06700 OCCUPATIONAL THERAPY 0 67.00 C 0 0 67.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 Ω 71 00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 C 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 ol 0 76.98 07699 LI THOTRI PSY 76.99 0 0 76.99 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 7, 244 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 99.10 0 0 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 99.20 0 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 99 30 0 C 0 0 0 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 0 99.40 99.40 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 66, 468 0 38, 266 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19203 PHYSI CI ANS' PRI VATE OFFI CES 0 192.00 C 0 0 192.01 0 0 0 0 0 192.02 192. 02 19201 ASSISTED LIVING 0 0 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 0 202.00 202.00 TOTAL (sum lines 118 through 201) 0 0 38, 266 66.468

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1332

						11/20/2023 2:	02 pm
	Cost Center Description	PURCHASI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
			SERVICES &		RECORDS &	SERVI CE	
			SUPPLY		LI BRARY		
0.51	HEDAL CERVILOE COCT CENTERS	14. 01	14. 02	15. 00	16. 00	17. 00	
	NERAL SERVICE COST CENTERS						1 00
	100 CAP REL COSTS-BLDG & FIXT					ļ	1.00
	200 CAP REL COSTS-MVBLE EQUIP					ļ	2.00
	400 EMPLOYEE BENEFITS DEPARTMENT					ļ	4.00
	592 ADMINISTRATION & GENERAL					ļ	5. 01
	600 MAINTENANCE & REPAIRS					ļ	6. 00
	700 OPERATION OF PLANT					ļ	7. 00
8.00 008	BOO LAUNDRY & LINEN SERVICE					ļ	8. 00
9.00 009	900 HOUSEKEEPI NG					ļ	9. 00
10.00 010	DOO DI ETARY						10.00
11. 00 01	100 CAFETERI A					ļ	11.00
12.00 012	200 MAINTENANCE OF PERSONNEL					l	12.00
13. 00 01;	300 NURSING ADMINISTRATION					ļ	13.00
14. 00 014	400 CENTRAL SERVICES & SUPPLY					ļ	14.00
	401 PURCHASI NG	0				l	14. 01
	402 CENTRAL SERVICES & SUPPLY	0	18, 603			ļ	14. 02
	500 PHARMACY	0	52	25, 568		ļ	15.00
	600 MEDICAL RECORDS & LIBRARY	0	41	0	24, 002	ļ	16.00
	700 SOCIAL SERVICE	0	0	0	21,002	7	17.00
	900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	Ó	
	DOO NURSI NG PROGRAM	0	0	0	0	0	1
	100 I&R SERVICES-SALARY & FRINGES A	0	0	0		0	
		0	0	0	0	-	
	200 I&R SERVICES-OTHER PRGM COSTS A	0	-	- 1	- 1	0	
23. 00 023	BOO PARAMED ED PRGM-(SPECIFY)	U	0	0	0	0	23. 00
	PATIENT ROUTINE SERVICE COST CENTERS		(50	404	4 405		00.00
	000 ADULTS & PEDIATRICS	0	658	131	1, 485	7	30.00
	CILLARY SERVICE COST CENTERS			0.51	0.400		
	OOO OPERATING ROOM	0	4, 470	25	2, 123	0	
	300 ANESTHESI OLOGY	0	116		227	0	
	400 RADI OLOGY-DI AGNOSTI C	0	483	552	5, 893	0	
	040 ULTRA SOUND	0	368		953	0	1
	600 RADI OI SOTOPE	0	59	1, 631	1, 267	0	56.00
	DOO LABORATORY	0	10, 437	0	4, 228	0	60.00
62. 30 062	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06!	500 RESPI RATORY THERAPY	0	0	0	315	0	65.00
65. 50 06!	501 SLEEP LAB	0	0	0	219	0	65. 50
66.00 066	600 PHYSI CAL THERAPY	0	161	0	2, 075	0	66.00
67.00 06	700 OCCUPATI ONAL THERAPY	0	25	0	227	0	67.00
69.00 069	900 ELECTROCARDI OLOGY	0	2	0	309	0	69.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PAT	0	582	0	598	0	71.00
73. 00 07:	300 DRUGS CHARGED TO PATIENTS	0	0	23, 055	870	0	73.00
	697 CARDIAC REHABILITATION	0	0	0	o	0	76. 97
76. 98 076	698 HYPERBARIC OXYGEN THERAPY	0	0	0	o	0	76. 98
	699 LI THOTRI PSY	0	0	o	o	0	76. 99
	FPATIENT SERVICE COST CENTERS			- 1			
	DOO CLI NI C	0	89	21	117	0	90.00
	100 EMERGENCY	0	1, 060		3, 096	0	
	200 OBSERVATION BEDS (NON-DISTINCT	_	.,		2, 2.2	-	92.00
	HER REIMBURSABLE COST CENTERS						/2.00
	910 CORF	0	0	0	0	0	99. 10
	920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
	930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	Ö	0	0	
	940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	1
	ECLAL PURPOSE COST CENTERS	0	0	0	<u> </u>	0	77.40
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	18, 603	25, 568	24, 002	7	118.00
	NREI MBURSABLE COST CENTERS	<u> </u>	10, 003	23, 300	24,002	,	110.00
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
	203 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	201 ASSISTED LIVING	0	0		0		192.01
200.00	Cross Foot Adjustments	U	U		٩		200.00
200.00	Negative Cost Centers	0	0				200.00
201.00	TOTAL (sum lines 118 through 201)	0	18, 603	25, 568	24, 002		201.00
202.00	TOTAL (Sum TIMES TTO LINGUIGHT 201)	U	10, 003	20,000	24, 002	/	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1332

						11/20/2023 2:	:02 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	NONPHYSI CI AN	NURSI NG		SERVI CES-OTHE	PARAMED ED	
		ANESTHETI STS	PROGRAM	RY & FRINGES		PRGM	
		10.00	20.00	A 21 00	A	22.00	
-	GENERAL SERVICE COST CENTERS	19. 00	20. 00	21.00	22. 00	23. 00	
-	DO100 CAP REL COSTS-BLDG & FLXT			1			1.00
1	00200 CAP REL COSTS-MVBLE EQUIP					1	2.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
1	00592 ADMINISTRATION & GENERAL					1	5. 01
	00600 MAINTENANCE & REPAIRS						6.00
	00700 OPERATION OF PLANT						7. 00
	DO800 LAUNDRY & LINEN SERVICE						8.00
4	00900 HOUSEKEEPI NG						9.00
4	01000 DI ETARY						10.00
1	D1100 CAFETERI A						11.00
1	D1200 MAINTENANCE OF PERSONNEL						12.00
1	D1300 NURSI NG ADMI NI STRATI ON						13.00
1	01400 CENTRAL SERVICES & SUPPLY						14.00
4	01401 PURCHASI NG						14. 01
1	01402 CENTRAL SERVICES & SUPPLY						14. 02
1	D1500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY						16.00
4	01700 SOCIAL SERVICE						17. 00
	01900 NONPHYSICIAN ANESTHETISTS	n					19.00
1	D2000 NURSI NG PROGRAM		o				20.00
4	D2100 &R SERVICES-SALARY & FRINGES A			1 0			21.00
4	D2200 I &R SERVICES-OTHER PRGM COSTS A				0		22.00
	D2300 PARAMED ED PRGM-(SPECIFY)					C	
	NPATIENT ROUTINE SERVICE COST CENTERS			l			25.00
	D3000 ADULTS & PEDIATRICS						30.00
<u> </u>	ANCILLARY SERVICE COST CENTERS	<u>I</u>					
	05000 OPERATING ROOM						50.00
53.00	D5300 ANESTHESI OLOGY						53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C						54.00
54. 01	03040 ULTRA SOUND						54. 01
56.00	D5600 RADI OI SOTOPE						56.00
60.00	06000 LABORATORY						60.00
	D6250 BLOOD CLOTTING FOR HEMOPHILIACS						62. 30
65.00	D6500 RESPIRATORY THERAPY						65.00
65. 50	D6501 SLEEP LAB						65. 50
	D6600 PHYSI CAL THERAPY						66. 00
	06700 OCCUPATI ONAL THERAPY						67. 00
	06900 ELECTROCARDI OLOGY						69. 00
1	07100 MEDICAL SUPPLIES CHARGED TO PAT						71.00
	D7300 DRUGS CHARGED TO PATIENTS						73.00
	07697 CARDI AC REHABI LI TATI ON						76. 97
1	07698 HYPERBARIC OXYGEN THERAPY						76. 98
	07699 LI THOTRI PSY						76. 99
H	OUTPATIENT SERVICE COST CENTERS			1			
4	09000 CLI NI C						90.00
	09100 EMERGENCY						91.00
	09200 OBSERVATION BEDS (NON-DISTINCT						92. 00
	OTHER REIMBURSABLE COST CENTERS			I			00.10
	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY					l	99. 10 99. 20
99. 20	20020 OUTPATIENT OCCUPATIONAL THERAPY						•
	09930 OUTPATIENT OCCUPATIONAL THERAPY						99. 30
	D9940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS						99. 40
		0					1110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0	0	0		118. 00
	19200 PHYSICIANS' PRIVATE OFFICES						192. 00
	19200 PHYSICIANS PRIVATE OFFICES						192.00
	19203 PHTSICIANS PRIVATE OFFICES						192.01
200.00	Cross Foot Adjustments	0	0	0	0		200.00
200.00	Negative Cost Centers	0	-				201.00
201.00	TOTAL (sum lines 118 through 201)	O		l .			202.00
202.00	1.51712 (5411 111165 116 till bugit 201)	1	٠ -	1		,	1-02.00

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

Period: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 11/20/2023 2: 02 pm Provider CCN: 14-1332

						11/20/2023 2:	02 pm
		Cost Center Description	Subtotal	Intern &	Total		
				Residents			
				Cost & Post			
				Stepdown			
			24. 00	Adjustments 25.00	26. 00		
	GENER	AL SERVICE COST CENTERS	24.00	25.00	20.00		
1.00		CAP REL COSTS-BLDG & FLXT					1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP					2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	1	ADMINISTRATION & GENERAL					5. 01
6.00		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	1	CAFETERI A					11.00
12.00	1	MAINTENANCE OF PERSONNEL					12. 00
13.00	1	NURSI NG ADMI NI STRATI ON					13.00
14.00		CENTRAL SERVICES & SUPPLY					14.00
14. 01	1	PURCHASI NG					14. 01
14. 02		CENTRAL SERVICES & SUPPLY					14. 02
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY					15. 00 16. 00
17. 00		SOCIAL SERVICE					17.00
17.00	1	NONPHYSI CI AN ANESTHETI STS					19.00
20.00	1	NURSI NG PROGRAM					20.00
21. 00		I&R SERVICES-SALARY & FRINGES A					21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS A					22.00
23. 00	1	PARAMED ED PRGM-(SPECIFY)					23. 00
		LENT ROUTINE SERVICE COST CENTERS			l.		1
30.00		ADULTS & PEDIATRICS	372, 805	0	372, 805		30.00
	ANCI L	LARY SERVICE COST CENTERS					
50.00		OPERATING ROOM	154, 718	0	154, 718		50.00
53.00		ANESTHESI OLOGY	1, 888	0	,		53.00
54.00		RADI OLOGY-DI AGNOSTI C	86, 875	0	86, 875		54.00
54. 01		ULTRA SOUND	9, 510	0	9, 510		54. 01
56.00		RADI OI SOTOPE	30, 119	0			56.00
60.00		LABORATORY	103, 742	0	103, 742		60.00
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS	22 252	0	0		62.30
65. 50		RESPI RATORY THERAPY SLEEP LAB	22, 253 7, 224	0	22, 253 7, 224		65. 00 65. 50
66.00	1	PHYSI CAL THERAPY	120, 245	0			66.00
67. 00	1	OCCUPATI ONAL THERAPY	8, 198	0	8, 198		67.00
69. 00		ELECTROCARDI OLOGY	879	0	879		69.00
71. 00		MEDICAL SUPPLIES CHARGED TO PAT	2, 521	0	2, 521		71.00
73. 00	1	DRUGS CHARGED TO PATIENTS	33, 241	0			73.00
76. 97		CARDIAC REHABILITATION	0	0			76. 97
76. 98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76. 98
76. 99	07699	LI THOTRI PSY	0	0	0		76. 99
	OUTPA"	TIENT SERVICE COST CENTERS					
		CLI NI C	17, 047	0			90.00
		EMERGENCY	159, 472	0			91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT		0			92.00
00.40		REIMBURSABLE COST CENTERS	ام	0			- 00 10
			0	0	0		99. 10
		OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY	U	0	0		99. 20 99. 30
99. 40		OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY	0	0			99. 40
77. 40		AL PURPOSE COST CENTERS	U _I	U	ı U		77.40
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 130, 737	0	1, 130, 737		118.00
1 10.00	_	IMBURSABLE COST CENTERS	1, 130, 737		1, 130, 737		1.10.00
192. 00		PHYSICIANS' PRIVATE OFFICES	0	0	0		192. 00
	4	PHYSICIANS' PRIVATE OFFICES	ol	0	l		192. 01
		ASSISTED LIVING	29, 464	0	29, 464		192. 02
200.00		Cross Foot Adjustments	O	0	0		200.00
201.00		Negative Cost Centers	o	0	0		201.00
202.00)	TOTAL (sum lines 118 through 201)	1, 160, 201	0	1, 160, 201		202.00

leal th Fi nanci al Systems

Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:
From 07/01/2022
To 06/30/2023

