HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/05/2015 Time: 11:51 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 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 the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) _____
Officer or Administrator of Provider(s)

H
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		41,956	-259,992	42,555	79,651	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		86,882				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		128,838	-259,992	42,555	79,651	200

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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this 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 appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1200 E. TREMONT	P.O. Box:		1
2	City: HILLSBORO	State: IL	ZIP Code: 62049	County: MONTGOMERY	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	HILLSBORO AREA HOSPITAL	14-1332	99914	1	09 / 06 / 1975	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	HILLSBORO AREA HOSPITAL	14-Z332	99914		04 / 01 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 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.	2	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	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 column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, 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.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
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
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci 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

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 and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

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 and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	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.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in 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 oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, 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)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers				1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?			Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no 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-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	28,212			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §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.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:		Contractor's Number:		141
142	Street:	P.O. Box:				142
143	City:	State:	ZIP Code:			143
144	Are provider based physicians' costs included in Worksheet A?			Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for 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.			N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and '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.			N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N		149

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)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	43,423		168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10 / 01 / 2013	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/03/2015	Y	09/03/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	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 the cost report? If yes, see instructions.	Y		Y		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	N	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	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.	N		38
39	If line 36 is yes, did the provider render servcies to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: MARK	Last name: DALLAS	Title: PARTNER	41
42	Employer: KERBER, ECK & BRAECKEL			42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM		43

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	22,608.00		657	81	942	1
2	HMO and other (see instructions)						103			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,742		1,742	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	22,608.00		2,399	81	2,684	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	22,608.00		2,399	81	2,684	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								384	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					243	39	353	1
2	HMO and other (see instructions)					35			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		128.09			243	39	353	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		128.09						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/01/2004	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.440791	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	607,337	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	685,327	5
6	Medicaid charges	6,848,874	6
7	Medicaid cost (line 1 times line 6)	3,018,922	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,726,258	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,726,258	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	340,139	450,265	790,404	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	149,930	198,473	348,403	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	149,930	198,473	348,403	23

24	Does the amount in 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?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,087,235	26
27	Medicare bad debts for the entire hospital complex (see instructions)	256,571	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	830,664	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	366,149	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	714,552	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,440,810	31

