HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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: 11/14/2016 Time: 13:22 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 HILLSBORO AREA HOSPITAL (14-1332) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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		-18,571	130,510	104,270	103,372	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		21,560				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		2,989	130,510	104,270	103,372	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 / 2015	To: 06 / 30 / 2016	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
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
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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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

		1	2	
Rural Providers				
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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

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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)	106,398		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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2015 12 / 31 / 2015	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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 Accountant? 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	09/01/2016	Y	09/01/2016	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

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.	Y	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	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 services 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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	9,150	23,304.00		719	89	971	1
2	HMO and other (see instructions)						76			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,253		1,253	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,150	23,304.00		1,972	89	2,224	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	9,150	23,304.00		1,972	89	2,224	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								417	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)					242	34	336	1
2	HMO and other (see instructions)					26			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)		129.41			242	34	336	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)		129.41						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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	0.416616	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)	2,853,350	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.	1,560,686	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)	1,560,686	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	223,124	436,513	659,637	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	92,957	181,858	274,815	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	92,957	181,858	274,815	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)	1,303,403	26
27	Medicare bad debts for the entire hospital complex (see instructions)	227,782	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,075,621	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	448,121	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	722,936	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,283,622	31

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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		774,846	774,846	-122,178	652,668	-241,649	411,019	1
2	00200	Cap Rel Costs-Mvble Equip		998,484	998,484	12,245	1,010,729	-139,660	871,069	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	69,906	2,398,926	2,468,832		2,468,832	-811	2,468,021	4
5.01	00592	ADMINISTRATION & ACCOUNTING	314,025	755,723	1,069,748		1,069,748	-74,298	995,450	5.01
5.02	00591	GENERAL	198,659	863,271	1,061,930	-48,020	1,013,910	-413,233	600,677	5.02
5.03	00570	ADMITTING	121,528	15,673	137,201		137,201		137,201	5.03
5.04	00580	PATIENT ACCOUNTING	205,415	146,723	352,138		352,138		352,138	5.04
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	191,480	347,010	538,490		538,490		538,490	7
8	00800	Laundry & Linen Service	56,580	40,446	97,026		97,026		97,026	8
9	00900	Housekeeping	121,243	8,404	129,647		129,647		129,647	9
10	01000	Dietary	136,034	117,610	253,644		253,644	-46,332	207,312	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
13.01	01301	UR/QUALITY IMPROVEMENT	164,134	40,036	204,170		204,170		204,170	13.01
13.02	01302	NURSING ADMINISTRATION	211,533	9,051	220,584		220,584		220,584	13.02
14	01400	Central Services & Supply								14
14.01	01401	PURCHASING								14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	45,155	2,382	47,537		47,537		47,537	14.02
15	01500	Pharmacy		921,280	921,280	-493,427	427,853		427,853	15
16	01600	Medical Records & Library	182,267	57,301	239,568		239,568	-3,822	235,746	16
17	01700	Social Service		676	676		676		676	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	1,034,962	160,790	1,195,752	-198	1,195,554		1,195,554	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	550,161	380,343	930,504	25,114	955,618		955,618	50
53	05300	Anesthesiology		169,580	169,580	-65,091	104,489	-88,756	15,733	53
54	05400	Radiology-Diagnostic	412,599	292,187	704,786		704,786	-25	704,761	54
54.01	03040	ULTRA SOUND		173,257	173,257		173,257		173,257	54.01
56	05600	Radioisotope	71,824	392,204	464,028		464,028		464,028	56
60	06000	Laboratory	440,089	808,773	1,248,862		1,248,862	-63,629	1,185,233	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	133,915	31,783	165,698	-13,571	152,127		152,127	65
65.50	06501	SLEEP LAB	54,248	86,456	140,704		140,704	-17,175	123,529	65.50
66	06600	Physical Therapy	818,622	104,174	922,796		922,796	-26	922,770	66
67	06700	Occupational Therapy	119,090	4,996	124,086		124,086		124,086	67
69	06900	Electrocardiology		53,663	53,663		53,663	-29,899	23,764	69
71	07100	Medical Supplies Charged to Patients		37,137	37,137	57,020	94,157	-190	93,967	71
73	07300	Drugs Charged to Patients				490,471	490,471		490,471	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	687,445	1,781,231	2,468,676	-318	2,468,358	-989,202	1,479,156	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)	6,340,914	11,974,416	18,315,330	-157,953	18,157,377	-2,108,707	16,048,670	118
		NONREIMBURSABLE COST CENTERS								
192.02	19201	ASSISTED LIVING	690,093	469,788	1,159,881	157,953	1,317,834	-540	1,317,294	192.02
192.03	19202	CARDIAC REHAB	691		691		691		691	192.03
200		TOTAL (sum of lines 118-199)	7,031,698	12,444,204	19,475,902		19,475,902	-2,109,247	17,366,655	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		490,471	1
500	Total reclassifications					490,471	500
	Code Letter - A						
1	TO RECLASS MED SUPPLY FROM PHARMACY	B	Medical Supplies Charged to P	71		745	1
500	Total reclassifications					745	500
	Code Letter - B						
1	TO RECLASS MED SUPPLY FROM OR	C	Medical Supplies Charged to P	71		38,688	1
500	Total reclassifications					38,688	500
	Code Letter - C						
1	TO RECLASS OXGEN FROM RT TO MED SUP	D	Medical Supplies Charged to P	71		13,571	1
500	Total reclassifications					13,571	500
	Code Letter - D						
1	TO RECLASS INSURANCE	E	Cap Rel Costs-Bldg & Fixt	1		18,728	1
2			Cap Rel Costs-Mvble Equip	2		29,292	2
500	Total reclassifications					48,020	500
	Code Letter - E						
1	TO RECLASS DEPRECIATION	F	ASSISTED LIVING	192.02		157,953	1
2							2
500	Total reclassifications					157,953	500
	Code Letter - F						
1	TO RECLASS ONCALL EXPENSE	G	Operating Room	50		65,000	1
500	Total reclassifications					65,000	500
	Code Letter - G						
1	TO RECLASS IV THERAPY TO MED SUP	H	Medical Supplies Charged to P	71		4,016	1
2							2
3							3
4							4
5							5
500	Total reclassifications					4,016	500
	Code Letter - H						
	GRAND TOTAL (Increases)					818,464	