Date/Time Prepared:

					o 06/30/2023	Date/Time Pre	
		CAPITAL REL	ATED COSTS			11/20/2023 2:	02 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEE	MVBLE EQUIP (SQUARE FEE	EMPLOYEE BENEFITS	Reconciliatio n	ADMI NI STRATI O N & GENERAL	
		T)	T)	DEPARTMENT (GROSS		(ACCUM. COST)	
		1. 00	2. 00	SALARI ES) 4. 00	5A. 01	5. 01	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA. 01	3.01	
1. 00	00100 CAP REL COSTS-BLDG & FLXT	7, 277, 599					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	22, 200	7, 277, 599 22, 200	10, 889, 407			2. 00 4. 00
5. 01	00592 ADMINISTRATION & GENERAL	2, 202, 753	2, 202, 753	1, 533, 834		22, 483, 224	5. 01
6. 00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7.00	00700 OPERATION OF PLANT	589, 933	589, 933	280, 527	0	967, 600	
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	213, 033 29, 333	213, 033 29, 333	34, 302 196, 677	0	192, 834 301, 341	8. 00 9. 00
10. 00	01000 DI ETARY	315, 900	315, 900	222, 743	Ö		1
	01100 CAFETERI A	O	O	0	0	0	11. 00
	01200 MAINTENANCE OF PERSONNEL	152,200	152,200	100.047	0	(17 447	12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	153, 200 0	153, 200 0	199, 047 0	0	617, 447 0	13. 00 14. 00
	01401 PURCHASI NG	Ö	Ö	0	O	ő	14. 01
	01402 CENTRAL SERVICES & SUPPLY	90, 500	90, 500	67, 811	0	109, 970	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	99, 737 82, 810	99, 737 82, 810	0 229, 502	_	443, 309 540, 710	
	01700 SOCI AL SERVI CE	02, 010	02, 810	229, 302			1
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
	02100 &R SERVICES-SALARY & FRINGES A 02200 &R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0	21.00 22.00
	02300 PARAMED ED PRGM-(SPECIFY)	o	o	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					1	[
30. 00	03000 ADULTS & PEDIATRICS	1, 065, 587	1, 065, 587	1, 504, 762	0	2, 901, 248	30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	617, 700	617, 700	791, 272	0	1, 738, 469	50.00
53. 00	05300 ANESTHESI OLOGY	6, 000	6, 000	0	0		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	321, 113	321, 113	652, 008		1, 272, 683	1
54. 01 56. 00	03040 ULTRA SOUND 05600 RADI OI SOTOPE	22, 100 104, 400	22, 100 104, 400	74, 242	0	260, 372 491, 425	54. 01 56. 00
60.00	06000 LABORATORY	197, 800	197, 800	904, 846			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	82, 100	82, 100	213, 851	0	,	1
65. 50 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	28, 000 467, 600	28, 000 467, 600	20, 567 1, 322, 787	0	104, 610 1, 947, 177	65. 50 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	10, 700	10, 700	274, 024	0	374, 824	1
	06900 ELECTROCARDI OLOGY	0	0	0	0	36, 315	1
71. 00 73. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	85, 763 595, 595	1
	07697 CARDI AC REHABI LI TATI ON	0	o	0	0		
	07698 HYPERBARIC OXYGEN THERAPY	0		0	0		
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	19, 500	19, 500	521, 011	0	832, 287	90.00
	09100 EMERGENCY	535, 600		1, 030, 194			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
99 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	O	ol	0	0	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	Ö	Ö	0	_		
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 40
118. 00		7, 277, 599	7, 277, 599	10, 074, 007	-4, 972, 882	20, 616, 376	118. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	_		192.00
	19203 PHYSICIANS' PRIVATE OFFICES 19201 ASSISTED LIVING	0	0	0 815, 400		l .	192.01
200.00	l l			010, 400		1, 000, 040	200.00
201.00	Negative Cost Centers						201. 00
202. 00	''	420, 201	740, 000	3, 592, 075		4, 972, 882	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 057739	0. 101682	0. 329869		0. 221182	203. 00
204. 00	Cost to be allocated (per Wkst. B,			3, 539		351, 661	
205 00	Part II)			0 000335		0.015441	205 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000325		0. 015641	203.00
		'	'		1	'	•

Heal th Fi nanci al Systems HILLSBORO AREA HOSPITAL

(per Wkst. B-2)

207.00

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

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 14-1332 Worksheet B-1 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIO N & GENERAL (ACCUM. COST) (SQUARE FEE (SQUARE FEE **BENEFITS** n DEPARTMENT T) T) (GROSS SALARI ES) 1. 00 2.00 4.00 5A. 01 5. 01 206.00 NAHE adjustment amount to be allocated 206. 00

207.00

Heal th Fi nanci al Systems STATE HILLSBORO AREA HOSPITAL

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEE (PATI ENT **REPAIRS** PLANT (SQUARE FEET) (SQUARE FEE (PATI ENT DAYS) T) T) DAYS' 6. 00 9. 00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00592 ADMINISTRATION & GENERAL 5.01 5.01 6.00 00600 MAINTENANCE & REPAIRS 6.00 000000000000000 00700 OPERATION OF PLANT 4, 462, 713 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 213, 033 2,054 8.00 9 00 00900 HOUSEKEEPI NG 29, 333 0 4, 220, 347 9 00 01000 DI ETARY 315, 900 2,054 10.00 315, 900 0 10.00 01100 CAFETERI A 0 11.00 Λ 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 13.00 01300 NURSING ADMINISTRATION 153, 200 153, 200 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 14.00 0 0 0 14.01 01401 PURCHASI NG 0 0 14.01 14.02 01402 CENTRAL SERVICES & SUPPLY 90,500 90,500 14.02 15.00 01500 PHARMACY 99, 737 0 99, 737 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 82, 810 82, 810 0 16,00 17.00 01700 SOCIAL SERVICE 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 C 0 0 0 19.00 02000 NURSI NG PROGRAM 0 0 20.00 20.00 0 C 02100 I&R SERVICES-SALARY & FRINGES A 0 21.00 C 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS A 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 2, 054 2, 054 30.00 1, 065, 587 1, 065, 587 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 0 50.00 50.00 617, 700 0 617, 700 05300 ANESTHESI OLOGY 0 53.00 6,000 0 6,000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 321, 113 0 321, 113 0 54.00 54.01 03040 ULTRA SOUND 0 0 22, 100 0 22, 100 0 54.01 56 00 05600 RADI OI SOTOPE 104 400 O 104 400 56 00 0 06000 LABORATORY 0 60.00 197, 800 197, 800 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 0 82, 100 82, 100 0 65.00 06501 SLEEP LAB 28, 000 O 28, 000 65 50 0 65 50 66.00 06600 PHYSI CAL THERAPY 467,600 0 467,600 0 66.00 06700 OCCUPATI ONAL THERAPY 10, 700 0 67.00 10,700 67.00 69.00 06900 ELECTROCARDI OLOGY 0 0 C 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71 00 71 00 C 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 C 76.97 07697 CARDIAC REHABILITATION 0 C 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76. 98 0 0 07699 LI THOTRI PSY 76.99 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 19, 500 19, 500 90.00 91.00 09100 EMERGENCY 0 535, 600 0 0 91.00 535,600 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 n 0 0 n 99.10 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 0 99.20 C 0 0 0 99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 C 0 0 0 99.30 99 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 0 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 4, 462, 713 2,054 4, 220, 347 2, 054 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 192. 01 19203 PHYSICIANS' PRIVATE OFFICES 0 C 0 0 0 192, 01 192. 02 19201 ASSISTED LIVING 0 0 0 0 192.02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 0 291, 891 375, 759 700, 377 202. 00 202.00 1, 181, 616 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0. 264775 142. 108569 0.089035 340. 981986 203. 00 Cost to be allocated (per Wkst. B, 66, 468 204. 00 204.00 109, 273 42, 205 10, 172 Part II) 20. 547712 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.024486 0.002410 32. 360273 205. 00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207 00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

				10	06/30/2023	Date/lime Pre 11/20/2023 2:	
	Cost Center Description	CAFETERI A (GROSS SALARI ES)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSI NG ADMI NI STRATI O N (NURSI NG SALARI ES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PURCHASI NG (COSTED REQ UI S.)	SZ piii
		11. 00	12. 00	13.00	14. 00	14. 01	
1. 00 2. 00 4. 00 5. 01 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 14. 01	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00592 ADMINISTRATION & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01401 PURCHASING	7, 805, 924 0 199, 047 0 0	0 0 0 0 0		0	0	
20. 00 21. 00 22. 00 23. 00	01402 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES A 02200 I &R SERVICES-OTHER PRGM COSTS A 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	67, 811 0 229, 502 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 504, 762	0	2, 480, 824	0	0	30.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03040 ULTRA SOUND 05600 RADI OI SOTOPE 06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PAT 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	791, 272 0 652, 008 0 74, 242 904, 846 0 213, 851 20, 567 1, 322, 787 274, 024 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 904, 846 0 213, 851 20, 567 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53. 00 54. 00 54. 01 56. 00 60. 00 62. 30 65. 00 66. 00 67. 00 69. 00 71. 00 73. 00 76. 97 76. 98 76. 99
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
99. 20 99. 30	OTHER REIMBURSABLE COST CENTERS 09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 0 0 0 0	0 0 0 0	0 0	0 0 0 0	0 0 0 0	99. 20 99. 30
192. 01	19200 PHYSICIANS' PRIVATE OFFICES 19203 PHYSICIANS' PRIVATE OFFICES 19201 ASSISTED LIVING Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	O O O	0 0 0	0	0 0 0	0	192. 00 192. 01 192. 02 200. 00 201. 00 202. 00
203. 00 204. 00	Cost to be allocated (per Wkst. B, Part II)	0. 000000	0. 000000	38, 266	0. 000000 0		204. 00
205. 00 206. 00		0. 000000	0. 000000	0.007032	0. 000000	0. 000000	205. 00 206. 00

Heal th Financial Systems HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Peri od: From 07/01/2022 To 06/30/2023 Provi der CCN: 14-1332 Worksheet B-1 Date/Time Prepared: 11/20/2023 2:02 pm Cost Center Description CAFETERI A MAI NTENANCE NURSI NG CENTRAL PURCHASI NG (GROSS OF PERSONNEL ADMI NI STRATI O SERVICES & (COSTED REQ SALARI ES) (NUMBER Ν SUPPLY UIS.) (COSTED HOUSED) (NURSI NG SALARI ES) REQUIS.) 11. 00 12.00 13.00 14.01 14.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) 207.00 207.00

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Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332
From 07/01/2022
To 06/30/2023
Period:
From 07/01/2022
To 06/30/2023
Date/Time Prepared:
11/20/2023 2: 02 pm

		Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQ UIS.) 14.02	PHARMACY (COSTED REQ UIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	SOCI AL SERVI CE (PATI ENT DAYS)	11/20/2023 2: NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	
		AL SERVICE COST CENTERS	14.02	13.00	10.00	17.00	17.00	
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		ADMINISTRATION & GENERAL						5. 01
6. 00		MAINTENANCE & REPAIRS						6.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9. 00
10.00	1	DI ETARY						10.00
11. 00 12. 00		CAFETERIA MAINTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	1	NURSING ADMINISTRATION						13.00
14.00	1	CENTRAL SERVICES & SUPPLY						14.00
14. 01 14. 02		PURCHASING CENTRAL SERVICES & SUPPLY	1, 941, 051					14. 01 14. 02
15. 00	01500	PHARMACY	5, 396	660, 487				15.00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	4, 288	0	61, 387, 975	2.054		16. 00 17. 00
17.00		NONPHYSICIAN ANESTHETISTS	0	0		2, 054 0	0	1
20.00	02000	NURSI NG PROGRAM	o	0	О	0		20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES A I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0		21. 00 22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	0	0	O	0		23.00
		IENT ROUTINE SERVICE COST CENTERS]
30. 00		ADULTS & PEDIATRICS LARY SERVICE COST CENTERS	68, 650	3, 392	3, 798, 090	2, 054	0	30.00
50.00	05000	OPERATING ROOM	466, 407	637		0	0	
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	12, 065 50, 408	1, 132 14, 251	580, 557 15, 076, 085	0	0	53. 00 54. 00
54. 00	1	ULTRA SOUND	38, 436	14, 231		0	0	1
56. 00	1	RADI OI SOTOPE	6, 145	42, 133		o	0	
60. 00 62. 30	1	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	1, 089, 042	0	10, 812, 327	0	0	60. 00 62. 30
65. 00		RESPIRATORY THERAPY	Ö	0	805, 892	o	0	65.00
65. 50		SLEEP LAB	0	0	559, 106	0	0	65. 50
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	16, 756 2, 630	0	5, 307, 936 580, 044	0	0	66. 00 67. 00
69. 00	06900	ELECTROCARDI OLOGY	215	0	789, 693	0	0	69.00
71. 00 73. 00	1	MEDICAL SUPPLIES CHARGED TO PAT DRUGS CHARGED TO PATIENTS	60, 729	0	1, 528, 912	0	0	
73. 00 76. 97		CARDIAC REHABILITATION	0 0	595, 595 0	2, 225, 850	0	0	73. 00 76. 97
76. 98	07698	HYPERBARI C OXYGEN THERAPY	o	0		0	0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90.00		CLINIC	9, 270	543	299, 185	0	0	90.00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT	110, 614	2, 804	7, 918, 078	0	0	91.00 92.00
92.00		REIMBURSABLE COST CENTERS						92.00
99. 10			0	0		0	0	
99. 20 99. 30		OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
99. 40	09940	OUTPATIENT SPEECH PATHOLOGY	Ö	0	Ö	Ö	0	
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1, 941, 051	660, 487	61, 387, 975	2, 054	0	118. 00
110.00		IMBURSABLE COST CENTERS	1, 941, 051	000, 467	01, 367, 973	2, 054]110.00
	1	PHYSICIANS' PRIVATE OFFICES	0	0	-	0		192. 00
		PHYSICIANS' PRIVATE OFFICES ASSISTED LIVING	0	0	0	0		192. 01 192. 02
200.00		Cross Foot Adjustments	J	J		J	Ü	200.00
201.00		Negative Cost Centers	1// 212	F77 111	(00.071	F00	0	201.00
202.00	ĺ	Cost to be allocated (per Wkst. B, Part I)	166, 313	577, 111	689, 971	580	U	202. 00
203.00	1	Unit cost multiplier (Wkst. B, Part I)	0. 085682	0. 873766		0. 282376	0. 000000	
204.00)	Cost to be allocated (per Wkst. B, Part II)	18, 603	25, 568	24, 002	7	0	204. 00
205.00)	Unit cost multiplier (Wkst. B, Part	0. 009584	0. 038711	0. 000391	0. 003408	0. 000000	205. 00
206.00		NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)						l