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		803,531	803,531	-121,762	681,769	-67,799	613,970	1
2	00200	Cap Rel Costs-Mvble Equip		1,263,162	1,263,162	28,820	1,291,982	-356,435	935,547	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	72,530	2,401,621	2,474,151		2,474,151	-720	2,473,431	4
5.01	00592	ADMINISTRATION & ACCOUNTING	309,695	845,309	1,155,004		1,155,004	-73,972	1,081,032	5.01
5.02	00591	GENERAL	192,239	833,606	1,025,845	-47,246	978,599	-439,699	538,900	5.02
5.03	00570	ADMITTING	109,172	16,890	126,062		126,062		126,062	5.03
5.04	00580	PATIENT ACCOUNTING	200,022	187,598	387,620		387,620		387,620	5.04
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	186,866	371,628	558,494		558,494		558,494	7
8	00800	Laundry & Linen Service	47,175	38,469	85,644		85,644		85,644	8
9	00900	Housekeeping	121,457	17,827	139,284		139,284		139,284	9
10	01000	Dietary	136,162	136,647	272,809		272,809	-45,835	226,974	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
13.01	01301	UR/QUALITY IMPROVEMENT	131,057	4,303	135,360		135,360		135,360	13.01
13.02	01302	NURSING ADMINISTRATION	189,213	12,479	201,692		201,692		201,692	13.02
14	01400	Central Services & Supply								14
14.01	01401	PURCHASING								14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	41,846	2,517	44,363		44,363		44,363	14.02
15	01500	Pharmacy		828,505	828,505	-393,662	434,843		434,843	15
16	01600	Medical Records & Library	196,920	43,021	239,941		239,941	-5,016	234,925	16
17	01700	Social Service		729	729		729		729	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	980,498	169,419	1,149,917	-447	1,149,470		1,149,470	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	547,345	394,363	941,708	119,537	1,061,245		1,061,245	50
53	05300	Anesthesiology		229,316	229,316	-150,248	79,068	-62,643	16,425	53
54	05400	Radiology-Diagnostic	401,395	275,900	677,295		677,295		677,295	54
54.01	03040	ULTRA SOUND		171,514	171,514		171,514		171,514	54.01
56	05600	Radioisotope	63,824	371,920	435,744		435,744		435,744	56
60	06000	Laboratory	423,674	713,402	1,137,076		1,137,076	-62,603	1,074,473	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	131,543	44,072	175,615	-10,098	165,517		165,517	65
65.50	06501	SLEEP LAB	50,235	80,210	130,445		130,445	-15,325	115,120	65.50
66	06600	Physical Therapy	752,179	91,166	843,345		843,345		843,345	66
67	06700	Occupational Therapy	112,799	3,904	116,703		116,703		116,703	67
69	06900	Electrocardiology		47,188	47,188		47,188	-26,607	20,581	69
71	07100	Medical Supplies Charged to Patients		34,935	34,935	44,216	79,151	-240	78,911	71
73	07300	Drugs Charged to Patients				391,009	391,009		391,009	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	707,444	1,633,922	2,341,366	-307	2,341,059	-998,549	1,342,510	91
92	09200	Observation Beds (Non-Distinct Part)								92
		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
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	6,105,290	12,069,073	18,174,363	-140,188	18,034,175	-2,155,443	15,878,732	118
		NONREIMBURSABLE COST CENTERS								
192.02	19201	ASSISTED LIVING	669,332	404,542	1,073,874	140,188	1,214,062	-584	1,213,478	192.02
192.03	19202	CARDIAC REHAB	1,457		1,457		1,457		1,457	192.03
200		TOTAL (sum of lines 118-199)	6,776,079	12,473,615	19,249,694		19,249,694	-2,156,027	17,093,667	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS DRUG COST FROM PHARMACY	A	Drugs Charged to Patients	73		391,009	1
500	Total reclassifications					391,009	500
	Code Letter - A						
1	TO RECLASS MED SUPPLY FROM PHARMACY	B	Medical Supplies Charged to P	71		748	1
500	Total reclassifications					748	500
	Code Letter - B						
1	TO RECLASS MED SUPPLY FROM OR	C	Medical Supplies Charged to P	71		29,513	1
500	Total reclassifications					29,513	500
	Code Letter - C						
1	TO RECLASS OXGEN FROM RT TO MED SUP	D	Medical Supplies Charged to P	71		10,098	1
500	Total reclassifications					10,098	500
	Code Letter - D						
1	TO RECLASS INSURANCE	E	Cap Rel Costs-Bldg & Fixt	1		18,426	1
2			Cap Rel Costs-Mvble Equip	2		28,820	2
500	Total reclassifications					47,246	500
	Code Letter - E						
1	TO RECLASS DEPRECIATION	F	ASSISTED LIVING	192.02		140,188	1
500	Total reclassifications					140,188	500
	Code Letter - F						
1	TO RECLASS ONCALL EXPENSE	G	Operating Room	50		150,125	1
500	Total reclassifications					150,125	500
	Code Letter - G						
1	TO RECLASS IV THERAPY TO MED SUP	H	Medical Supplies Charged to P	71		3,857	1
2							2
3							3
4							4
5							5
500	Total reclassifications					3,857	500
	Code Letter - H						
	GRAND TOTAL (Increases)					772,784	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS DRUG COST FROM PHARMACY	A	Pharmacy	15		391,009		1
500	Total reclassifications					391,009		500
	Code letter - A							
1	TO RECLASS MED SUPPLY FROM PHARMACY	B	Pharmacy	15		748		1
500	Total reclassifications					748		500
	Code letter - B							
1	TO RECLASS MED SUPPLY FROM OR	C	Operating Room	50		29,513		1
500	Total reclassifications					29,513		500
	Code letter - C							
1	TO RECLASS OXGEN FROM RT TO MED SUP	D	Respiratory Therapy	65		10,098		1
500	Total reclassifications					10,098		500
	Code letter - D							
1	TO RECLASS INSURANCE	E	GENERAL	5.02		47,246	12	1
2							12	2
500	Total reclassifications					47,246		500
	Code letter - E							
1	TO RECLASS DEPRECIATION	F	Cap Rel Costs-Bldg & Fixt	1		140,188	9	1
500	Total reclassifications					140,188		500
	Code letter - F							
1	TO RECLASS ONCALL EXPENSE	G	Anesthesiology	53		150,125		1
500	Total reclassifications					150,125		500
	Code letter - G							
1	TO RECLASS IV THERAPY TO MED SUP	H	Pharmacy	15		1,905		1
2			Adults & Pediatrics	30		447		2
3			Operating Room	50		1,075		3
4			Anesthesiology	53		123		4
5			Emergency	91		307		5
500	Total reclassifications					3,857		500
	Code letter - H							
	GRAND TOTAL (Decreases)					772,784		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	237,677	28,070		28,070		265,747		1
2	Land Improvements	1,687,647					1,687,647		2
3	Buildings and Fixtures	16,443,968	191,649		191,649	181,790	16,453,827		3
4	Building Improvements								4
5	Fixed Equipment	164,333					164,333		5
6	Movable Equipment	11,222,434	385,572		385,572	23,437	11,584,569		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	29,756,059	605,291		605,291	205,227	30,156,123		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	29,756,059	605,291		605,291	205,227	30,156,123		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	803,531						803,531	1
2	Cap Rel Costs-Mvble Equip	1,263,162						1,263,162	2
3	Total (sum of lines 1-2)	2,066,693						2,066,693	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	18,571,554		18,571,554	0.615847					1
2	Cap Rel Costs-Mvble Equ	11,584,569		11,584,569	0.384153					2
3	Total (sum of lines 1-2)	30,156,123		30,156,123	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	595,544			18,426			613,970	1
2	Cap Rel Costs-Mvble Equip	906,727			28,820			935,547	2
3	Total (sum of lines 1-2)	1,502,271			47,246			1,549,517	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-57,387	Cap Rel Costs-Bldg & Fixt	1	9	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-4,529	ADMINISTRATION & ACCOUNTING	5.01		4
5	Refunds and rebates of expenses (chapter 8)	B	-4,710	ADMINISTRATION & ACCOUNTING	5.01		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-535	GENERAL	5.02		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,103,084				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-38,734	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-240	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-5,016	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-351,332	Cap Rel Costs-Mvble Equip	2	9	32
33	NUTRITIONAL SERVICES	A	-7,101	Dietary	10		33
34	CRNA	A	-62,643	Anesthesiology	53		34
35	LOBBYING PORTION OF DUES	A	-10,643	ADMINISTRATION & ACCOUNTING	5.01		35
36	MARKETING COSTS	A	-120,053	GENERAL	5.02		36
37							37
38							38
39							39
40							40
41	EMPLOYEE MEALS - ALF	B	-584	ASSISTED LIVING	192.02		41
42	OTHER HOSPITAL DUES	B	-20	ADMINISTRATION & ACCOUNTING	5.01		42
43	ALCOHOLIC BEVERAGES	A	-470	Employee Benefits Department	4		43
44	DIAMOND CLUB FEES	B	-12,660	GENERAL	5.02		44
45	DAYCARE REVENUE	B	-3,656	ADMINISTRATION & ACCOUNTING	5.01		45
45.01	AMBULANCE RECEIPTS	B	-5,195	ADMINISTRATION & ACCOUNTING	5.01		45.01
45.05	MEDICAID TAX ASSESSMENT	A	-306,451	GENERAL	5.02		45.05
45.06	RETIREMENT OBLIGATION	A	-1,692	Cap Rel Costs-Bldg & Fixt	1	9	45.06
45.07	ACCRETION EXPENSE	A	-8,720	Cap Rel Costs-Bldg & Fixt	1	9	45.07
45.48	DONATIONS	A	-842	ADMINISTRATION & ACCOUNTING	5.01		45.48
45.49	PHYSICIAN RECRUITMENT	A	-44,336	ADMINISTRATION & ACCOUNTING	5.01		45.49
45.50	LAND RENTAL TO HILLSBORO HEALTH SV	A	-41	ADMINISTRATION & ACCOUNTING	5.01		45.50
46	DONATIONS	A	-250	Employee Benefits Department	4		46
47	PATIENT TV DEPRECIATION	A	-5,103	Cap Rel Costs-Mvble Equip	2	9	47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,156,027				50

(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.