(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.

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		490,471		1
500	Total reclassifications					490,471		500
	Code letter - A							
1	TO RECLASS MED SUPPLY FROM PHARMACY	B	Pharmacy	15		745		1
500	Total reclassifications					745		500
	Code letter - B							
1	TO RECLASS MED SUPPLY FROM OR	C	Operating Room	50		38,688		1
500	Total reclassifications					38,688		500
	Code letter - C							
1	TO RECLASS OXGEN FROM RT TO MED SUP	D	Respiratory Therapy	65		13,571		1
500	Total reclassifications					13,571		500
	Code letter - D							
1	TO RECLASS INSURANCE	E	GENERAL	5.02		48,020	12	1
2							12	2
500	Total reclassifications					48,020		500
	Code letter - E							
1	TO RECLASS DEPRECIATION	F	Cap Rel Costs-Bldg & Fixt	1		140,906	9	1
2			Cap Rel Costs-Mvble Equip	2		17,047	9	2
500	Total reclassifications					157,953		500
	Code letter - F							
1	TO RECLASS ONCALL EXPENSE	G	Anesthesiology	53		65,000		1
500	Total reclassifications					65,000		500
	Code letter - G							
1	TO RECLASS IV THERAPY TO MED SUP	H	Pharmacy	15		2,211		1
2			Adults & Pediatrics	30		198		2
3			Operating Room	50		1,198		3
4			Anesthesiology	53		91		4
5			Emergency	91		318		5
500	Total reclassifications					4,016		500
	Code letter - H							
	GRAND TOTAL (Decreases)					818,464		

(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.