Heal th Fi nanci al Systems STATE HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Peri od: From 07/01/2022 To 06/30/2023 Provi der CCN: 14-1332 Worksheet B-1 Date/Time Prepared: 11/20/2023 2:02 pm NONPHYSICIAN Cost Center Description CENTRAL PHARMACY MEDI CAL SOCI AL SERVICES & (COSTED REQ RECORDS & SERVI CE **ANESTHETI STS** SUPPLY UIS.) LI BRARY (PATI ENT (ASSI GNED (COSTED REQ (GROSS CHARGES) DAYS) TIME) UIS.) 14. 02 15. 00 16.00 17.00 19.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) 207.00 207.00

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

Cost Center Description					To	06/30/2023	Date/Time Prep 11/20/2023 2:0	
PROCESSAN ASSIGNATION AS				INTERNS &	RESI DENTS		1172072020 2. 0	PE DIII
PROCESSAN ASSIGNATION AS		Cost Contor Description	NUDSTNC	SEDVICES SALA	SEDVI CES OTHE	DADAMED ED		
ASSIGNED THE		cost center bescription						
THE								
20.00 21.00 22.00 23.0			TIME)			TIME)		
ENRIGHED STRONG COST CAMPLES 1.00			20.00			23 00		
2.00		GENERAL SERVICE COST CENTERS	20.00	21.00	22.00	20.00		
0.000 OMOO DIFFLOYEE BENEFITS DEPARTMENT		1						
5.01		1						
6.00 OGROD (MAINTENANCE & REPAIRS		1						
2.00 00700 OPERATION OF PLANT								
9.00 00000 HOLISTERFF IN NO. 10.00 11.		l I						
10.00 01000 DIETARY	8.00	00800 LAUNDRY & LINEN SERVICE						8.00
11.00		1						
12.00 01200 MAINTEARANCE OF PERSONNEL 12.00 13.00 1300 MISSIN AGAININ STRATION 13.00 1300 MISSIN AGAININ STRATION 14.00		1						
13.00 1300 NURSI NG ADMINISTRATION 14.00 1		1						
14.0		1						
14. 02 01402 CENTRAL SERVICES & SUPPLY 14. 02	14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY								
16.00 01-000 MEDICAL RECORDS & LIBRARY 10.00 10.00 10.00 01-0000 01-0000 01-0000 01-0000 01-0000 01-0000 01-0000 01-0000 01-0000 01-0000 01-0000 01-00000 01-0000 01-000000 01-000000 01-000000 01-000000 01-000000 01-000000 01-000000 01-000000 01-000000 01-000000 01-000000 01-000000 01-0000000 01-0000000 01-00000000 01-0000000000		l I						
17.00 01700 SOCIAL SERVICE		l I						
19.00 01900 NOMPHYSI CLAIN AMESTHETISTS 20.00 20.00 20.00 20.00 20.00 NURSI NO PROGRAM 0 21.00 20.00 22.00 22.00 RS ERRIVEGES-SALARY & FRINGES A 0 22.00 22.00 22.00 RS ERRIVEGES-SALARY & FRINGES A 0 22.00 22.00 22.00 RS ERRIVEGES-SHIRER PROGROSTS A 0 0 0 22.00 20.								
20.00 02000 JURSINO FROGRAM 0 22.00 22.00 12.00 22.00 12.00 22.00 12.00 12.00 22.00 22.00 12.00 12.00 22.00 22.00 22.00 12.00 22.00								
22.00		l I	0					20.00
23.00				0				
IMPATIENT ROUTINE SERVICE COST CENTERS 0		1			0			
30.00 03000 03000 00 0 0 0 0	23. 00					0		23.00
ANCILLARY SERVICE COST CENTERS 50.00 50.00 60.00 60 60 60 60 60	30. 00		0	0	0	0		30.00
53.00 05300 ANESTHESIOLOGY 0 0 0 0 53.00				_	-			
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 54. 00 56. 01 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 54. 00 56. 00 05600 RADIOLOGY-DIAGNOSTIC 0 0 0 0 0 56. 00 05600 RADIOLOGY-DIAGNOSTIC 0 0 0 0 0 62. 30 06250 BLOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 65. 00 06500 RESPIRATORY HERAPY 0 0 0 0 0 65. 00 06500 RESPIRATORY HERAPY 0 0 0 0 0 66. 00 06500 RESPIRATORY HERAPY 0 0 0 0 0 66. 00 06600 PHYSICAL HERAPY 0 0 0 0 0 67. 00 06700 OCCUPATIONAL HERAPY 0 0 0 0 0 68. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 69. 00 073.00 07300 DRUGS CHARGED TO PATI TO 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI TO 0 0 0 0 74. 09 07699 APPERBARIC OXYGEN HERAPY 0 0 0 0 0 75. 09 07699 CAPPG CARDIAC CARGED TO PATI TO 0 0 0 76. 99 07699 LITHOTIS PSY 0 0 0 0 76. 90 07699 LITHOTIS PSY 0 0 0 0 76. 90 07699 LITHOTIS PSY 0 0 0 0 77. 00 07100 OSCOPALTIONAL THERAPY 0 0 0 0 77. 00 07100 OSCOPALTIONAL THERAPY 0 0 0 0 77. 00 07100 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07690 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 77. 07 07600 OSCOPALTIONAL THERAPY 0 0 0 0 78. 00 OSCOPALTIONAL THERAPY 0 0 0 0 0 79. 00 OSCOPALTIONAL THERAPY 0 0 0 0 0 79. 00 OSCOPALTIONAL THERAPY 0 0 0 0 0 79. 00 OSCOPALTIO		l I		l e				
54. 01 03040 LITRA SOUND		1 1		1	1		1	
56.00 05.00 ABDATORY 0 0 0 0 0 0 0 0 0		1	0	1	1	0		
60.0 0 66000 LABORATORY		1	0	· -	1	0		
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0		1	0	· -	Ö	0		
65.50 06501 SLEEP LAB 66.00 06600 PHYSI CAL THERAPY 70 0 0 0 0 0 0 0 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 80 0 0 0 0 0 0 0 0 0 0 0 0 0 67.00 69.00 06900 ELECTROCARDIOLOGY 90 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 70.300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 76.97 07697 CARDI AC REHABILITATION 0 0 0 0 0 76.98 07698 HYPERABRIC COXYCEN THERAPY 0 0 0 0 0 76.99 07699 LITHOTRIPSY 0 0 0 0 0 76.99 07699 LITHOTRIPSY 0 0 0 0 76.99 07699 LITHOTRIPSY 0 0 0 0 76.99 07699 LITHOTRIPSY 0 0 0 0 76.99 07699 UTHATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 91.00 09000 09000 09000 09000 91.00 09000 09000 09000 09000 92.00 09000 09000 09000 09000 92.00 09000 09000 09000 09000 92.00 09000 09000 09000 09000 92.00 09000 09000 09000 09000 92.00 09000 09000 09000 0 92.00 09000 09000 09000 0 92.00 09000 09000 09000 0 92.00 09000 09000 09000 00000 92.00 09000 00000 0 92.00 09000 00000 00000 0 92.00 09000 00000 00000 0 92.00 09000 000000 000000 0 92.00 09000 0000000 0 92.00 09000 0000000 0 92.00 09000 00000000 0 92.00 09000 00000000000000000000000000		1	0	0	0	0		
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 67. 00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATLENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATLENTS 0 0 0 0 0 0 74. 97 07697 CARDIA C REHABILLITATION 0 0 0 0 0 0 76. 97 07697 CARDIA C REHABILLITATION 0 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98 07699 LITHOTRI PSY 0 0 0 0 0 0 76. 99 00 09000 CLINI C 0 0 0 0 0 76. 99 00 09000 CLINI C 0 0 0 0 0 76. 99 00 09000 CLINI C 0 0 0 0 0 77. 00 09000 OSSERVATION BEDS (NON-DISTINCT 0 0 0 0 0 79. 10 09100 EMERGENCY 0 0 0 0 0 0 79. 10 09910 CORF 09910 CORF 09910 CORF 09910 CORF 79. 10 09910 CORF 09910 CORF 0 0 0 0 0 79. 30 09930 OUTPATIENT PHYSI CAL THERAPY 0 0 0 0 0 79. 30 09940 OUTPATIENT SPECCH PATHOLOGY 0 0 0 0 79. 40 09940 OUTPATIENT SPEECH PATHOLOGY 0 0 0 0 79. 40 OSPECIAL PURPOSE COST CENTERS 79. 10 OSPE		1	0	0	0	0		
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 76.97 07697 CARDIA C REHABILITATION 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 07699 10 0 0 0 0 76.99 07699 07699 0 0 0 0 76.98 07699 0 0 0 0 0 76.98 07699 07699 0 0 0 0 76.98 07699 07699 0 0 0 0 76.98 07699 07699 0 0 0 0 76.98 07699 07699 0 0 0 0 0 76.98 07699 0 0 0 0 0 76.98 07699 07699 0 0 0 0 0 76.98 07699 0 0 0 0 0 0 76.98 07699 07699 0 0 0 0 0 0 76.98 07699 07699 0 0 0 0 0 76.98 07699 0 0 0 0 0 0 76.98 07699 0 0		1	0		1	0		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 71. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 97 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0		l	0	Ö	Ö	0		
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 76. 98 00. 00 0000 CLINIC 0 0 0 0 0 0 0 90.00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 0 99. 20 99. 30 09930 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 0 99. 20 99. 40 09940 OUTPATIENT SPECH PATHOLOGY 0 0 0 0 0 99. 30 99. 40 09940 OUTPATIENT SPECH PATHOLOGY 0 0 0 0 0 99. 30 99. 40 09940 OUTPATIENT SPECH PATHOLOGY 0 0 0 0 0 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 0 0 118. 00 100 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSIC LANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 01 192. 01 19203 PHYSIC LANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 01 192. 02 19201 ASSISTED LIVING 0 0 0 0 0 192. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0		
76. 98			0	0	0	0		
76.99			0	0	0	0		
OUTPATLENT SERVICE COST CENTERS O			0	0	0	0		
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 DEMERGENCY 0 0 0 0 0 0 0 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT 92. 00 DITHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 99. 20 9920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 99. 20 99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0 99. 30 99. 40 SPECIAL PURPOSE COST CENTERS 99. 40 SPECIAL PURPOSE COST CENTERS 99. 40 SPECIAL PURPOSE COST CENTERS 99. 40 SPECIAL PURPOSE COST CENTERS 99. 40 99. 4	70. 77		0		0			70. 77
92.00 09200 0BSERVATION BEDS (NON-DISTINCT 0THER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 0 0 99.10 99.20 09920 0UTPATIENT PHYSICAL THERAPY 0 0 0 0 0 0 99.20 99.30 09930 0UTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0 0 99.30 99.40 09940 0UTPATIENT SPEECH PATHOLOGY 0 0 0 0 0 0 99.40 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 0 0 0 0 0 192.01 19203 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.02 19201 ASSISTED LIVING 0 0 0 0 0 192.02 19201 ASSISTED LIVING 0 0 0 0 192.02 19201 ASSISTED LIVING 0 0 0 0 201.00 Negative Cost Centers 200.00 202.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 0.000000 205.00 Unit cost multiplier (Wkst. B, Part I) 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	90.00		0	0	0	0		90.00
OTHER REIMBURSABLE COST CENTERS O		l I	0	0	0	0		
99. 10 09910 CORF 0 0 0 0 0 0 99. 10 99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 0 99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 99. 40 09940 OUTPATI ENT SPECH PATHOLOGY 0 0 0 0 99. 40 OP940 OUTPATI ENT SPECH PATHOLOGY 0 0 0 0 99. 40 SPECIAL PURPOSE COST CENTERS	92. 00							92.00
99. 20	QQ 10		0			^		QQ 1∩
99. 30 09930 0UTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0 99. 30 99. 40 09940 0UTPATIENT SPECH PATHOLOGY 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 0 NONREI MBURSABLE COST CENTERS 192. 00 192.00 192.01 192.02 192.01 192.03 194. 194. 194. 194. 194. 194. 194. 194.			0) n		-	l .	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) O O O O O O 118.00				1	0	0		
SUBTOTALS (SUM OF LINES 1 through 117)	99. 40		0	0	0	0		99. 40
NONREL MBURSABLE COST CENTERS 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 192.01 192.02 19201 19203 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 192.01 192.02 19201 ASSISTED LIVING 0 0 0 0 0 0 0 192.02 19201 ASSISTED LIVING 0 0 0 0 0 0 0 0 192.02 19201 19202 19202 19201 19202 192	118.00		0	0	0	0		118. 00
192.01 19203 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.01 192.02 19201 ASSISTED LIVING 0 0 0 0 192.02 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 0.000000 0.000000 0.000000	102 00		0		I 0	0		102 00
192.02 19201 ASSISTED LIVING 0 0 0 192.02 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 0.000000			0	0	0			
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 203.00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 0.000000 205.00			0	Ō	0	0		
202.00 Cost to be allocated (per Wkst. B, Part I) 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.00000		, ,						
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Dilit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) Dilit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			_	_		_		
203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 0.000000 0.000000 0.000000 0.000000	202.00		0	0	0	0		202.00
204.00 Cost to be allocated (per Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 205.00	203.00		0. 000000	0. 000000	0. 000000	0. 000000		203. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 205.00			0.00000	0	0	0.000000		
		Part II)						
	205.00	· · · · · · · · · · · · · · · · · · ·	0. 000000	0. 000000	0. 000000	0. 000000	2	205. 00
		11)		I	ı		ı I	