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	66	Physical Therapy	RENT	36,343	36,343			1
2	4	Employee Benefits Department	WELLNESS BENEFIT	125,000	125,000			2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			161,343	161,343			5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	G	HILLSBORO HEALTH SERVICES		HILLSBORO HEALTH SERVICES		HEALTH RELATED SERVICES	6
7	G	HILLSBORO HEALTH SERVICES		HILLSBORO HEALTH SERVICES		HEALTH RELATED SERVICES	7
8							8
9							9
10							10

(1) Use the following symbols to indicate the 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.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify: NON-FINANCIAL

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	60	Laboratory LAB	106,107	62,603	43,504					1
2	69	Electrocardiology EKG	26,607	26,607						2
3	91	Emergency ER	1,473,222	998,549	474,673					3
4	65.50	SLEEP LAB SLEEP LAB	15,325	15,325						4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,621,261	1,103,084	518,177					200

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	60	Laboratory LAB							62,603	1
2	69	Electrocardiology EKG							26,607	2
3	91	Emergency ER							998,549	3
4	65.50	SLEEP LAB SLEEP LAB							15,325	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,103,084	200

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATION & ACCOUNTING	
		0	1	2	4	4A	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	613,970	613,970					1
2	Cap Rel Costs-Mvble Equip	935,547		935,547				2
4	Employee Benefits Department	2,473,431	2,146	173	2,475,750			4
5.01	ADMINISTRATION & ACCOUNTING	1,081,032	87,311	16,737	114,376	1,299,456	1,299,456	5.01
5.02	GENERAL	538,900	87,313	287,414	70,998	984,625	81,009	5.02
5.03	ADMITTING	126,062	6,209	667	40,319	173,257	14,255	5.03
5.04	PATIENT ACCOUNTING	387,620	9,322	440	73,872	471,254	38,772	5.04
6	Maintenance & Repairs							6
7	Operation of Plant	558,494	39,076	7,081	69,013	673,664	55,425	7
8	Laundry & Linen Service	85,644	17,223	1,458	17,423	121,748	10,017	8
9	Housekeeping	139,284	2,371	1,390	44,856	187,901	15,459	9
10	Dietary	226,974	25,539	3,441	50,287	306,241	25,196	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	135,360	865	63	48,402	184,690	15,195	13.01
13.02	NURSING ADMINISTRATION	201,692	16,767	37	69,880	288,376	23,726	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	44,363	7,317	716	15,455	67,851	5,582	14.02
15	Pharmacy	434,843	4,624	10,779		450,246	37,044	15
16	Medical Records & Library	234,925	15,867	4,885	72,726	328,403	27,019	16
17	Social Service	729				729	60	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,149,470	86,206	25,960	362,118	1,623,754	133,593	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,061,245	51,691	72,124	202,145	1,387,205	114,131	50
53	Anesthesiology	16,425	485	1,431		18,341	1,509	53
54	Radiology-Diagnostic	677,295	31,338	203,238	148,243	1,060,114	87,220	54
54.01	ULTRA SOUND	171,514	1,787	290		173,591	14,282	54.01
56	Radioisotope	435,744	14,021	173,588	23,571	646,924	53,225	56
60	Laboratory	1,074,473	15,991	24,570	156,471	1,271,505	104,612	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	165,517	7,397	3,117	48,581	224,612	18,480	65
65.50	SLEEP LAB	115,120	2,840	281	18,553	136,794	11,255	65.50
66	Physical Therapy	843,345	34,715	14,207	277,794	1,170,061	96,266	66
67	Occupational Therapy	116,703		237	41,659	158,599	13,049	67
69	Electrocardiology	20,581		3,662		24,243	1,995	69
71	Medical Supplies Charged to Patients	78,911				78,911	6,492	71
73	Drugs Charged to Patients	391,009				391,009	32,170	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,342,510	45,549	65,936	261,273	1,715,268	141,122	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	15,878,732	613,970	923,922	2,228,015	15,619,372	1,178,160	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING	1,213,478		11,378	247,197	1,472,053	121,112	192.02
192.03	CARDIAC REHAB	1,457		247	538	2,242	184	192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	17,093,667	613,970	935,547	2,475,750	17,093,667	1,299,456	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4)	GENERAL	PURCHASING RECEIVING AND STORES	PATIENT AC COUNTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5.03	5.04	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL	1,065,634	1,065,634					5.02
5.03	ADMITTING	187,512	13,843	201,355				5.03
5.04	PATIENT ACCOUNTING	510,026	37,652		547,678			5.04
6	Maintenance & Repairs							6
7	Operation of Plant	729,089	53,824			782,913		7
8	Laundry & Linen Service	131,765	9,727			35,244	176,736	8
9	Housekeeping	203,360	15,013			4,853	10,916	9
10	Dietary	331,437	24,468			52,262	4,281	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	199,885	14,756			1,770		13.01
13.02	NURSING ADMINISTRATION	312,102	23,041			34,312		13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	73,433	5,421			14,972		14.02
15	Pharmacy	487,290	35,974			9,463		15
16	Medical Records & Library	355,422	26,239			32,470		16
17	Social Service	789	58					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,757,347	129,734	13,294	36,161	176,403	92,351	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,501,336	110,835	20,666	56,213	105,777	12,206	50
53	Anesthesiology	19,850	1,465	2,795	7,603	993		53
54	Radiology-Diagnostic	1,147,334	84,701	43,633	118,666	64,127	14,928	54
54.01	ULTRA SOUND	187,873	13,870	8,094	22,016	3,656		54.01
56	Radioisotope	700,149	51,688	13,957	37,962	28,691		56
60	Laboratory	1,376,117	101,590	30,100	81,874	32,724		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	243,092	17,946	2,167	5,896	15,138		65
65.50	SLEEP LAB	148,049	10,930	3,213	8,740	5,811	1,891	65.50
66	Physical Therapy	1,266,327	93,485	18,169	49,420	71,039	19,857	66
67	Occupational Therapy	171,648	12,672	1,472	4,003			67
69	Electrocardiology	26,238	1,937	2,297	6,249			69
71	Medical Supplies Charged to Patients	85,403	6,305	6,575	17,883			71
73	Drugs Charged to Patients	423,179	31,241	10,620	28,888			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,856,390	137,040	24,303	66,104	93,208	20,306	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	15,498,076	1,065,455	201,355	547,678	782,913	176,736	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING	1,593,165						192.02
192.03	CARDIAC REHAB	2,426	179					192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	17,093,667	1,065,634	201,355	547,678	782,913	176,736	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	UR/QUALITY IMPROVEMENT	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9	10	11	13.01	13.02	14.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL							5.02
5.03	ADMITTING							5.03
5.04	PATIENT ACCOUNTING							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	234,142						9
10	Dietary		412,448					10
11	Cafeteria	4,574	251,076	255,650				11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT			6,139	222,550			13.01
13.02	NURSING ADMINISTRATION	1,864		7,639		378,958		13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY			4,895			98,721	14.02
15	Pharmacy	3,727					633	15
16	Medical Records & Library	1,694		15,476			403	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	83,186	138,115	63,828	222,550	164,042	8,438	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	62,856	23,257	24,473		89,465	33,248	50
53	Anesthesiology						1,189	53
54	Radiology-Diagnostic	16,265		20,767			5,032	54
54.01	ULTRA SOUND	2,202					122	54.01
56	Radioisotope	1,017		3,197			1,408	56
60	Laboratory	4,405		25,265			30,906	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,930		6,620		1,847		65
65.50	SLEEP LAB	1,186		3,027		1,783	2	65.50
66	Physical Therapy	5,930		33,300			1,155	66
67	Occupational Therapy			4,866			78	67
69	Electrocardiology						184	69
71	Medical Supplies Charged to Patients						9,440	71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	39,306		36,158		121,821	6,483	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	234,142	412,448	255,650	222,550	378,958	98,721	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	234,142	412,448	255,650	222,550	378,958	98,721	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	17	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL							5.02
5.03	ADMITTING							5.03
5.04	PATIENT ACCOUNTING							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT							13.01
13.02	NURSING ADMINISTRATION							13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy	537,087						15
16	Medical Records & Library		431,704					16
17	Social Service			847				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,782	125,798	847	3,016,876		3,016,876	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,513	86,853		2,128,698		2,128,698	50
53	Anesthesiology	1,646			35,541		35,541	53
54	Radiology-Diagnostic	16,004	62,770		1,594,227		1,594,227	54
54.01	ULTRA SOUND				237,833		237,833	54.01
56	Radioisotope	28,249			866,318		866,318	56
60	Laboratory		23,315		1,706,296		1,706,296	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,636		304,272		304,272	65
65.50	SLEEP LAB		7,942		192,574		192,574	65.50
66	Physical Therapy	2	16,909		1,575,593		1,575,593	66
67	Occupational Therapy		3,074		197,813		197,813	67
69	Electrocardiology				36,905		36,905	69
71	Medical Supplies Charged to Patients				125,606		125,606	71
73	Drugs Charged to Patients	482,887			976,815		976,815	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,004	99,407		2,502,530		2,502,530	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	537,087	431,704	847	15,497,897		15,497,897	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING				1,593,165		1,593,165	192.02
192.03	CARDIAC REHAB				2,605		2,605	192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	537,087	431,704	847	17,093,667		17,093,667	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & ACCOUNTING	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		2,146	173	2,319	2,319		4