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	265,747					265,747		1
2	Land Improvements	1,687,647					1,687,647		2
3	Buildings and Fixtures	16,453,827	156,238		156,238	103,276	16,506,789		3
4	Building Improvements								4
5	Fixed Equipment	164,333					164,333		5
6	Movable Equipment	11,584,569	495,797		495,797		12,080,366		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	30,156,123	652,035		652,035	103,276	30,704,882		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	30,156,123	652,035		652,035	103,276	30,704,882		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	774,846						774,846	1
2	Cap Rel Costs-Mvble Equip	998,484						998,484	2
3	Total (sum of lines 1-2)	1,773,330						1,773,330	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	18,460,183		18,460,183	0.601213					1
2	Cap Rel Costs-Mvble Equ	12,244,699		12,244,699	0.398787					2
3	Total (sum of lines 1-2)	30,704,882		30,704,882	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	392,291			18,728			411,019	1
2	Cap Rel Costs-Mvble Equip	841,777			29,292			871,069	2
3	Total (sum of lines 1-2)	1,234,068			48,020			1,282,088	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	-230,745	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	-3,861	ADMINISTRATION & ACCOUNTING	5.01		4
5	Refunds and rebates of expenses (chapter 8)	B	-3,861	ADMINISTRATION & ACCOUNTING	5.01		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-346	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	-1,099,905				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	-40,335	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-190	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-3,822	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	-134,557	Cap Rel Costs-Mvble Equip	2	9	32
33	NUTRITIONAL SERVICES	A	-5,997	Dietary	10		33
34	CRNA	A	-88,756	Anesthesiology	53		34
35	LOBBYING PORTION OF DUES	A	-9,330	ADMINISTRATION & ACCOUNTING	5.01		35
36	MARKETING COSTS	A	-102,396	GENERAL	5.02		36
37							37
38							38
39							39
40	ALCOHOLIC BEVERAGES	A	-26	Physical Therapy	66		40
41	EMPLOYEE MEALS - ALF	B	-540	ASSISTED LIVING	192.02		41
42	OTHER MISCELLANEOUS	B	-25	Radiology-Diagnostic	54		42
43	ALCOHOLIC BEVERAGES	A	-811	Employee Benefits Department	4		43
44	DIAMOND CLUB FEES	B	-10,946	GENERAL	5.02		44
45	DAYCARE REVENUE	B	-3,762	ADMINISTRATION & ACCOUNTING	5.01		45
45.01	AMBULANCE RECEIPTS	B	-6,762	ADMINISTRATION & ACCOUNTING	5.01		45.01
45.05	MEDICAID TAX ASSESSMENT	A	-299,545	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	-9,212	Cap Rel Costs-Bldg & Fixt	1	9	45.07
45.48	DONATIONS	A	-1,000	ADMINISTRATION & ACCOUNTING	5.01		45.48
45.49	PHYSICIAN RECRUITMENT	A	-45,681	ADMINISTRATION & ACCOUNTING	5.01		45.49
45.50	LAND RENTAL TO HILLSBORO HEALTH SV	A	-41	ADMINISTRATION & ACCOUNTING	5.01		45.50
46							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)		-2,109,247				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	34,608	34,608			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			159,608	159,608			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	107,846	63,629	44,217					1
2	69	Electrocardiology EKG	29,899	29,899						2
3	91	Emergency ER	1,537,089	989,202	547,887					3
4	65.50	SLEEP LAB SLEEP LAB	17,175	17,175						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	1,692,009	1,099,905	592,104					200

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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							63,629	1
2	69	Electrocardiology EKG							29,899	2
3	91	Emergency ER							989,202	3
4	65.50	SLEEP LAB SLEEP LAB							17,175	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							1,099,905	200