Heal th Fi nanci al Systems STATE HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 14-1332 Worksheet B-1 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm INTERNS & RESIDENTS Cost Center Description NURSI NG SERVI CES-SALA | SERVI CES-OTHE PARAMED ED PROGRAM (ASSI GNED PRGM (ASSI GNED RY & FRINGES R PRGM COSTS (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 20. 00 21. 00 22. 00 23.00 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV) 207.00 0.000000 0.000000 207.00

In Lieu of Form CMS-2552-10

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Provider CCN: 14-1332

			Title	XVIII	Hospi tal	Cost	<u></u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 332, 822		5, 332, 822	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 560, 611		2, 560, 611	0	0	
53.00	05300 ANESTHESI OLOGY	40, 620		40, 620	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 853, 988		1, 853, 988	0	0	54.00
	03040 ULTRA SOUND	356, 460		356, 460	0	0	54. 01
56.00	05600 RADI 0I SOTOPE	710, 816		710, 816	0	0	56.00
60.00	06000 LABORATORY	3, 976, 837		3, 976, 837	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	465, 539	0	465, 539	0	0	65.00
65.50	06501 SLEEP LAB	146, 994	0	146, 994	0	0	65. 50
66.00	06600 PHYSI CAL THERAPY	2, 604, 397	0	2, 604, 397	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	468, 259	0	468, 259	0	0	67.00
69.00	06900 ELECTROCARDI OLOGY	53, 241		53, 241	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	127, 120		127, 120	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 272, 760		1, 272, 760	0	0	73.00
76. 97	07697 CARDIAC REHABILITATION	0		0	0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0		0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	1, 027, 904		1, 027, 904	0	0	90.00
91.00	09100 EMERGENCY	4, 177, 977		4, 177, 977	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1, 360, 466		1, 360, 466		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0		0		0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0		0		0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0	99. 40
200.00	Subtotal (see instructions)	26, 536, 811	0	26, 536, 811	0	0	200.00
201.00		1, 360, 466		1, 360, 466			201. 00
202.00	Total (see instructions)	25, 176, 345	0	25, 176, 345	0	0	202. 00

Health Financial Systems

In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1332 Peri od: Worksheet C

Part I

201 00

202.00

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 747, 516 30.00 03000 ADULTS & PEDIATRICS 1, 747, 516 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 122, 855 5, 306, 866 5, 429, 721 0. 471592 0.000000 50.00 53.00 05300 ANESTHESI OLOGY 13, 115 567, 442 580, 557 0.069967 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 14, 521, 773 15, 076, 085 0.122975 0.000000 54.00 554.312 54.00 54.01 03040 ULTRA SOUND 113, 254 2, 323, 169 2, 436, 423 0.146305 0.000000 54.01 56.00 05600 RADI OI SOTOPE 76, 522 3, 163, 554 3, 240, 076 0.219383 0.000000 56.00 06000 LABORATORY 0.367806 9, 706, 159 10, 812, 327 0.000000 60.00 1, 106, 168 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 62 30 65.00 06500 RESPIRATORY THERAPY 254, 173 551, 719 805, 892 0.577669 0.000000 65.00 65.50 06501 SLEEP LAB 559, 106 559, 106 0. 262909 0.000000 65.50 66.00 06600 PHYSI CAL THERAPY 261, 902 5,046,034 5, 307, 936 0.490661 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 87, 014 493,030 580,044 0.807282 0.000000 67.00 06900 ELECTROCARDI OLOGY 50, 122 789, 693 0.067420 69.00 739, 571 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 458, 941 1, 528, 912 0.083144 0.000000 71.00 1,069,971 71.00 07300 DRUGS CHARGED TO PATIENTS 73 00 474, 153 1, 751, 697 2, 225, 850 0.571809 0.000000 73 00 76.97 07697 CARDIAC REHABILITATION 0.000000 0.000000 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0.000000 0.000000 76.98 76.99 07699 LI THOTRI PSY 76.99 0 0 0.000000 0.000000 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 299, 185 299, 185 3. 435680 0.000000 90.00 91.00 09100 EMERGENCY 8,089 7, 909, 989 7, 918, 078 0.527650 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 0.663456 92.00 207, 478 1, 843, 096 2, 050, 574 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 99. 10 09910 CORE 09920 OUTPATIENT PHYSICAL THERAPY 0 0 99. 20 99.20 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 99.30 C 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 200.00 200.00 Subtotal (see instructions) 5, 535, 614 55, 852, 361 61, 387, 975

5, 535, 614

55, 852, 361

61, 387, 975

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Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1332 Title XVIII

			II LIC XVIII	1103pi tai	0031
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0. 000000			50.00
	05300 ANESTHESI OLOGY	0. 000000			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
	03040 ULTRA SOUND	0. 000000			54. 01
	05600 RADI OI SOTOPE	0. 000000			56.00
	06000 LABORATORY	0. 000000			60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
	06500 RESPI RATORY THERAPY	0. 000000			65.00
65. 50	06501 SLEEP LAB	0. 000000			65. 50
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000			71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0. 000000			76. 98
76. 99	07699 LI THOTRI PSY	0. 000000			76. 99
Ī	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 000000			90.00
91. 00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.00
	OTHER REIMBURSABLE COST CENTERS				
99. 10	09910 CORF				99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY				99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
200.00		1			200.00
201.00					201.00
202.00					202.00
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Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1332 | Period: | Worksheet C

From 07/01/2022

25, 176, 345

06/30/2023

Part I

Date/Time Prepared:

25, 176, 345 202. 00

11/20/2023 2:02 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 5, 332, 822 5, 332, 822 5, 332, 822 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 560, 611 2, 560, 611 0 2, 560, 611 50.00 05300 ANESTHESI OLOGY 0 53.00 40, 620 40, 620 40,620 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 853, 988 1, 853, 988 1, 853, 988 54.00 54.01 03040 ULTRA SOUND 356, 460 356, 460 0 356, 460 54.01 0 05600 RADI OI SOTOPE 710, 816 710, 816 710, 816 56,00 56,00 06000 LABORATORY 3, 976, 837 3, 976, 837 3, 976, 837 60.00 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 465, 539 465, 539 465, 539 65.00 06501 SLEEP LAB 146, 994 146, 994 146, 994 65.50 65.50 06600 PHYSI CAL THERAPY 2, 604, 397 66.00 2,604,397 2, 604, 397 66.00 67.00 06700 OCCUPATIONAL THERAPY 468, 259 468, 259 468, 259 67.00 69.00 06900 ELECTROCARDI OLOGY 53, 241 53, 241 53, 241 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 127, 120 127, 120 127, 120 71 00 71 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 272, 760 1, 272, 760 1, 272, 760 73.00 07697 CARDIAC REHABILITATION 0 76. 97 76.97 0 0 0 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 0 0 07699 LI THOTRI PSY 76. 99 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 1, 027, 904 1, 027, 904 1, 027, 904 90.00 91.00 09100 EMERGENCY 4, 177, 977 4, 177, 977 0 4, 177, 977 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 1, 360, 466 1, 360, 466 92.00 1, 360, 466 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 99. 10 0 0 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 99.20 0 99. 30 | 09930 | OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 0 0 26, 536, 811 200. 00 200 00 Subtotal (see instructions) 26, 536, 811 0 26, 536, 811 0 1, 360, 466 201. 00 201.00 Less Observation Beds 1, 360, 466 1, 360, 466

25, 176, 345

202.00

Total (see instructions)

Health Financial Systems

In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1332 Peri od: Worksheet C

Part I

201 00

202.00

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 747, 516 30 00 30.00 03000 ADULTS & PEDIATRICS 1, 747, 516 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 122, 855 5, 306, 866 5, 429, 721 0. 471592 0.000000 50.00 53.00 05300 ANESTHESI OLOGY 13, 115 567, 442 580, 557 0.069967 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 14, 521, 773 15, 076, 085 0.122975 0.000000 54.00 554.312 54.00 54.01 03040 ULTRA SOUND 113, 254 2, 323, 169 2, 436, 423 0.146305 0.000000 54.01 56.00 05600 RADI OI SOTOPE 76, 522 3, 163, 554 3, 240, 076 0.219383 0.000000 56.00 06000 LABORATORY 0.367806 9, 706, 159 10, 812, 327 0.000000 60.00 1, 106, 168 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 62 30 65.00 06500 RESPIRATORY THERAPY 254, 173 551, 719 805, 892 0.577669 0.000000 65.00 65.50 06501 SLEEP LAB 559, 106 559, 106 0. 262909 0.000000 65.50 66.00 06600 PHYSI CAL THERAPY 261, 902 5,046,034 5, 307, 936 0.490661 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 87, 014 493,030 580,044 0.807282 0.000000 67.00 06900 ELECTROCARDI OLOGY 50, 122 789, 693 0.067420 69.00 739, 571 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 458, 941 1, 528, 912 0.083144 0.000000 71.00 1,069,971 71.00 07300 DRUGS CHARGED TO PATIENTS 73 00 474, 153 1, 751, 697 2, 225, 850 0.571809 0.000000 73 00 76.97 07697 CARDIAC REHABILITATION 0.000000 0.000000 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0.000000 0.000000 76.98 76.99 07699 LI THOTRI PSY 76.99 0 0 0.000000 0.000000 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 299, 185 299, 185 3. 435680 0.000000 90.00 91.00 09100 EMERGENCY 8,089 7, 909, 989 7, 918, 078 0.527650 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 0.663456 92.00 207, 478 1, 843, 096 2, 050, 574 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 99. 10 09910 CORE 09920 OUTPATIENT PHYSICAL THERAPY 0 0 99. 20 99.20 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 99.30 C 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 200.00 200.00 Subtotal (see instructions) 5, 535, 614 55, 852, 361 61, 387, 975

5, 535, 614

55, 852, 361

61, 387, 975

201 00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1332 Title XIX

			II LI E AIA	nospi tai	COST
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50.00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54.01	03040 ULTRA SOUND	0. 000000			54. 01
56.00	05600 RADI 0I SOTOPE	0. 000000			56.00
60.00	06000 LABORATORY	0. 000000			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65.00	06500 RESPI RATORY THERAPY	0. 000000			65.00
65.50	06501 SLEEP LAB	0. 000000			65. 50
66.00	06600 PHYSI CAL THERAPY	0. 000000			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99	07699 LI THOTRI PSY	0. 000000			76. 99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 000000			90.00
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.00
	OTHER REIMBURSABLE COST CENTERS				
99. 10	09910 CORF				99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY				99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY				99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
200.00					200.00
201.00	,				201.00
202.00					202.00
					1