5.01	ADMINISTRATION & ACCOUNTING		87,311	16,737	104,048	107	104,155	5.01
5.02	GENERAL		87,313	287,414	374,727	67	6,494	5.02
5.03	ADMITTING		6,209	667	6,876	38	1,143	5.03
5.04	PATIENT ACCOUNTING		9,322	440	9,762	69	3,108	5.04
6	Maintenance & Repairs							6
7	Operation of Plant		39,076	7,081	46,157	65	4,443	7
8	Laundry & Linen Service		17,223	1,458	18,681	16	803	8
9	Housekeeping		2,371	1,390	3,761	42	1,239	9
10	Dietary		25,539	3,441	28,980	47	2,020	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT		865	63	928	45	1,218	13.01
13.02	NURSING ADMINISTRATION		16,767	37	16,804	65	1,902	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY		7,317	716	8,033	14	447	14.02
15	Pharmacy		4,624	10,779	15,403		2,969	15
16	Medical Records & Library		15,867	4,885	20,752	68	2,166	16
17	Social Service						5	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		86,206	25,960	112,166	339	10,709	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		51,691	72,124	123,815	189	9,149	50
53	Anesthesiology		485	1,431	1,916		121	53
54	Radiology-Diagnostic		31,338	203,238	234,576	139	6,991	54
54.01	ULTRA SOUND		1,787	290	2,077		1,145	54.01
56	Radioisotope		14,021	173,588	187,609	22	4,266	56
60	Laboratory		15,991	24,570	40,561	147	8,386	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		7,397	3,117	10,514	46	1,481	65
65.50	SLEEP LAB		2,840	281	3,121	17	902	65.50
66	Physical Therapy		34,715	14,207	48,922	260	7,717	66
67	Occupational Therapy			237	237	39	1,046	67
69	Electrocardiology			3,662	3,662		160	69
71	Medical Supplies Charged to Patients						520	71
73	Drugs Charged to Patients						2,579	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		45,549	65,936	111,485	245	11,303	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		613,970	923,922	1,537,892	2,086	94,432	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING			11,378	11,378	232	9,708	192.02
192.03	CARDIAC REHAB			247	247	1	15	192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		613,970	935,547	1,549,517	2,319	104,155	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	GENERAL	PURCHASING RECEIVING AND STORES	PATIENT AC COUNTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	
		5.02	5.03	5.04	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL	381,288						5.02
5.03	ADMITTING	4,953	13,010					5.03
5.04	PATIENT ACCOUNTING	13,472		26,411				5.04
6	Maintenance & Repairs							6
7	Operation of Plant	19,258			69,923			7
8	Laundry & Linen Service	3,480			3,148	26,128		8
9	Housekeeping	5,372			433	1,614	12,461	9
10	Dietary	8,755			4,667	633		10
11	Cafeteria						243	11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	5,280			158			13.01
13.02	NURSING ADMINISTRATION	8,244			3,064		99	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	1,940			1,337			14.02
15	Pharmacy	12,871			845		198	15
16	Medical Records & Library	9,388			2,900		90	16
17	Social Service	21						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	46,419	859	1,745	15,758	13,652	4,428	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	39,656	1,335	2,712	9,447	1,804	3,345	50
53	Anesthesiology	524	181	367	89			53
54	Radiology-Diagnostic	30,306	2,821	5,714	5,727	2,207	866	54
54.01	ULTRA SOUND	4,962	523	1,062	327		117	54.01
56	Radioisotope	18,494	901	1,831	2,562		54	56
60	Laboratory	36,349	1,944	3,950	2,922		234	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,421	140	284	1,352		316	65
65.50	SLEEP LAB	3,911	208	422	519	280	63	65.50
66	Physical Therapy	33,449	1,174	2,384	6,344	2,936	316	66
67	Occupational Therapy	4,534	95	193				67
69	Electrocardiology	693	148	301				69
71	Medical Supplies Charged to Patients	2,256	425	863				71
73	Drugs Charged to Patients	11,178	686	1,394				73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	49,038	1,570	3,189	8,324	3,002	2,092	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	381,224	13,010	26,411	69,923	26,128	12,461	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB	64						192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	381,288	13,010	26,411	69,923	26,128	12,461	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	UR/QUALITY IMPROVEMENT	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13.01	13.02	14.02	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL							5.02
5.03	ADMITTING							5.03
5.04	PATIENT ACCOUNTING							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	45,102						10
11	Cafeteria	27,456	27,699					11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT		665	8,294				13.01
13.02	NURSING ADMINISTRATION		828		31,006			13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY		530			12,301		14.02
15	Pharmacy					79	32,365	15
16	Medical Records & Library		1,677			50		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,103	6,916	8,294	13,422	1,051	288	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,543	2,652		7,320	4,144	91	50
53	Anesthesiology					148	99	53
54	Radiology-Diagnostic		2,250			627	964	54
54.01	ULTRA SOUND					15		54.01
56	Radioisotope		346			175	1,702	56
60	Laboratory		2,737			3,851		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		717		151			65
65.50	SLEEP LAB		328		146			65.50
66	Physical Therapy		3,608			144		66
67	Occupational Therapy		527			10		67
69	Electrocardiology					23		69
71	Medical Supplies Charged to Patients					1,176		71
73	Drugs Charged to Patients						29,100	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		3,918		9,967	808	121	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	45,102	27,699	8,294	31,006	12,301	32,365	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	45,102	27,699	8,294	31,006	12,301	32,365	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL							5.02
5.03	ADMITTING							5.03
5.04	PATIENT ACCOUNTING							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT							13.01
13.02	NURSING ADMINISTRATION							13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy							15
16	Medical Records & Library	37,091						16
17	Social Service		26					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,809	26	261,984		261,984		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,462		215,664		215,664		50
53	Anesthesiology			3,445		3,445		53
54	Radiology-Diagnostic	5,393		298,581		298,581		54
54.01	ULTRA SOUND			10,228		10,228		54.01
56	Radioisotope			217,962		217,962		56
60	Laboratory	2,003		103,084		103,084		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	484		21,906		21,906		65
65.50	SLEEP LAB	682		10,599		10,599		65.50
66	Physical Therapy	1,453		108,707		108,707		66
67	Occupational Therapy	264		6,945		6,945		67
69	Electrocardiology			4,987		4,987		69
71	Medical Supplies Charged to Patients			5,240		5,240		71
73	Drugs Charged to Patients			44,937		44,937		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	8,541		213,603		213,603		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	37,091	26	1,527,872		1,527,872		118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING			21,318		21,318		192.02
192.03	CARDIAC REHAB			327		327		192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	37,091	26	1,549,517		1,549,517		202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINISTRATION & ACCOUNTING ACCUM COST	RECON-CILIATION	
		1	2	4	5A.01	5.01		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	7,594,345						1
2	Cap Rel Costs-Mvble Equip		1,263,162					2
4	Employee Benefits Department	26,545	233	6,703,549				4
5.01	ADMINISTRATION & ACCOUNTING	1,079,995	22,598	309,695	-1,299,456	15,794,211		5.01
5.02	GENERAL	1,079,995	388,062	192,239		984,625	-1,065,634	5.02
5.03	ADMITTING	76,800	901	109,172		173,257		5.03
5.04	PATIENT ACCOUNTING	115,300	594	200,022		471,254		5.04
6	Maintenance & Repairs							6
7	Operation of Plant	483,333	9,561	186,866		673,664		7
8	Laundry & Linen Service	213,033	1,969	47,175		121,748		8
9	Housekeeping	29,333	1,877	121,457		187,901		9
10	Dietary	315,900	4,646	136,162		306,241		10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	10,700	85	131,057		184,690		13.01
13.02	NURSING ADMINISTRATION	207,400	50	189,213		288,376		13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	90,500	967	41,846		67,851		14.02
15	Pharmacy	57,200	14,553			450,246		15
16	Medical Records & Library	196,265	6,595	196,920		328,403		16
17	Social Service					729		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,066,300	35,051	980,498		1,623,754		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	639,376	97,381	547,345		1,387,205		50
53	Anesthesiology	6,000	1,932			18,341		53
54	Radiology-Diagnostic	387,622	274,409	401,395		1,060,114		54
54.01	ULTRA SOUND	22,100	391			173,591		54.01
56	Radioisotope	173,424	234,376	63,824		646,924		56
60	Laboratory	197,800	33,174	423,674		1,271,505		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	91,500	4,209	131,543		224,612		65
65.50	SLEEP LAB	35,124	380	50,235		136,794		65.50
66	Physical Therapy	429,400	19,182	752,179		1,170,061		66
67	Occupational Therapy		320	112,799		158,599		67
69	Electrocardiology		4,944			24,243		69
71	Medical Supplies Charged to Patients					78,911		71
73	Drugs Charged to Patients					391,009		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	563,400	89,026	707,444		1,715,268		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	7,594,345	1,247,466	6,032,760	-1,299,456	14,319,916	-1,065,634	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING		15,362	669,332		1,472,053	-1,593,165	192.02
192.03	CARDIAC REHAB		334	1,457		2,242		192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	613,970	935,547	2,475,750		1,299,456		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.080846	0.740639	0.369319		0.082274		203
204	Cost to be allocated (Per Wkst. B, Part II)			2,319		104,155		204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000346		0.006595		205