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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	411,019	411,019					1
2	Cap Rel Costs-Mvble Equip	871,069		871,069				2
4	Employee Benefits Department	2,468,021	1,454	203	2,469,678			4
5.01	ADMINISTRATION & ACCOUNTING	995,450	59,148	15,645	111,399	1,181,642	1,181,642	5.01
5.02	GENERAL	600,677	59,150	190,274	70,474	920,575	67,209	5.02
5.03	ADMITTING	137,201	4,206	786	43,112	185,305	13,529	5.03
5.04	PATIENT ACCOUNTING	352,138	6,315	514	72,870	431,837	31,528	5.04
6	Maintenance & Repairs							6
7	Operation of Plant	538,490	26,472	10,590	67,927	643,479	46,979	7
8	Laundry & Linen Service	97,026	11,668	2,222	20,072	130,988	9,563	8
9	Housekeeping	129,647	1,607	1,523	43,011	175,788	12,834	9
10	Dietary	207,312	17,302	3,959	48,258	276,831	20,211	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	204,170	586	62	58,226	263,044	19,204	13.01
13.02	NURSING ADMINISTRATION	220,584	11,359	30	75,041	307,014	22,414	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	47,537	4,957	792	16,019	69,305	5,060	14.02
15	Pharmacy	427,853	3,133	12,605		443,591	32,386	15
16	Medical Records & Library	235,746	10,749	3,005	64,659	314,159	22,936	16
17	Social Service	676				676	49	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	1,195,554	58,400	33,087	367,152	1,654,193	120,769	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	955,618	35,408	83,117	195,168	1,269,311	92,670	50
53	Anesthesiology	15,733	329	2,339		18,401	1,343	53
54	Radiology-Diagnostic	704,761	20,095	220,325	146,368	1,091,549	79,692	54
54.01	ULTRA SOUND	173,257	1,210	341		174,808	12,762	54.01
56	Radioisotope	464,028	5,718	205,750	25,479	700,975	51,177	56
60	Laboratory	1,185,233	10,833	13,718	156,120	1,365,904	99,722	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	152,127	5,011	4,099	47,506	208,743	15,240	65
65.50	SLEEP LAB	123,529	1,534	610	19,244	144,917	10,580	65.50
66	Physical Therapy	922,770	23,518	16,987	290,404	1,253,679	91,529	66
67	Occupational Therapy	124,086		279	42,247	166,612	12,164	67
69	Electrocardiology	23,764		4,313		28,077	2,050	69
71	Medical Supplies Charged to Patients	93,967				93,967	6,860	71
73	Drugs Charged to Patients	490,471				490,471	35,808	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	1,479,156	30,857	28,731	243,869	1,782,613	130,152	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)	16,048,670	411,019	855,906	2,224,625	15,788,454	1,066,420	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING	1,317,294		14,872	244,808	1,576,974	115,132	192.02
192.03	CARDIAC REHAB	691		291	245	1,227	90	192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	17,366,655	411,019	871,069	2,469,678	17,366,655	1,181,642	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL (cols.0-4)	GENERAL	ADMITTING	PATIENT ACCOUNTING	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	987,784	987,784					5.02
5.03	ADMITTING	198,834	13,373	212,207				5.03
5.04	PATIENT ACCOUNTING	463,365	31,165		494,530			5.04
6	Maintenance & Repairs							6
7	Operation of Plant	690,458	46,438			736,896		7
8	Laundry & Linen Service	140,551	9,453			33,813	183,817	8
9	Housekeeping	188,622	12,686			4,656	10,897	9
10	Dietary	297,042	19,978			50,141	4,247	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	282,248	18,983			1,698		13.01
13.02	NURSING ADMINISTRATION	329,428	22,156			32,919		13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	74,365	5,002			14,365		14.02
15	Pharmacy	475,977	32,013			9,079		15
16	Medical Records & Library	337,095	22,672			31,152		16
17	Social Service	725	49					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	1,774,962	119,379	12,371	28,828	169,247	100,431	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,361,981	91,603	20,771	48,402	102,615	10,217	50
53	Anesthesiology	19,744	1,328	2,863	6,673	952		53
54	Radiology-Diagnostic	1,171,241	78,774	49,885	116,273	58,236	14,061	54
54.01	ULTRA SOUND	187,570	12,615	9,188	21,411	3,508		54.01
56	Radioisotope	752,152	50,587	15,446	35,994	16,571		56
60	Laboratory	1,465,626	98,574	30,877	71,952	31,396		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	223,983	15,064	2,044	4,762	14,523		65
65.50	SLEEP LAB	155,497	10,458	3,683	8,583	4,444	2,559	65.50
66	Physical Therapy	1,345,208	90,475	16,600	38,682	68,156	18,445	66
67	Occupational Therapy	178,776	12,024	1,011	2,356			67
69	Electrocardiology	30,127	2,026	2,666	6,213			69
71	Medical Supplies Charged to Patients	100,827	6,781	6,652	15,501			71
73	Drugs Charged to Patients	526,279	35,396	11,819	27,542			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	1,912,765	128,643	26,331	61,358	89,425	22,960	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)	15,673,232	987,695	212,207	494,530	736,896	183,817	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING	1,692,106						192.02
192.03	CARDIAC REHAB	1,317	89					192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	17,366,655	987,784	212,207	494,530	736,896	183,817	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	216,861						9
10	Dietary		371,408					10