Heal th Fi nanci al Systems HILLSBORO AREA HOSPITAL

From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/20/2023 2:02 pm Title XVIII Hospi tal Cost Cost Center Description Total Charges Ratio of Cost Capital Costs Capi tal Inpati ent to Charges Related Cost (column 3 x (from Wkst. Program column 4) (from Wkst. C, Part I, (col. 1 ÷ Charges B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 3.00 4. 00 5. 00 ANCILLARY SERVICE COST CENTERS 50 00 0.028495 697 50 00 05000 OPERATING ROOM 154, 718 5, 429, 721 24, 445 53.00 05300 ANESTHESI OLOGY 1,888 580, 557 0.003252 3, 934 53.00 13 05400 RADI OLOGY-DI AGNOSTI C 86, 875 15, 076, 085 0.005762 252, 061 54.00 1, 452 54.00 03040 ULTRA SOUND 50, 819 0.003903 54.01 9,510 2, 436, 423 198 54.01 05600 RADI OI SOTOPE 0.009296 56.00 30, 119 3, 240, 076 32, 227 300 56.00 60.00 06000 LABORATORY 103, 742 10, 812, 327 0.009595 416, 561 3, 997 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0 06500 RESPIRATORY THERAPY 65.00 22, 253 805, 892 0.027613 106, 196 2, 932 65.00 06501 SLEEP LAB 65.50 7, 224 559, 106 0.012921 0 65.50 66.00 06600 PHYSI CAL THERAPY 120, 245 5, 307, 936 0.022654 43, 197 979 66.00 06700 OCCUPATI ONAL THERAPY 67.00 8, 198 580, 044 0.014133 13, 091 185 67.00 06900 ELECTROCARDI OLOGY 879 789, 693 0.001113 69.00 69.00 23, 606 26 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 2, 521 1, 528, 912 0.001649 227, 281 375 71.00 07300 DRUGS CHARGED TO PATIENTS 73.00 33, 241 2, 225, 850 0.014934 126, 107 1,883 73.00 07697 CARDIAC REHABILITATION 76.97 0.000000 76.97 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0.000000 0 0 76.98 07699 LI THOTRI PSY 0.000000 0 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 17, 047 299, 185 0.056978 Ω 91.00 09100 EMERGENCY 159, 472 7, 918, 078 0.020140 7,645 154 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 95, 107 92.00 2,050,574 0.046381 0

853, 039

59, 640, 459

1, 327, 170

13, 191 200. 00

200.00

Total (lines 50 through 199)

Health Financial Systems

HILLSBORO AREA HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1332

In Lieu of Form CMS-2552-10

THROUGH COSTS

Peri od: Worksheet D From 07/01/2022 Part IV To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm

						11/20/2023 2.	uz piii
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54. 01	03040 ULTRA SOUND	0	0		0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
60.00	06000 LABORATORY	0	0		0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
65. 50	06501 SLEEP LAB	0	0		0	0	65. 50
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0	0	90.00
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0			O	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 (C	0	200. 00

Health Financial Systems

HILLSBORO AREA HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1332 In Lieu of Form CMS-2552-10

Peri od: Worksheet D From 07/01/2022 Part IV To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm THROUGH COSTS

					11/20/2023 2.	oz pili
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	5, 429, 721		1
53. 00 05300 ANESTHESI OLOGY	0	0	0	580, 557	0.000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	15, 076, 085	0.000000	54.00
54. 01 03040 ULTRA SOUND	0	0	0	2, 436, 423	0.000000	54. 01
56. 00 05600 RADI 01 SOTOPE	0	0	0	3, 240, 076	0.000000	
60. 00 06000 LABORATORY	0	0	0	10, 812, 327	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	0	805, 892	0.000000	65.00
65. 50 06501 SLEEP LAB	0	0	0	559, 106	0.000000	65. 50
66. 00 06600 PHYSI CAL THERAPY	0	0	0	5, 307, 936	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	580, 044		67.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	789, 693	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1, 528, 912	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 225, 850	0.000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0.000000	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	C	0	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	C	0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	299, 185	0. 000000	90.00
91. 00 09100 EMERGENCY	0	0	0	7, 918, 078	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	2, 050, 574	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	59, 640, 459		200. 00

Health Financial Systems

HILLSBORO AREA HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1332

In Lieu of Form CMS-2552-10

Peri od: Worksheet D From 07/01/2022 Part IV To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm THROUGH COSTS

					11/20/2023 2.	uz piii
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	24, 445	0	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	3, 934	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	252, 061	0	0	0	54.00
54.01 03040 ULTRA SOUND	0. 000000	50, 819	0	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	32, 227	0	0	0	56.00
60. 00 06000 LABORATORY	0. 000000	416, 561	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	106, 196	0	0	0	65.00
65. 50 06501 SLEEP LAB	0. 000000	0	0	0	0	65. 50
66. 00 06600 PHYSI CAL THERAPY	0. 000000	43, 197	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	13, 091	0	0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	23, 606	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	227, 281		0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	126, 107	0	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		<u>'</u>		<u>'</u>	
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	7, 645	0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		1, 327, 170	0	0	0	200.00

eal th Financial Systems STATE HILLSBORD AREA HOSPITAL

Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1332

Period:
From 07/01/2022
To 06/30/2023
Part V
Date/Time Prepared:
11/20/2023 2:02 pm

					11/20/2023 2:	02 pm
		Title	: XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not	,	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	,	Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 471592	0	1, 749, 428	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 069967	l o	194, 636	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122975	0	4, 493, 183		0	54.00
54. 01 03040 ULTRA SOUND	0. 146305		733, 453		0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 219383		1, 059, 225		0	56.00
60. 00 06000 LABORATORY	0. 367806		2, 749, 720		0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000		2,7.17,720	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 577669		177, 814	0	0	65.00
65. 50 06501 SLEEP LAB	0. 262909		158, 791		٥	65. 50
66. 00 06600 PHYSI CAL THERAPY	0. 490661	0	1, 122, 994		o o	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 807282	0	86, 418		o o	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 067420		263, 479		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 083144		465, 544		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 571809		1, 153, 359		i o	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000		1, 155, 557	0	١	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			0	١	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			0	0	1
OUTPATIENT SERVICE COST CENTERS	0.00000			0	0	70.77
90. 00 09000 CLINIC	3. 435680		99, 296	0	0	90.00
91. 00 09100 EMERGENCY	0. 527650		1, 960, 577		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 663456		688, 851		0	1
200.00 Subtotal (see instructions)	0.003430		1			200.00
201.00 Less PBP Clinic Lab. Services-Program		0	17, 130, 700	0	0	201.00
Only Charges			١			201.00
202.00 Net Charges (line 200 - line 201)	1	0	17, 156, 768	0	_	202. 00
202. 00 Net Charges (Trile 200 - Trile 201)	1	ı	17, 130, 768	l 0	l 0	1202.00

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

| In Lieu of Form CMG-2002 | Period: | Worksheet D | Part V | To 06/30/2023 | Date/Time Prepared: | 11/20/2023 2:02 pm | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Provider CCN: 14-1332 Title XVIII

			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	CILLARY SERVICE COST CENTERS						
50.00 05	000 OPERATING ROOM	825, 016	0				50.00
53.00 05	300 ANESTHESI OLOGY	13, 618	0				53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	552, 549	0				54.00
54. 01 03	040 ULTRA SOUND	107, 308	0				54.01
56.00 05	600 RADI OI SOTOPE	232, 376	0				56.00
60.00 06	000 LABORATORY	1, 011, 364	0				60.00
62. 30 06.	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65. 00 06	500 RESPI RATORY THERAPY	102, 718	0				65.00
65. 50 06	501 SLEEP LAB	41, 748	0				65.50
66. 00 06	600 PHYSI CAL THERAPY	551, 009	0				66.00
67. 00 06	700 OCCUPATI ONAL THERAPY	69, 764	0				67.00
69. 00 06	900 ELECTROCARDI OLOGY	17, 764	0				69.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PAT	38, 707	0				71.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	659, 501	0				73.00
76. 97 07	697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 07	698 HYPERBARIC OXYGEN THERAPY	0	0				76. 98
76. 99 07	699 LI THOTRI PSY	0	0				76. 99
OU.	TPATIENT SERVICE COST CENTERS	<u>'</u>		•			
90.00 09	000 CLI NI C	341, 149	0				90.00
91.00 09	100 EMERGENCY	1, 034, 498	0				91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT	457, 022	0				92.00
200. 00	Subtotal (see instructions)	6, 056, 111	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	6, 056, 111	0			2	202.00

Health Financial Systems HILLSBORO AR
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

In Lieu of Form CMS-2552-10

Provider CCN: 14-1332 Component CCN: 14-Z332 Peri od: From 07/01/2022 To 06/30/2023

Worksheet D Part V Date/Time Prepared: 11/20/2023 2:02 pm

		Title	XVIII S	wing Beds - SNF	Cost	<u></u>
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 471592	l .	0	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 069967		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122975	0	0	0	0	54.00
54. 01 03040 ULTRA SOUND	0. 146305	0	0	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 219383	0	0	0	0	56.00
60. 00 06000 LABORATORY	0. 367806	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 577669	0	0	0	0	65.00
65. 50 06501 SLEEP LAB	0. 262909	0	0	0	0	65.50
66. 00 06600 PHYSI CAL THERAPY	0. 490661	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 807282	0	0	0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 067420	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 083144	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 571809	0	0	0	0	
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	3. 435680	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 527650	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 663456	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			0	0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	0	0	0	202.00

Health Financial Systems HILLSBORO AR
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

In Lieu of Form CMS-2552-10

Peri od: Worksheet D
From 07/01/2022 Part V
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm
Swing Beds - SNF Cost Provider CCN: 14-1332 Component CCN: 14-Z332

						11/20/2023 2:	02 pm
				XVIII	Swing Beds - SNF	Cost	
		Cos	its				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00	1			
ANCI	LLARY SERVICE COST CENTERS			•			
50. 00 0500	O OPERATING ROOM	0	0				50.00
53.00 0530	O ANESTHESI OLOGY	l ol	0				53.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C	0	0	,			54.00
	O ULTRA SOUND	o	0	,			54. 01
	O RADI OI SOTOPE	أم	0	,			56.00
	O LABORATORY		0	,			60.00
	O BLOOD CLOTTING FOR HEMOPHILIACS		0				62. 30
	O RESPIRATORY THERAPY		0				65.00
65. 50 0650			0				65. 50
•	O PHYSI CAL THERAPY		0				66.00
	O OCCUPATI ONAL THERAPY		0				67.00
•	O ELECTROCARDI OLOGY		0				69.00
•	O MEDICAL SUPPLIES CHARGED TO PAT		0				71.00
	O DRUGS CHARGED TO PATIENTS		0				73.00
•	7 CARDI AC REHABI LI TATI ON		0				76. 97
•	8 HYPERBARI C OXYGEN THERAPY		0				76. 98
	9 LI THOTRI PSY	0	0				76. 99
	ATIENT SERVICE COST CENTERS	ı v	U	1			70.99
90. 00 0900		1 0	0				90.00
	O EMERGENCY	0	0				91.00
		0	0				
	O OBSERVATION BEDS (NON-DISTINCT	0	0				92.00
200. 00	Subtotal (see instructions)	0	0				200.00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
202 20	Only Charges		_				000 00
202. 00	Net Charges (line 200 - line 201)	0	0	1			202.00

Health Financial Systems

COMPUTATION OF INPATIENT OPERATING COST In Lieu of Form CMS-2552-10
Worksheet D-1 Peri od: | Worksnee: | Trom 07/01/2022 | To 06/30/2023 | Date/Ti me Prepared: | 11/20/2023 2: 02 pm | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost | Cost Provider CCN: 14-1332 Title XVIII

	·	Title XVIII	Hospi tal	Cost	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			2, 054	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 383	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		859	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	394	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	277	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m daya) through Dagambar	21 of the cost	0	7 00
7. 00	reporting period	ili days) trii ougii beceiibei	31 Of the Cost	U	7. 00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	398	9. 00
10. 00	<pre>newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or</pre>	nly (including private r	oom days)	311	10. 00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	311	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	200	11.00
40.00	December 31 of the cost reporting period (if calendar year, e				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar y			· ·	10.00
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10 00	reporting period				10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through becember 31 of	the cost	170. 00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	170. 00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instruction		ing ported (line	5, 332, 822	
22.00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)	er 31 of the cost report	ing period (iine	0	22. 00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
20.00	x line 20)	or or the deat reperting	po ou (o	· ·	20.00
26.00	Total swing-bed cost (see instructions)			1, 742, 124	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 590, 698	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed em	ai ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuo line 22) (coe instrue	+: 000)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		LI OIIS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	110 31)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 590, 698	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2, 596. 31	38. 00
39.00	Program general inpatient routine service cost per diem (see	*		1, 033, 331	
40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 033, 331	41.00

Health Financial Systems In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1332 Peri od: Worksheet D-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Title XVIII Hospi tal Cost Cost Center Description Total Total Average Per Program Days Program Cost (col. 3 x Inpati ent Inpati ent Diem (col. Cost Days ÷ col. 2) col. 4) 1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 42.00 Intensive Care Type Inpatient Hospital Units 43 00 INTENSIVE CARE UNIT 43 00 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 46.00 SURGICAL INTENSIVE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) 47.00 47.00 Cost Center Description 1 00 48.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 400, 260 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48 01 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 1, 433, 591 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50.00 50.00 0 $\Pi\Pi$ 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 0 51.00 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 52.00 0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 0 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges 54.00 55.00 Target amount per discharge 0.00 55.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 0.00 55.02 Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56,00 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 0 57 00 Bonus payment (see instructions) 58.00 0 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 59.00 updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 60.00 market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 0 61.00 61.00 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 62.00 Relief payment (see instructions) 0 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 807, 452 64.00 64.00 instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 519, 262 65.00 instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 1, 326, 714 66.00 CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 0 67.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 68.00 68.00 0 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 69.00 69.00 0 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 76.00 77.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79 00 79 00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00

86. 00 To	otal Program inpatient operating costs (sum of lines 83 through 85)		86.00
PA	RT IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87. 00 To	otal observation bed days (see instructions)	524	87.00
88. 00 A	djusted general inpatient routine cost per diem (line 27 ÷ line 2)	2, 596. 31	88. 00

81.00

82 00

83.00

84.00

85.00

Inpatient routine service cost per diem limitation

Program inpatient ancillary services (see instructions)