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	GENERAL ACCUM COST	PURCHASING RECEIVING AND STORES SQUARE FEET	PATIENT ACCOUNTING GROSS CHARGES	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	
		5.02	5.03	5.04	7	8	9	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL	14,434,868						5.02
5.03	ADMITTING	187,512	34,224,556					5.03
5.04	PATIENT ACCOUNTING	510,026		34,224,556				5.04
6	Maintenance & Repairs							6
7	Operation of Plant	729,089			4,732,377			7
8	Laundry & Linen Service	131,765			213,033	157,174		8
9	Housekeeping	203,360			29,333	9,708	1,382	9
10	Dietary	331,437			315,900	3,807		10
11	Cafeteria						27	11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	199,885			10,700			13.01
13.02	NURSING ADMINISTRATION	312,102			207,400		11	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	73,433			90,500			14.02
15	Pharmacy	487,290			57,200		22	15
16	Medical Records & Library	355,422			196,265		10	16
17	Social Service	789						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,757,347	2,259,750	2,259,750	1,066,300	82,129	491	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,501,336	3,512,847	3,512,847	639,376	10,855	371	50
53	Anesthesiology	19,850	475,137	475,137	6,000			53
54	Radiology-Diagnostic	1,147,334	7,414,761	7,414,761	387,622	13,276	96	54
54.01	ULTRA SOUND	187,873	1,375,856	1,375,856	22,100		13	54.01
56	Radioisotope	700,149	2,372,351	2,372,351	173,424		6	56
60	Laboratory	1,376,117	5,116,467	5,116,467	197,800		26	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	243,092	368,426	368,426	91,500		35	65
65.50	SLEEP LAB	148,049	546,155	546,155	35,124	1,682	7	65.50
66	Physical Therapy	1,266,327	3,088,341	3,088,341	429,400	17,659	35	66
67	Occupational Therapy	171,648	250,183	250,183				67
69	Electrocardiology	26,238	390,492	390,492				69
71	Medical Supplies Charged to Patients	85,403	1,117,545	1,117,545				71
73	Drugs Charged to Patients	423,179	1,805,260	1,805,260				73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,856,390	4,130,985	4,130,985	563,400	18,058	232	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,432,442	34,224,556	34,224,556	4,732,377	157,174	1,382	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB	2,426						192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,065,634	201,355	547,678	782,913	176,736	234,142	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.073824	0.005883	0.016002	0.165438	1.124461	169.422576	203
204	Cost to be allocated (Per Wkst. B, Part II)	381,288	13,010	26,411	69,923	26,128	12,461	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.026414	0.000380	0.000772	0.014775	0.166236	9.016643	205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	DIETARY MEALS SERV ED	CAFETERIA FTE'S SERV ED	UR/QUALITY IMPROVEMENT DIRECT NRS ING HRS	NURSING ADMINISTRATION DIRECT NRS ING HRS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	PHARMACY COSTED REQ UIS.	
		10	11	13.01	13.02	14.02	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL							5.02
5.03	ADMITTING							5.03
5.04	PATIENT ACCOUNTING							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	26,939						10
11	Cafeteria	16,399	9,036					11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT		217	2,681				13.01
13.02	NURSING ADMINISTRATION		270		53,549			13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY		173			784,067		14.02
15	Pharmacy					5,028	434,897	15
16	Medical Records & Library		547			3,197		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,021	2,256	2,681	23,180	67,016	3,872	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,519	865		12,642	264,081	1,225	50
53	Anesthesiology					9,445	1,333	53
54	Radiology-Diagnostic		734			39,966	12,959	54
54.01	ULTRA SOUND					966		54.01
56	Radioisotope		113			11,180	22,874	56
60	Laboratory		893			245,464		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		234		261			65
65.50	SLEEP LAB		107		252	12		65.50
66	Physical Therapy		1,177			9,170	2	66
67	Occupational Therapy		172			622		67
69	Electrocardiology					1,461		69
71	Medical Supplies Charged to Patients					74,971		71
73	Drugs Charged to Patients						391,009	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		1,278		17,214	51,488	1,623	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	26,939	9,036	2,681	53,549	784,067	434,897	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB							192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	412,448	255,650	222,550	378,958	98,721	537,087	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.310442	28.292386	83.010071	7.076846	0.125909	1.234975	203
204	Cost to be allocated (Per Wkst. B, Part II)	45,102	27,699	8,294	31,006	12,301	32,365	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.674227	3.065405	3.093622	0.579021	0.015689	0.074420	205

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT					
		16	17					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL							5.02
5.03	ADMITTING							5.03
5.04	PATIENT ACCOUNTING							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT							13.01
13.02	NURSING ADMINISTRATION							13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy							15
16	Medical Records & Library	1,685						16
17	Social Service		100					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	491	100					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	339						50
53	Anesthesiology							53
54	Radiology-Diagnostic	245						54
54.01	ULTRA SOUND							54.01
56	Radioisotope							56
60	Laboratory	91						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	22						65
65.50	SLEEP LAB	31						65.50
66	Physical Therapy	66						66
67	Occupational Therapy	12						67
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	388						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,685	100					118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB							192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	431,704	847					202
203	Unit Cost Multiplier (Wkst. B, Part I)	256.204154	8.470000					203
204	Cost to be allocated (Per Wkst. B, Part II)	37,091	26					204
205	Unit Cost Multiplier (Wkst. B, Part II)	22.012463	0.260000					205

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,016,876		3,016,876			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,128,698		2,128,698			50
53	Anesthesiology	35,541		35,541			53
54	Radiology-Diagnostic	1,594,227		1,594,227			54
54.01	ULTRA SOUND	237,833		237,833			54.01
56	Radioisotope	866,318		866,318			56
60	Laboratory	1,706,296		1,706,296			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	304,272		304,272			65
65.50	SLEEP LAB	192,574		192,574			65.50
66	Physical Therapy	1,575,593		1,575,593			66
67	Occupational Therapy	197,813		197,813			67
69	Electrocardiology	36,905		36,905			69
71	Medical Supplies Charged to Patients	125,606		125,606			71
73	Drugs Charged to Patients	976,815		976,815			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	2,502,530		2,502,530			91
92	Observation Beds (Non-Distinct Part)	377,599		377,599			92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	15,875,496		15,875,496			200
201	Less Observation Beds	377,599		377,599			201
202	Total (line 200 minus line 201)	15,497,897		15,497,897			202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	2,259,750		2,259,750				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	45,825	3,467,022	3,512,847	0.605975			50
53	Anesthesiology	7,903	467,234	475,137	0.074802			53
54	Radiology-Diagnostic	237,691	7,177,070	7,414,761	0.215007			54
54.01	ULTRA SOUND	98,853	1,277,003	1,375,856	0.172862			54.01
56	Radioisotope	47,658	2,324,693	2,372,351	0.365173			56
60	Laboratory	581,451	4,535,016	5,116,467	0.333491			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	136,912	231,514	368,426	0.825870			65
65.50	SLEEP LAB	7,655	538,500	546,155	0.352600			65.50
66	Physical Therapy	371,442	2,716,899	3,088,341	0.510175			66
67	Occupational Therapy	140,313	109,870	250,183	0.790673			67
69	Electrocardiology	18,572	371,920	390,492	0.094509			69
71	Medical Supplies Charged to Patients	416,321	701,224	1,117,545	0.112395			71
73	Drugs Charged to Patients	588,687	1,216,573	1,805,260	0.541094			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,512	4,128,473	4,130,985	0.605795			91
92	Observation Beds (Non-Distinct Part)	135,309	799,403	934,712	0.403974			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	5,096,854	30,062,414	35,159,268				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,096,854	30,062,414	35,159,268				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1332** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.605975		1,571,573			952,334		50
53	Anesthesiology	0.074802		199,986			14,959		53
54	Radiology-Diagnostic	0.215007		2,640,728			567,775		54
54.01	ULTRA SOUND	0.172862		510,090			88,175		54.01
56	Radioisotope	0.365173		925,429			337,942		56
60	Laboratory	0.333491		1,973,459			658,131		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.825870		81,231			67,086		65
65.50	SLEEP LAB	0.352600		189,304			66,749		65.50
66	Physical Therapy	0.510175		927,543			473,209		66
67	Occupational Therapy	0.790673		50,689			40,078		67
69	Electrocardiology	0.094509		181,677			17,170		69
71	Medical Supplies Charged to Pat	0.112395		381,231			42,848		71
73	Drugs Charged to Patients	0.541094		916,803			496,077		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.605795		1,438,277			871,301		91
92	Observation Beds (Non-Distinct	0.403974		244,750			98,873		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			12,232,770			4,792,707		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			12,232,770			4,792,707		202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z332** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.605975							50
53	Anesthesiology	0.074802							53
54	Radiology-Diagnostic	0.215007							54
54.01	ULTRA SOUND	0.172862							54.01
56	Radioisotope	0.365173							56
60	Laboratory	0.333491							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.825870							65
65.50	SLEEP LAB	0.352600							65.50
66	Physical Therapy	0.510175							66
67	Occupational Therapy	0.790673							67
69	Electrocardiology	0.094509							69
71	Medical Supplies Charged to Pat	0.112395							71
73	Drugs Charged to Patients	0.541094							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.605795							91
92	Observation Beds (Non-Distinct	0.403974							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	261,984	148,754	113,230	1,326	85.39	81	6,917	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	261,984		113,230	1,326		81	6,917	200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1332** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	215,664	3,512,847	0.061393			50
53	Anesthesiology	3,445	475,137	0.007251			53
54	Radiology-Diagnostic	298,581	7,414,761	0.040268			54
54.01	ULTRA SOUND	10,228	1,375,856	0.007434			54.01
56	Radioisotope	217,962	2,372,351	0.091876			56
60	Laboratory	103,084	5,116,467	0.020147			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	21,906	368,426	0.059458			65
65.50	SLEEP LAB	10,599	546,155	0.019407			65.50
66	Physical Therapy	108,707	3,088,341	0.035199			66
67	Occupational Therapy	6,945	250,183	0.027760			67
69	Electrocardiology	4,987	390,492	0.012771			69
71	Medical Supplies Charged to Pat	5,240	1,117,545	0.004689			71
73	Drugs Charged to Patients	44,937	1,805,260	0.024892			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	213,603	4,130,985	0.051708			91
92	Observation Beds (Non-Distinct	75,869	934,712	0.081168			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,341,757	32,899,518				200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,326		81		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	1,326		81		200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1332** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRA SOUND							54.01
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy							66
67	Occupational Therapy							67
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1332** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	3,512,847							50
53	Anesthesiology	475,137							53
54	Radiology-Diagnostic	7,414,761							54
54.01	ULTRA SOUND	1,375,856							54.01
56	Radioisotope	2,372,351							56
60	Laboratory	5,116,467							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	368,426							65
65.50	SLEEP LAB	546,155							65.50
66	Physical Therapy	3,088,341							66
67	Occupational Therapy	250,183							67
69	Electrocardiology	390,492							69
71	Medical Supplies Charged to Pat	1,117,545							71
73	Drugs Charged to Patients	1,805,260							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	4,130,985							91
92	Observation Beds (Non-Distinct	934,712							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	32,899,518							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1332** **WORKSHEET D PART V**