85.00 Utilization review - physician compensation (see instructions)

Inpatient routine service cost limitation (line 9 x line 81)

Reasonable inpatient routine service costs (see instructions)

81.00

82 00

83.00

84.00

Heal th Financial Systems

COMPUTATION OF INPATIENT OPERATING COST

Provider CON 14 1323 Paris

COMPUTATION OF INPATIENT OPERATING COST		Provi der Co	CN: 14-1332	Peri od: From 07/01/2022	Worksheet D-1	
				To 06/30/2023	Date/Time Pre 11/20/2023 2:	pared: 02 pm_
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			1, 360, 466	89. 00
Cost Center Description	Cost	Routine Cost	col umn 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	372, 805	5, 332, 822	0. 06990	1, 360, 466	95, 107	90.00
91.00 Nursing Program cost	0	5, 332, 822	0. 00000	0 1, 360, 466	0	91.00
92.00 Allied health cost	0	5, 332, 822	0. 00000	0 1, 360, 466	0	92.00
93.00 All other Medical Education	0	5, 332, 822	0. 00000	1, 360, 466	0	93.00

In Lieu of Form CMS-2552-10

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1332 | Period: From 07/01/2022 To 06/30/2023 | Date/Time Prepared: 11/20/2023 2: 02 pm

Title XIX | Hospital | Cost

PART 1 - ALL PROVIDER CREMPINENS PART 1 - ALL PROVIDER CREMPINENS 1.00			T: +1 - VIV	11	11/20/2023 2:	02 pm
DART 1 - ALL PROVIDER COMPONENTS 1.00		Cost Center Description	Title XIX	Hospi tal	Cost	
		cost center bescription			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 2,064 1,00						
Inipatient days (including private room days, excluding swing-bed and nesborn days) 1,383 2,00	4 00				0.054	
A country of the provided systex (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line. 4.00 Seni-private room days (excluding swing-bed and observation bed days). 5.01 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendary year, enter 0 on this line). 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 7.00 Ital swing-bed MF type inpatient days (including private room days) shrough December 31 of the cost reporting period (if calendary year, enter 0 on this line). 8.00 Intak swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (in line). 8.01 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (in line). 8.00 Swing-bed SMF type inpatient days applicable to the Program (excluding saing-bed and newborn days) (see instructions). 8.01 Swing-bed SMF type inpatient days applicable to title WIII and Iy (including private room days) after December 31 of the cost reporting period (it is WIII and Iy (including private room days). 8.01 Swing-bed SMF type inpatient days applicable to title WIII and Iy (including private room days). 8.02 Swing-bed SMF type inpatient days applicable to title WIII and Iy (including private room days). 8.03 Swing-bed SMF type inpatient days applicable to services through December 31 of the cost reporting period (it calendary year, enter 0 on this line). 8.04 Swing-bed SMF type inpatient days applicable to services through December 31 of the cost reporting period (it in while and I was applicable to service through December 31 of the cost reporting period (it in while I was applicable to service shrough December 31 of the cost (it is a was applicable to SMF type Inpatient days applicable to services after December 31						1
do not complete this line. 4. 05 Semis-private room days (excluding swing-bed and observation bed days) 5. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 7. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 7. 00 Total sang-bed M type inpatient days (including private room days) after December 31 of the cost or coporting period (if calendary year, enter 0 on this line) 8. 00 Total sang-bed M type inpatient days (including private room days) after December 31 of the cost on this line) 9. 00 Total Inpatient days including private room days after December 31 of the cost on this line) 10. 00 Swing-bed SM type inpatient days applicable to the Program (excluding swing-bed and newton days) (see Instructions) 8. 00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and newton days) (see Instructions) 10. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SM type inpatient days applicable to title swing the private room days after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 13. 00 Swing-bed SM type inpatient days applicable to title swing the private room days applicable to title swing the private room days applicable to title swing the private room days applicable to title swing the private room days applicable to title swing the private room days applicable to title swing the private room days applicable to title swing the private room days applicable to title swing the private room days applicable to title swing the private room days applicable to swing the private room days applicable to swing the private room days applicable to swing the p				sivato room days		1
5.00 Total swing-bed SR type inpatient days (including private room days) after December 31 of the cost reporting period for claim and the cost reporting period for cost cost claim and the cost reporting period for claim and the cost reporting period for claim and the cost reporting period for claim and the cost cost reporting period for claim and the cost reporting period for claim and the cost cost cost cost claim and the cost cost cost cost cost cost cost cost	3.00		lys). If you have only pr	I vate 100iii days,	U	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost roporting period in the private room days) after December 31 of the cost roporting period in the private room days after December 31 of the cost reporting period in the private room days after December 31 of the cost reporting period in the patient days (including private room days) after December 31 of the cost reporting period in patient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Total inpatient days including private room days applicable to the Program (excluding swing-bed and national period (if calendar year, enter 0 on this line) 10. Total inpatient days including private room days applicable to the Program (excluding swing-bed and national period (if calendar year, enter 0 on this line) 10. Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11. Os Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. Os Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13. Os Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14. Os Modically necessary private room days applicable to the Program (excluding private room days) 15. Os Total nursery days (title V or XIX only) 16. Os Nursery days (title V or XIX only) 17. Os Modically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 18. Os Medical craft for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including period period (including private room days) 18. Os Medical craft for swing-bed SNF services after December 31 of the cost reporting peri	4.00		ed days)		859	4.00
cool fortal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if celledary pere, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if celledary swing-bed swi	5.00			er 31 of the cost	394	5.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total as ing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period as ing-bed NF services applicable to the Program (excluding swing-bed and newborn days) (including private room days) after December 31 of the cost of through December 31 of the cost of the newborn days) (including private room days) applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.00 Swing-bed cost applicable Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-be						
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost on the cost reporting period (if calendar year, enter 0 on this line)	6. 00		om days) after December	31 of the cost	277	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title xVIII only (including private room days) after 0 on the program of the cost reporting period (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to title xVIII only (including private room days) after 0 on the program of the cost reporting period (see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to title xVIII only (including private room days) after 0 through December 31 of the cost reporting period (see instructions) 13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after 0 on the suine of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 1 d. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.	7 00		m days) through Docombor	21 of the cost	0	7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 10.00	7.00		ili days) trii dugii beceiibei	31 Of the Cost	O	7.00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SMF type inpatient days applicable to tittle XVIII only (including private room days) 11.00 Swing-bed SMF pice inpatient days applicable to tittle XVIII only (including private room days) after on through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF pice inpatient days applicable to tittle XVIII only (including private room days) after on through December 31 of the cost reporting period 12.00 Swing-bed SMF type inpatient days applicable to tittle SV or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to tittle SV or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to title SV or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period 19.00 Medical care rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period 19.00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 130.00 reporting period 19.00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost 130.00 reporting period (line 6 22.00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 22.00 Medical draft for swing-bed MF services through December 31 of the cost reporting period (line 6 22.00 Medical draft for swing-bed cost sp	8. 00		m days) after December 3	31 of the cost	0	8.00
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x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30. 00 Average private room per diem charge (line 29 + line 3) 31. 00 Average semi-private room per diem charge (line 30 + line 4) 32. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 590, 698) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25 00		21 of the cost reporting	noried (line 9	0	25 00
27. 00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,590,698 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 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) 0 30. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0. 000000 31. 00 Average private room per diem charge (line 29 ÷ line 3) 0. 00 32. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 0. 00 33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0. 00 35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 Average per diem private room cost differential (line 34 x line 35) 0. 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37. 590, 698 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 2,596. 31 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 2,596. 31 39. 00 Program general inpatient routine service cost (line 9 x line 38) 28,559 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	23.00		or the cost reporting	g perrou (Trile o	O	23.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 33.00 Average semi-pri vate room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem pri vate room cost differential (line 34 x line 31) 35.00 Average per diem pri vate room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 3, 590, 698) 37.00 Frogram inpatient outine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 28, 559 39.00 40.00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 30.00	26.00	Total swing-bed cost (see instructions)			1, 742, 124	26.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 590, 698) 30.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Aocon and charges 30.00 Aocon and	27. 00		(line 21 minus line 26)		3, 590, 698	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 590, 698) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 30.00 31.00 32.00 3	20.00		d and absorbert on had al	20000	0	20.00
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 590, 698 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 33.00 37.00 35.00 37.00 27	31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 590, 698 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2.596.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						•
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PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,596.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 28,559 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	and private room cost di	fferential (line		1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,596.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 28,559 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			·			
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,596.31 38.00 Program general inpatient routine service cost (line 9 x line 38) 28,559 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			LICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 28,559 39.00 40.00	38 00			T	2 506 21	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 28,559 41.00						1
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		28, 559	41.00

leal th Fi nanci al Systems STATE HILLSBORO AREA HOSPI TAL

Health Financial Systems In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1332 Peri od: Worksheet D-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Title XIX Hospi tal Cost Average Per Cost Center Description Total Total Program Days Program Cost (col. 3 x Inpati ent Inpati ent Diem (col. Cost Days ÷ col. 2) col. 4) 1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 42.00 Intensive Care Type Inpatient Hospital Units 43 00 INTENSIVE CARE UNIT 43 00 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 46.00 SURGICAL INTENSIVE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) 47.00 47.00 Cost Center Description 1.00 48.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 0 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) Λ 48 01 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 28, 559 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50.00 50.00 0 $\Pi\Pi$ 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 0 51.00 and IV) Total Program excludable cost (sum of lines 50 and 51) 52.00 52.00 0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 0 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges 54.00 55.00 Target amount per discharge 0.00 55.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 0.00 Adjustment amount per discharge (contractor use only) 55.02 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56,00 0 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57 00 Bonus payment (see instructions) 58.00 0 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 59.00 updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 60.00 market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 0 61.00 61.00 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 62.00 Relief payment (see instructions) 0 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 64.00 0 64.00 instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 0 65.00 65.00 instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 0 66.00 66.00 CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 0 67.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 68.00 68.00 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 69.00 69.00 0 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 76.00 77.00 Program capital-related costs (line 9 x line 76) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79 00 79 00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82 00 82 00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00

86.00

87.00

524

2, 596. 31 88. 00

86.00

Total Program inpatient operating costs (sum of lines 83 through 85)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Total observation bed days (see instructions)

COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	CN: 14-1332	Peri od: From 07/01/2022	Worksheet D-1	
				To 06/30/2023	Date/Time Pre 11/20/2023 2:	pared: 02 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 360, 466	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	372, 805	5, 332, 822	0. 06990	1, 360, 466	95, 107	90.00
91.00 Nursing Program cost	0	5, 332, 822	0. 00000	1, 360, 466	0	91.00
92.00 Allied health cost	0	5, 332, 822	0. 00000	1, 360, 466	0	92.00
93.00 All other Medical Education	0	5, 332, 822	0. 00000	1, 360, 466	0	93.00

In Lieu of Form CMS-2552-10

Heal th Fi nanci al Systems HILLSBORO AREA HOSPI TAL

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 14-1332 Peri od: Worksheet D-3 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Title XVIII Hospi tal Cost Cost Center Description Ratio of Cost Inpati ent Inpati ent Program Costs To Charges Program (col. 1 x Charges col. 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 660, 008 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0. 471592 24, 445 11, 528 50.00 53.00 05300 ANESTHESI OLOGY 0.069967 3, 934 275 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.122975 252, 061 30, 997 54.00 54.00 54.01 03040 ULTRA SOUND 0.146305 50, 819 7, 435 54.01 56.00 05600 RADI OI SOTOPE 0.219383 32, 227 7,070 56.00 06000 LABORATORY 0. 367806 60.00 416, 561 153, 214 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 Λ 62.30 65.00 06500 RESPIRATORY THERAPY 0.577669 106, 196 61, 346 65.00 65.50 06501 SLEEP LAB 0.262909 65.50 0 43, 197 21, 195 66.00 06600 PHYSI CAL THERAPY 0.490661 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0.807282 13,091 10, 568 67.00 69.00 06900 ELECTROCARDI OLOGY 0.067420 23,606 1, 592 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 0.083144 227, 281 18, 897 71.00 07300 DRUGS CHARGED TO PATIENTS 0.571809 72, 109 73.00 73.00 126, 107 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0.000000 76. 98 76. 98 0 0 07699 LI THOTRI PSY 0.000000 76.99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3.435680 0 90.00 91.00 09100 EMERGENCY 0.527650 91.00 7, 645 4,034 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 0.663456 92.00 0 Total (sum of lines 50 through 94 and 96 through 98) 400, 260 200. 00 200.00 1, 327, 170 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00

In Lieu of Form CMS-2552-10

1, 327, 170

202.00

202.00

Net charges (line 200 minus line 201)

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Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 14-1332 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/20/2023 2:02 pm

	Title XVIII S	wing Beds - SNF	Cost	02 piii
Cost Center Description	Ratio of Cost		Inpatient	
cost center bescription	To Charges		Program Costs	
	To charges	Charges	(col. 1 x	
		Charges	col. 2)	
	1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	,	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS	'	•		
50. 00 05000 OPERATING ROOM	0. 471592	2 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 06996	7 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 12297!	50, 545	6, 216	54.00
54. 01 03040 ULTRA SOUND	0. 14630	4, 360	638	54. 01
56. 00 05600 RADI OI SOTOPE	0. 21938	3, 406	747	56.00
60. 00 06000 LABORATORY	0. 36780	155, 170	57, 072	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.00000	0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 57766	23, 199	13, 401	65.00
65. 50 06501 SLEEP LAB	0. 26290	9 0	0	65. 50
66. 00 06600 PHYSI CAL THERAPY	0. 49066		68, 026	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 807283	48, 468	39, 127	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 067420	1, 688	114	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 08314	43, 805	3, 642	71.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 57180		60, 919	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY	0.00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	3. 435680		0	
91. 00 09100 EMERGENCY	0. 527650		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 66345		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		575, 821	249, 902	
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)		575, 821		202. 00