Check Applicable Boxes:

[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.605975							50
53	Anesthesiology	0.074802							53
54	Radiology-Diagnostic	0.215007							54
54.01	ULTRA SOUND	0.172862							54.01
56	Radioisotope	0.365173							56
60	Laboratory	0.333491							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.825870							65
65.50	SLEEP LAB	0.352600							65.50
66	Physical Therapy	0.510175							66
67	Occupational Therapy	0.790673							67
69	Electrocardiology	0.094509							69
71	Medical Supplies Charged to Pat	0.112395							71
73	Drugs Charged to Patients	0.541094							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.605795							91
92	Observation Beds (Non-Distinct	0.403974							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1332** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,068	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,326	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	942	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,742	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	657	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	1,742	10
11	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)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	130.00	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	130.00	20
21	Total general inpatient routine service cost (see instructions)	3,016,876	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	1,712,978	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,303,898	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,303,898	37

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1332** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	983.34	38
39	Program general inpatient routine service cost (line 9 x line 38)	646,054	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	646,054	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	320,265	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	966,319	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	1,712,978	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,712,978	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1332** **WORKSHEET D-1**
PARTS III & IV

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					384	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					983.33	88
89	Observation bed cost (line 87 x line 88) (see instructions)					377,599	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	261,984	1,303,898	0.200924	377,599	75,869	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1332** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,068	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,326	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	942	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,742	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	81	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	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)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	130.00	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	130.00	20
21	Total general inpatient routine service cost (see instructions)	3,016,876	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	1,712,978	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,303,898	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,303,898	37

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1332** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	983.34	38
39	Program general inpatient routine service cost (line 9 x line 38)	79,651	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	79,651	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	79,651	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	6,917	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	6,917	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1332** **WORKSHEET D-1**
PARTS III & IV

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					384	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1332** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		711,266		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.605975	14,769	8,950	50
53	Anesthesiology	0.074802	2,353	176	53
54	Radiology-Diagnostic	0.215007	110,878	23,840	54
54.01	ULTRA SOUND	0.172862	60,194	10,405	54.01
56	Radioisotope	0.365173	36,030	13,157	56
60	Laboratory	0.333491	240,784	80,299	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.825870	60,831	50,238	65
65.50	SLEEP LAB	0.352600			65.50
66	Physical Therapy	0.510175	30,647	15,635	66
67	Occupational Therapy	0.790673	10,296	8,141	67
69	Electrocardiology	0.094509	9,479	896	69
71	Medical Supplies Charged to Patients	0.112395	170,643	19,179	71
73	Drugs Charged to Patients	0.541094	165,127	89,349	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.605795			91
92	Observation Beds (Non-Distinct Part)	0.403974			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		912,031	320,265	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		912,031		202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z332** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other] [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.605975	1,879	1,139	50
53	Anesthesiology	0.074802	466	35	53
54	Radiology-Diagnostic	0.215007	83,091	17,865	54
54.01	ULTRA SOUND	0.172862	12,874	2,225	54.01
56	Radioisotope	0.365173	6,033	2,203	56
60	Laboratory	0.333491	232,032	77,381	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.825870	58,297	48,146	65
65.50	SLEEP LAB	0.352600	7,655	2,699	65.50
66	Physical Therapy	0.510175	336,878	171,867	66
67	Occupational Therapy	0.790673	129,454	102,356	67
69	Electrocardiology	0.094509	4,069	385	69
71	Medical Supplies Charged to Patients	0.112395	172,750	19,416	71
73	Drugs Charged to Patients	0.541094	356,136	192,703	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.605795	2,512	1,522	91
92	Observation Beds (Non-Distinct Part)	0.403974			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,404,126	639,942	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,404,126		202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1332** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.605975			50
53	Anesthesiology	0.074802			53
54	Radiology-Diagnostic	0.215007			54
54.01	ULTRA SOUND	0.172862			54.01
56	Radioisotope	0.365173			56
60	Laboratory	0.333491			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.825870			65
65.50	SLEEP LAB	0.352600			65.50
66	Physical Therapy	0.510175			66
67	Occupational Therapy	0.790673			67
69	Electrocardiology	0.094509			69
71	Medical Supplies Charged to Patients	0.112395			71
73	Drugs Charged to Patients	0.541094			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.605795			91
92	Observation Beds (Non-Distinct Part)	0.403974			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1332** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	4,792,707			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	4,792,707			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	4,840,634			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	36,839			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,076,351			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,727,444			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,727,444			30
31	Primary payer payments	924			31
32	Subtotal (line 30 minus line 31)	2,726,520			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	302,966			34
35	Adjusted reimbursable bad debts (see instructions)	230,254			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	302,966			36
37	Subtotal (see instructions)	2,956,774			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,956,774			40
40.01	Sequestration adjustment (see instructions)	59,135			40.01
41	Interim payments	3,157,631			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-259,992			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1332** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				783,793		3,242,825	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	02/20/2015	43,316	02/20/2015	58,073	3.51
		Provider	.52	06/18/2015	26,233	06/18/2015	27,121	3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-69,549		-85,194	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				714,244		3,157,631	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		41,956			6.01
	based on the cost report (1)		.02				-259,992	6.02
7	Total Medicare program liability (see instructions)				756,200		2,897,639	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z332** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [XX] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,295,727			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	02/20/2015	84,659			3.51
		Provider	.52	06/18/2015	48,955			3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-133,614			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,162,113			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		86,882			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,248,995			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	353	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	657	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	103	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	942	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	35,159,268	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	790,404	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	43,423	7
8	Calculation of the HIT incentive payment (see instructions)	43,423	8
9	Sequestration adjustment amount (see instructions)	868	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	42,555	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	42,555	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z332** **WORKSHEET E-2**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX** **[XX] Swing Bed - SNF** **[ ] Swing Bed - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	1,730,108		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	646,341		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,742		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,376,449		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	2,376,449		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	2,376,449		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	81,556		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,294,893		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	2,294,893		19
19.01	Sequestration adjustment (see instructions)	45,898		19.01
20	Interim payments	2,162,113		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	86,882		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART V**

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services	966,319	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	966,319	4
5	Primary payer payments		5
6	Total cost (see instructions)	975,982	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	975,982	19
20	Deductibles (exclude professional component)	230,666	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	745,316	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	745,316	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	34,628	25
26	Adjusted reimbursable bad debts (see instructions)	26,317	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,628	27
28	Subtotal (sum of lines 24 and 26)	771,633	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	771,633	30
30.01	Sequestration adjustment (see instructions)	15,433	30.01
31	Interim payments	714,244	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	41,956	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1332** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	79,651		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	79,651		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	79,651		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	79,651		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	79,651		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	79,651		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	79,651		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	79,651		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	79,651		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	79,651		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	1,719,802				1
2	Temporary investments	4,201,022				2
3	Notes receivable					3
4	Accounts receivable	3,268,873				4
5	Other receivables	76,114				5
6	Allowances for uncollectible notes and accounts receivable	-1,217,000				6
7	Inventory	402,399				7
8	Prepaid expenses	247,274				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	8,698,484				11
	FIXED ASSETS					
12	Land	265,746				12
13	Land improvements	1,687,647				13
14	Accumulated depreciation	-782,686				14
15	Buildings	16,453,827				15
16	Accumulated depreciation	-7,268,776				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	164,333				19
20	Accumulated depreciation	-161,931				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,584,569				23
24	Accumulated depreciation	-8,627,762				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	13,314,967				30
	OTHER ASSETS					
31	Investments	3,375,000				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	7,698,404				34
35	Total other assets (sum of lines 31-34)	11,073,404				35
36	Total assets (sum of lines 11, 30 and 35)	33,086,855				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,045,874				37
38	Salaries, wages and fees payable	555,143				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	283,466				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	541,718				43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	2,426,201				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	5,863,537				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	5,863,537				50
51	Total liabilities (sum of lines 45 and 50)	8,289,738				51
	CAPITAL ACCOUNTS					
52	General fund balance	24,797,117				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	24,797,117				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	33,086,855				60

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STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		23,157,728			1
2	Net income (loss) (from Worksheet G-3, line 29)		2,185,968			2
3	Total (sum of line 1 and line 2)		25,343,696			3
4	Additions (credit adjustments) (specify)					4
5	RETURN ON INVESTMENTS	3,703				5
6	CONTRIBUTIONS OF EQUIPTMENT	24,096				6
7	TRANSFERS FROM FOUNDATION	24,096				7
8	CHANGE IN INTEREST OF FOUNDATION	3,441				8
9						9
10	Total additions (sum of lines 4-9)		55,336			10
11	Subtotal (line 3 plus line 10)		25,399,032			11
12	Deductions (debit adjustments) (specify)					12
13	RELEASED CONTRIBUTIONS	43,405				13
14	TRANSFERS TO HILLSBORO AREA HEALTH	500,000				14
15	UNREALIZED CHANGE IN INVESTMENTS	58,510				15
16						16
17						17
18	Total deductions (sum of lines 12-17)		601,915			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,797,117			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	RETURN ON INVESTMENTS					5
6	CONTRIBUTIONS OF EQUIPTMENT					6
7	TRANSFERS FROM FOUNDATION					7
8	CHANGE IN INTEREST OF FOUNDATION					8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	RELEASED CONTRIBUTIONS					13
14	TRANSFERS TO HILLSBORO AREA HEALTH					14
15	UNREALIZED CHANGE IN INVESTMENTS					15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/05/2015 Run Time: 11:51 Version: 2015.10 (10/27/2015)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,478,930		3,478,930	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	3,478,930		3,478,930	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	3,478,930		3,478,930	17
18	Ancillary services	4,283,882		4,283,882	18
19	Outpatient services		31,465,460	31,465,460	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,762,812	31,465,460	39,228,272	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		19,249,694	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		19,249,694	43

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STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	39,228,272	1
2	Less contractual allowances and discounts on patients' accounts	18,291,573	2
3	Net patient revenues (line 1 minus line 2)	20,936,699	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	19,249,694	4
5	Net income from service to patients (line 3 minus line 4)	1,687,005	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	230,388	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	4,529	10
11	Rebates and refunds of expenses	4,710	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	39,318	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	5,016	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	7,123	22
23	Governmental appropriations		23
24	Other (MISC. INCOME/ADJUSTMENTS)	63,707	24
24.01	Other (EHR INCENTIVE PAYMENTS)	143,401	24.01
24.02	Other (GAIN ON DISPOSAL OF ASSETS)	771	24.02
25	Total other income (sum of lines 6-24)	498,963	25
26	Total (line 5 plus line 25)	2,185,968	26
29	Net income (or loss) for the period (line 26 minus line 28)	2,185,968	29

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATION & ACCOUNTING							5.01
5.02	GENERAL							5.02
5.03	ADMITTING							5.03
5.04	PATIENT ACCOUNTING							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT							13.01
13.02	NURSING ADMINISTRATION							13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRA SOUND							54.01
56	Radioisotope							56
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
65.50	SLEEP LAB							65.50
66	Physical Therapy							66
67	Occupational Therapy							67
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202