Heal th Financial Systems HILLSBORO AREA HOSPITAL

Title XVIII

Date/Time Prepared:

11/20/2023 2:02 pm

Cost

06/30/2023

Hospi tal

1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 6, 056, 111 Medical and other services reimbursed under OPPS (see instructions) 2.00 0 2.00 OPPS or REH payments 3.00 0 3 00 4.00 Outlier payment (see instructions) 0 4.00 4.01 Outlier reconciliation amount (see instructions) 0 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.00 Line 2 times line 5 0 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 9 00 0 10.00 Organ acquisitions Ω 10.00 6, 056, 111 Total cost (sum of lines 1 and 10) (see instructions) 11.00 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 0 12.00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 13.00 14.00 Total reasonable charges (sum of lines 12 and 13) 0 14.00 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 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.00 Total customary charges (see instructions) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 0 instructions) 21.00 Lesser of cost or charges (see instructions) 6, 116, 672 21.00 22.00 Interns and residents (see instructions) 0 22.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 0 23.00 Total prospective payment (sum of lines 3, 24.00 4. 4.01. 8 and 9) 0 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 41, 672 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 831, 575 26.00 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 3, 243, 425 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 REH facility payment amount 28.50 28.50 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) Λ 29.00 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 3, 243, 425 30.00 Primary payer payments 31.00 193 31.00 Subtotal (line 30 minus line 31) 32.00 3, 243, 232 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33.00 277, 274 34.00 Allowable bad debts (see instructions) 34.00 Adjusted reimbursable bad debts (see instructions) 35.00 180, 228 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 277, 274 36.00 37.00 Subtotal (see instructions) 3, 423, 460 37.00 38 00 MSP-LCC reconciliation amount from PS&R 38 00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.50 39. 75 N95 respirator payment adjustment amount (see instructions) 39.75 39 97 39 97 Demonstration payment adjustment amount before sequestration 0 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 Subtotal (see instructions) 3, 423, 460 40.00 Sequestration adjustment (see instructions) 40.01 68, 469 40 01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 3, 283, 760 41.00 Interim payments-PARHM 41.01 41.01 Tentative settlement (for contractors use only) 42.00 42.00 0 Tentative settlement-PARHM (for contractor use only) 42.01 42.01 71, 231 43.00 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 0 44.00 §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 92.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 93.00 93 00 0 94.00 Total (sum of lines 91 and 93) 0 94.00

Heal th Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1332 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/20/2023 2:02 pm

			11/20/2023 2:	02 pm
	Title XVIII	Hospi tal	Cost	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

Health Financial Systems HIL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1332

					11/20/2023 2:0	02 p
			XVIII	Hospi tal	Cost	
		Inpatien	it Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
00 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, 201, 655		3, 312, 741	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
11	Program to Provider ADJUSTMENTS TO PROVIDER	02/07/2023	13, 505	06/14/2023	4, 491	3.
01 02	ADJUSTMENTS TO PROVIDER	06/14/2023	5, 928		4, 491	3
03		00/14/2023	5, 926			3
)4						3
)5						3
J	Provider to Program			′I	1 0	3
0	ADJUSTMENTS TO PROGRAM			02/07/2023	33, 472	3
1					0	3
2					0	3
3					o	3
4					o	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		19, 433	3	-28, 981	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 221, 088	3	3, 283, 760	4
	TO BE COMPLETED BY CONTRACTOR					
0	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
	Program to Provider	<u> </u>				
1	TENTATI VE TO PROVI DER		(0	5
2			(0	5
3	Provider to Program		('	1 0	5
0	TENTATI VE TO PROGRAM				0	5
1	TELLITOR IN TROOPS WIT					5
2					l ől	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
1	SETTLEMENT TO PROVIDER		85, 054	ı	71, 231	6
2	SETTLEMENT TO PROGRAM		35,00		0	6
0	Total Medicare program liability (see instructions)		1, 306, 142		3, 354, 991	7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
				4 00		
00	Name of Contractor	NATI ONAL GOVER)	1. 00 06101	2. 00	8

Health Financial Systems HIL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1332

In Lieu of Form CMS-2552-10

Peri od: Worksheet E-1
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm

Swing Beds - SNF Cost Component CCN: 14-Z332 Title XVIII

		Title	XVIII Sv	ving Beds - SNF	Cost	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 432, 916		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	02/07/2023	15, 874		0	l 3. 01
3. 01	ADJUSTMENTS TO PROVIDER	06/14/2023	9, 186		0	3.01
3. 02		00/14/2023	9, 160		0	3.02
3. 03		}			0	3.03
3. 04					0	3.04
3.03	Provider to Program				0	3.00
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51	ADJUST MENTS TO TROOKAWI		l ő		0	3. 51
3. 52			0		l o	3.52
3. 53			l o		0	3. 53
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		25, 060		0	3.99
	3. 50-3. 98)		.,			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 457, 976		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1	T		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)					ļ
F 01	Program to Provider TENTATIVE TO PROVIDER	1			1 0	
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	5. 01 5. 02
5. 02		}	0		0	5.02
5.03	Provider to Program				0	j 5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51	TENTITY TO TROOM III		0		Ö	5. 51
5. 52			0		0	5.51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		l ő		0	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		84, 568		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 542, 544		0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1.00	2. 00	0.00
8. 00	Name of Contractor		NMENT SERVICES	06101		8.00
	I	I NC.		I	I	I

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Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1332

Period:
From 07/01/2022
To 06/30/2023
Date/Time Prepared:
11/20/2023 2:02 pm

Title XVIII Hospital

Cost

	IT THE AVITE HOSPITAL	COST	
		1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I		7. 00
	line 168		
8.00	Calculation of the HIT incentive payment (see instructions)		8. 00
9.00	Sequestration adjustment amount (see instructions)		9. 00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

eal th Financial Systems STATE HILLSBORD AREA HOSPITAL

		Title XVIII S	wing Beds - SNF	Cost	02 pm
		TITLE AVIII	Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		11.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 339, 981	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		252, 401	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing	-bed pass-through, see			
2 01	instructions)				2 01
3. 01 4. 00	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teachin	a program (soo		0. 00	3. 01 4. 00
4.00	instructions)	g program (see		0.00	4.00
5. 00	Program days		511	0	5.00
6.00	Interns and residents not in approved teaching program (see ins	tructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional meth		0		7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 592, 382	0	8. 00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 592, 382	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applica	ble to physician	0	0	11. 00
12. 00	professional services) Subtotal (line 10 minus line 11)		1, 592, 382	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coi nsurance	18, 358	0	13. 00
13.00	for physician professional services)	(exci due coi risul ance	10, 330	O	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		1, 574, 024	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16. 55	Rural community hospital demonstration project (§410A Demonstra	tion) payment	0		16. 55
	adjustment (see instructions)			_	
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17. 01 18. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	17. 01 18. 00
19. 00	Total (see instructions)	Ctions)	1, 574, 024	0	19.00
19. 00	Sequestration adjustment (see instructions)		31, 480	0	19.00
19. 02	Demonstration payment adjustment amount after sequestration)		31, 400	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs			Ü	19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		1, 457, 976	0	20.00
20. 01	Interim payments-PARHM				20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19. 25, 20, and 21)	84, 568	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)	i +L CMC Duk 1F 0		0	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	e with CMS Pub. 15-2,	0	0	23. 00
	Rural Community Hospital Demonstration Project (§410A Demonstra	tion) Adjustment			
200.00	Is this the first year of the current 5-year demonstration peri				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	ou diluoi tilo 210t			200.00
	Cost Reimbursement		<u>'</u>		
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wk	st. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, line	:		202. 00
000 00	200 (title XVIII swing-bed SNF))				000 00
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f	irst year of the curren	t 5 year demons:		204. 00
	period)	itst year of the curren	it 5-year deliloris	tration	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 tim	es line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse		'		
207.00	Program reimbursement under the §410A Demonstration (see instru				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines 1			208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	i ons)			209. 00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 20	0 plus line 210) (2	T		215 00
∠15.00	lotal adjustment to medicare swing-bed SNF PPS payment (line 20 instructions)	9 prus IIIle 210) (See			215. 00
	That uctions)		1		l

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HILLSBORO AREA HOSPITAL

Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1332

Period:
From 07/01/2022
To 06/30/2023
Part V
Date/Time Prepared:
11/20/2023 2:02 pm

Title XVIII Hospital

Cost

				11/20/2023 2:	02 pm_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1. 00	Inpatient services	17111 71 321111 323 3331	TET IIIDOTTOEIIIEITT	1, 433, 591	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	one)		1, 433, 371	2.00
		UIS)		0	3.00
3.00	Organ acqui si ti on			_	
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			1, 433, 591	4. 00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 447, 927	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service charges			0	7.00
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	
10.00	Customary charges			U	10.00
11 00	Aggregate amount actually collected from patients liable for	normant for carriage on	a charge basis	0	11. 00
11.00					
12. 00	Amounts that would have been realized from patients liable for		on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e	e)			
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete or	nly if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16.00	Excess of reasonable cost over customary charges (complete or	nly if line 6 exceeds lir	ne 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	·			
18.00	Direct graduate medical education payments (from Worksheet E-	-4. line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 447, 927	
20.00	Deductibles (exclude professional component)			127, 268	
21. 00	Excess reasonable cost (from line 16)			127, 200	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 320, 659	
23. 00	Coinsurance			1, 320, 039	
24. 00	Subtotal (line 22 minus line 23)			1, 320, 659	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		18, 675	
26.00	Adjusted reimbursable bad debts (see instructions)			12, 139	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		18, 675	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 332, 798	28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	29. 50
29. 98	Recovery of accelerated depreciation.	•		0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			1, 332, 798	
30. 01	Sequestration adjustment (see instructions)			26, 656	
30. 02	Demonstration payment adjustment amount after sequestration			20,030	
30. 02				U	30.02
	Sequestration adjustment-PARHM			4 004 000	
31.00	Interim payments			1, 221, 088	
31. 01	Interim payments-PARHM				31. 01
32.00	Tentative settlement (for contractor use only)			0	
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0	02, 31, and 32)		85, 054	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	ninus lines 30.03, 31.01,	and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2		•		
	• •		'	•	•

Heal th Financial Systems STATE HILLSBORO AREA HOSPITAL

Health Financial Systems HILLSBORO AREA HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-1332 Period: From 07/01/2022 Part VII

06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Title XIX Hospi tal Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.00 Inpatient hospital/SNF/NF services 28.559 Medical and other services 0 2.00 2.00 3.00 Organ acquisition (certified transplant programs only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 28, 559 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 0 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 28, 559 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 8.00 Ancillary service charges 0 O 9.00 9.00 Organ acquisition charges, net of revenue ol 10.00 10.00 Incentive from target amount computation 11 00 0 11 00 Total reasonable charges (sum of lines 8 through 11) 12.00 0 0 12.00 CUSTOMARY CHARGES Amount actually collected from patients liable for payment for services on a charge 13.00 0 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 Ratio of line 13 to line 14 (not to exceed 1.000000) 15.00 Total customary charges (see instructions) 16.00 16.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 0 17.00 line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 18.00 28.559 16) (see instructions) 19.00 19.00 Interns and Residents (see instructions) 0 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 Ω 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 28, 559 0 21.00 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. Other than outlier payments 22.00 0 0 Outlier payments 0 0 23.00 Program capital payments 0 24.00 o Capital exception payments (see instructions) 25.00 Routine and Ancillary service other pass through costs 0 26,00 0

22.00 23.00 24.00 25.00 26,00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 Customary charges (title V or XIX PPS covered services only) 28.00 0 0 28.00 Titles V or XIX (sum of lines 21 and 27) 29.00 28, 559 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 28.559 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 28, 559 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coi nsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 Utilization review 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 28, 559 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37.00 38.00 Subtotal (line 36 \pm line 37) 28, 559 0 38.00 39 00 Direct graduate medical education payments (from Wkst. E-4) 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 28, 559 0 40.00

28, 559

0

0

0 42.00

0

41.00

43.00

41.00

42.00

43 00

Interim payments

chapter 1, §115.2

Balance due provider/program (line 40 minus line 41)

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

In Lieu of Form CMS-2552-10 Worksheet G

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 14-1332 Peri od: From 07/01/2022 To 06/30/2023

Date/Time Prepared: 11/20/2023 2:02 pm

——————————————————————————————————————					11/20/2023 2:	O2 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
			Purpose Fund	Fund		
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-602, 074	0	0	0	1.00
2.00	Temporary investments	40, 126, 975	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12, 430, 041	0	0	0	4.00
5.00	Other recei vabl e	0	0	O	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9, 178, 649	0	o	0	6.00
7.00	Inventory	950, 820		o	0	7.00
8.00	Prepai d expenses	612, 027		o	0	8.00
9. 00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	o	0	
11. 00	Total current assets (sum of lines 1-10)	44, 339, 140	_	o	0	
11.00	FIXED ASSETS	11,007,110	<u> </u>	<u> </u>		11.00
12. 00	Land	330, 860	0	0	0	12.00
13. 00	Land improvements	1, 828, 208		o	0	1
14. 00	Accumulated depreciation	-1, 212, 207		0	0	1
15. 00	Buildings	18, 070, 843		0	0	1
16. 00		-10, 955, 947		0	0	1
	Accumulated depreciation	-10, 933, 947	0	o	0	1
17.00	Leasehold improvements	0	0	0		
18.00	Accumulated depreciation	1/4 222	1 1	U O	0	
19.00	Fixed equipment	164, 333		U	0	
20.00	Accumulated depreciation	-162, 092		0	0	20.00
21. 00	Automobiles and trucks	0		0	0	21.00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	17, 152, 434		0	0	
24.00	Accumulated depreciation	-14, 319, 349	0	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	
26.00	Accumul ated depreciation	0	0	0	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumul ated depreciation	0	0	0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	139, 299	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	11, 036, 382	0	O	0	30.00
	OTHER ASSETS					1
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	1
33. 00	Due from owners/officers	0	0	0	0	1
34. 00	Other assets	715, 160	0	0	0	
35. 00	Total other assets (sum of lines 31-34)	715, 160		o	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	56, 090, 682		o	0	1
00.00	CURRENT LIABILITIES	00,070,002	0	<u> </u>		30.00
37. 00	Accounts payable	2, 993, 810	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	305, 645		o	0	
39. 00	Payroll taxes payable	303, 043		0	0	1
40. 00		272 720	0	0	0	
	Notes and Loans payable (short term)	373, 729	0	0	0	1
41.00	Deferred income	0	٥	٩	U	
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	4 040 040	0	0	0	
44.00	Other current liabilities	1, 243, 962		0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44)	4, 917, 146	0	0	0	45. 00
	LONG TERM LIABILITIES		.1	.1		
46. 00	Mortgage payable	0		0	0	
47. 00	Notes payable	3, 152, 635		0	0	
48. 00	Unsecured Loans	0	_	0	0	1
49.00	Other long term liabilities	0	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	3, 152, 635		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8, 069, 781	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	48, 020, 901				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			O		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant			-	0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	1
	replacement, and expansion				· ·	
59.00	Total fund balances (sum of lines 52 thru 58)	48, 020, 901	0	o	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	56, 090, 682		o	0	
	59)]]	_	
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Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

In Lieu of Form CMS-2552-10
Worksheet G-1

Health Fi	nancial Systems	HILLSBORO ARE	A HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEMENT	OF CHANGES IN FUND BALANCES		Provider CC	N: 14-1332	Peri od:	Worksheet G-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	narod:
					10 00/30/2023	11/20/2023 2:	
		General	Fund	Speci al	Purpose Fund	Endowment	<u> </u>
				.,		Fund	
		1. 00	2.00	3.00	4. 00	5. 00	
	nd balances at beginning of period		46, 366, 085		0		1.00
	t income (loss) (from Wkst. G-3, line 29)		1, 654, 819				2.00
	tal (sum of line 1 and line 2)		48, 020, 904		0		3.00
	ditions (credit adjustments) (specify)	0			0	0	4.00
5. 00 CH	ANGE IN UNREALIZED GAINS	0			0	0	5. 00 6. 00
7. 00		0			0	0	7.00
8. 00		0			0	0	8.00
9. 00		Ö			0	0	9. 00
4	tal additions (sum of line 4-9)	o l	0		0	O	10.00
	btotal (line 3 plus line 10)		48, 020, 904		o		11.00
	ductions (debit adjustments) (specify)	o			0	0	12.00
	ANGE IN UNREALIZED LOSSES	o			0	0	13.00
14. 00 RO	UNDI NG	3			0	0	14.00
15. 00		0			0	0	15.00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17.00
	tal deductions (sum of lines 12-17)		3		0		18.00
	nd balance at end of period per balance		48, 020, 901		0		19. 00
ISII	eet (line 11 minus line 18)	Endowment	PI ant	Fund			
		Fund	Traire	Tana			
		6. 00	7. 00	8. 00			
	nd balances at beginning of period	0			0		1.00
	t income (loss) (from Wkst. G-3, line 29)						2.00
	tal (sum of line 1 and line 2)	0	_		0		3. 00
	ditions (credit adjustments) (specify)		0				4.00
	ANGE IN UNREALIZED GAINS		0				5.00
6. 00 7. 00			0				6. 00 7. 00
8. 00			0				8. 00
9. 00			0				9. 00
	tal additions (sum of line 4-9)	0			0		10.00
	btotal (line 3 plus line 10)	ol			o		11. 00
	ductions (debit adjustments) (specify)		0				12.00
13. 00 CH	ANGE IN UNREALIZED LOSSES		0				13.00
14. 00 RO	UNDI NG		0				14.00
15. 00			0				15.00
16. 00			0				16. 00
17. 00			0				17.00
	tal deductions (sum of lines 12-17)	0			0		18.00
	nd balance at end of period per balance	0			0		19. 00
Isn	eet (line 11 minus line 18)				1		l

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

In Lieu of Form CMS-2552-10

Peri od: Worksheet G-2
From 07/01/2022 Parts I & II
To 06/30/2023 Date/Time Prepared: 11/20/2023 2:02 pm Provider CCN: 14-1332

Description Inpatient Outpatient Total						11/20/2023 2:	02 pm_
PART - PATIENT REVENUES Seneral Hospital Routine Services 1.00 Hospital 1.747,516 1.747,516 1.00 2.00 3.00		Cost Center Description					
SIMPROVIDER I.PF				1.00	2. 00	3. 00	
Hospital							
2.00 SUBPROVIDER - IPF	1 00			1 747 51/		1 747 517	1 00
3.00 3.00				1, 747, 516		1, 747, 516	
SUBPROVIDER							
5.00 Swing bed - SNF							
0						0	
7. 00 SKILLÉED NURSING FACILITY				_			
8. 00 NURSING FACILITY 10. 00 1				l o		U	
OTHER LONG TERNI CARE 1,747,516 1,747,516 1,747,516 10,00 1,747,516 1,747,516 10,00 1,747,516							
10. 00							
Intensive Care Type Inpatient Hospital Services				1 7/7 514		1 7/7 514	
11. 00 INTENSIVE CARE UNIT	10.00			1, 747, 516		1, 747, 516	10.00
12.00 COROMARY CARE LUNIT	11 00						11 00
13.00 BURN INTENSIVE CARE LINIT 14.00 15.00 11.40 15.00 11.40 15.00 11.40 15.00 11.40 15.00 11.40 15.00 11.40 15.00 15.00 11.40 15.00 16.00 11.40 15.00 16.00 11.41 11.40 15.00 16.00 11.41 11.40 15.00 16.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.41 11.40 15.00 11.40 15.00 11.40 15.00 11.41 11.40 15.00 11.40 15.00 11.40 11.40 11.40 15.00 11.40 11.40 11.40 15.00 11.40							
14. 00 SURGICAL INTENSIVE CARE UNIT							
15. 00 OTHER SPECIAL CARE (SPECIFY) 0 15. 00 16. 00 11-15) 17. 00 11-15) 17. 00 11-15) 17. 00 11-15) 17. 00 11-15) 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18. 00 17. 00 17. 00 18. 00 17. 00 17. 00 18. 00 18. 00 19							
1-15 1-15							
11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 1, 747, 516 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1, 80 1, 80 1, 747, 516 1, 80 1		, ,	lines	0		0	
17. 00 Total inpatient routine care services (sum of lines 10 and 16) 1,747,516 3,800,743 55,858,388 59,659,131 18.00 19.00 0 0 0 0 0 0 0 0 0	10.00		111103	Ĭ		J	10.00
18. 00 Anciliary services 3,800,743 55,858,368 59,659,131 18. 00 0.00	17. 00)	1, 747, 516		1. 747. 516	17. 00
19.00 19.0			,		55, 858, 388		
20.00 RUMÂL HEALTH CLINIC		1					
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00							
22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 CMHC 24.00 24.10 CORF 0 0 0 0 24.10 24.20 24.20 24.30 24.20 24.30 24.40 24					o		
23. 00 24. 20 24. 20 25. 00 24. 20 25. 00 25. 00 26. 20 25. 00 27. 00 2							
24.00 CMHC 24.10 CORF 24.10 CORF 24.20 OUTPATIENT PHYSICAL THERAPY 24.20 OUTPATIENT OCCUPATIONAL THERAPY 30 OUTPATIENT OCCUPATIONAL THERAPY 4.40 OUTPATIENT SPEECH PATHOLOGY 4.30 OUTPATIENT SPEECH PATHOLOGY 4.50 ON AMBULATORY SURGICAL CENTER (D.P.) 4.50 ON HOSPICE 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ASSISTED LIVING 4.70 ON ON ON ON ON ON ON ON ON ON ON ON ON							23.00
24. 10 CORF							
24. 20 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 24. 20				0	0	0	
24. 30				O	o	0	
24. 40 OUTPATIENT SPEECH PATHOLOGY AMBULATORY SURGICAL CENTER (D. P.) 4.00 (D. 00)				O	o	0	
25. 00				O	o	0	
26. 00 HOSPICE 26. 00 27. 00 ASSISTED LIVING 1, 236, 016 0 1, 236, 016 0 0 0 0 0 0 0 0 0							
27. 00 ASSISTED LIVING 1, 236, 016 0 1, 236, 016 0 0 27. 00 27. 01 27. 02 28. 00 27. 01 28. 00 27. 01 28. 00	26.00						26.00
27. 02 PROFESSIONAL FEES 28. 00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.		ASSI STED LI VI NG		1, 236, 016	o	1, 236, 016	27.00
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.	27. 01	CARDI AC REHAB		0	0	0	27.01
G-3, line 1)	27. 02	PROFESSI ONAL FEES		676, 232	5, 148, 287	5, 824, 519	27.02
PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 30.00 31.00 31.00 BAD DEBT EXPENSE 2, 739, 442 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 30, 810, 105 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 810, 105 30, 00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00	28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	7, 460, 507	61, 006, 675	68, 467, 182	28.00
29.00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ADD (SPECIFY) 30.00 BAD DEBT EXPENSE 2,739,442 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 30.00 31.00 32.00 33.00 35.00 36.00 Total additions (sum of lines 30-35) 30.00 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 29 and 36 minus line 42)(transfer) 30,810,105 30,810,105 30,810,105 30,810,105 31.00 32.00 32.00 33.00 32.00 33.00 34.00 35.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 33,549,547 43.00							
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31.00 BAD DEBT EXPENSE 2,739,442 0 32.00 32.00 33.00 34.00 35.00 7					30, 810, 105		
32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) DEDUCT (SPECIFY) DEDUCT (SPECIFY) Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 32.00 33.00 34.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 33.549,547							
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) DEDUCT (SPECIFY) DEDUCT (SPECIFY) O 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) O 33.00 34.00 35.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 33.549,547		BAD DEBT EXPENSE					
34.00 35.00 36.00 Total additions (sum of lines 30-35) 36.00 37.00 BEDUCT (SPECIFY) 0 2,739,442 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 34.00 35.00 2,739,442 36.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 33,549,547							
35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 2,739,442 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 35.00 2,739,442 36.00 37.00 37.00 37.00 38.00 0 0 40.00 41.00 42.00 33,549,547							
36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 36.00 2,739,442 0 36.00 37.00 38.00 0 39.00 40.00 41.00 42.00 7 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 33,549,547 43.00				"			
37. 00 38. 00 39. 00 40. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 37. 00 0 38. 00 0 0 40. 00 40. 00 41. 00 42. 00 33, 549, 547 43. 00				0			
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33,549,547 43.00				_	2, 739, 442		
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33,549,547 33,549,547		DEDUCT (SPECIFY)					
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33,549,547 43.00							
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33,549,547 43.00							
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33,549,547 43.00				0			
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33,549,547 43.00		T-t-1 deductions (com of lines 07 44)		0			
			2) (+====================================		0		
IU WKSL. U-3, IIIIE 4)	43.00		2) (transfer		33, 549, 547		43. UU
		ILO MKSL. U-3, TITIE 4)		ı l	ļ		

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HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1332

Period:
From 07/01/2022
To 06/30/2023

Date/Time Prepared:

		00/30/2023	11/20/2023 2:0	
			1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		68, 467, 182	1.00
2.00	Less contractual allowances and discounts on patients' accounts		34, 691, 298	2.00
3.00	Net patient revenues (line 1 minus line 2)		33, 775, 884	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		33, 549, 547	4.00
5.00	Net income from service to patients (line 3 minus line 4)		226, 337	5.00
	OTHER I NCOME			
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		889, 041	7.00
8.00	Revenues from telephone and other miscellaneous communication 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		19, 817	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		43, 611	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
	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
	Revenue from gifts, flowers, coffee shops, and canteen		0	20.00
	Rental of vending machines		0	21.00
22. 00	Rental of hospital space		79, 313	
23.00			0	23.00
24.00			212, 242	24.00
24. 01			191, 264	24.01
24. 02			0	24.02
24. 50			0	24.50
25. 00	· · · · · · · · · · · · · · · · · · ·		1, 435, 288	
26. 00			1, 661, 625	
27. 00			6, 806	
	Total other expenses (sum of line 27 and subscripts)		6, 806	
29. 00	Net income (or loss) for the period (line 26 minus line 28)		1, 654, 819	29.00