11	Cafeteria	3,732	231,751	235,483				11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	5,390		6,401	314,720			13.01
13.02	NURSING ADMINISTRATION	553		7,279		392,335		13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	138		4,775			98,645	14.02
15	Pharmacy	276					411	15
16	Medical Records & Library	5,667		13,009			380	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	29,855	114,155	58,413	314,720	172,248	8,219	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	79,750	25,502	22,689		96,272	28,506	50
53	Anesthesiology	1,520					1,036	53
54	Radiology-Diagnostic	25,017		18,791			6,882	54
54.01	ULTRA SOUND	138					319	54.01
56	Radioisotope	1,659		3,175			1,546	56
60	Laboratory	5,529		22,792			32,472	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,529		6,350		1,856		65
65.50	SLEEP LAB	1,106		2,633		1,930	12	65.50
66	Physical Therapy	8,708		31,516			1,393	66
67	Occupational Therapy			4,517			73	67
69	Electrocardiology						296	69
71	Medical Supplies Charged to Patients						10,777	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	42,294		33,143		120,029	6,323	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)	216,861	371,408	235,483	314,720	392,335	98,645	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)	216,861	371,408	235,483	314,720	392,335	98,645	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	517,756						15
16	Medical Records & Library		409,975					16
17	Social Service			774				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	4,981	158,888	774	3,067,471		3,067,471	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,075	81,836		1,971,219		1,971,219	50
53	Anesthesiology	1,363			35,479		35,479	53
54	Radiology-Diagnostic	14,311	28,961		1,582,432		1,582,432	54
54.01	ULTRA SOUND				234,749		234,749	54.01
56	Radioisotope	23,275			900,405		900,405	56
60	Laboratory		24,710		1,783,928		1,783,928	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		9,034		283,145		283,145	65
65.50	SLEEP LAB		9,831		200,736		200,736	65.50
66	Physical Therapy	1	8,768		1,627,952		1,627,952	66
67	Occupational Therapy		3,454		202,211		202,211	67
69	Electrocardiology				41,328		41,328	69
71	Medical Supplies Charged to Patients				140,538		140,538	71
73	Drugs Charged to Patients	470,319			1,071,355		1,071,355	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	2,431	84,493		2,530,195		2,530,195	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)	517,756	409,975	774	15,673,143		15,673,143	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING				1,692,106		1,692,106	192.02
192.03	CARDIAC REHAB				1,406		1,406	192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	517,756	409,975	774	17,366,655		17,366,655	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		1,454	203	1,657	1,657		4
5.01	ADMINISTRATION & ACCOUNTING		59,148	15,645	74,793	75	74,868	5.01
5.02	GENERAL		59,150	190,274	249,424	47	4,259	5.02
5.03	ADMITTING		4,206	786	4,992	29	857	5.03
5.04	PATIENT ACCOUNTING		6,315	514	6,829	49	1,998	5.04
6	Maintenance & Repairs							6
7	Operation of Plant		26,472	10,590	37,062	46	2,977	7
8	Laundry & Linen Service		11,668	2,222	13,890	13	606	8
9	Housekeeping		1,607	1,523	3,130	29	813	9
10	Dietary		17,302	3,959	21,261	32	1,281	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT		586	62	648	39	1,217	13.01
13.02	NURSING ADMINISTRATION		11,359	30	11,389	50	1,420	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY		4,957	792	5,749	11	321	14.02
15	Pharmacy		3,133	12,605	15,738		2,052	15
16	Medical Records & Library		10,749	3,005	13,754	43	1,453	16
17	Social Service						3	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		58,400	33,087	91,487	247	7,652	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		35,408	83,117	118,525	131	5,872	50
53	Anesthesiology		329	2,339	2,668		85	53
54	Radiology-Diagnostic		20,095	220,325	240,420	98	5,050	54
54.01	ULTRA SOUND		1,210	341	1,551		809	54.01
56	Radioisotope		5,718	205,750	211,468	17	3,243	56
60	Laboratory		10,833	13,718	24,551	105	6,319	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,011	4,099	9,110	32	966	65
65.50	SLEEP LAB		1,534	610	2,144	13	670	65.50
66	Physical Therapy		23,518	16,987	40,505	195	5,800	66
67	Occupational Therapy			279	279	28	771	67
69	Electrocardiology			4,313	4,313		130	69
71	Medical Supplies Charged to Patients						435	71
73	Drugs Charged to Patients						2,269	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		30,857	28,731	59,588	164	8,239	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)		411,019	855,906	1,266,925	1,493	67,567	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING			14,872	14,872	164	7,295	192.02
192.03	CARDIAC REHAB			291	291		6	192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		411,019	871,069	1,282,088	1,657	74,868	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	GENERAL	ADMITTING	PATIENT ACCOUNTING	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	253,730						5.02
5.03	ADMITTING	3,435	9,313					5.03
5.04	PATIENT ACCOUNTING	8,005		16,881				5.04
6	Maintenance & Repairs							6
7	Operation of Plant	11,928			52,013			7
8	Laundry & Linen Service	2,428			2,387	19,324		8
9	Housekeeping	3,259			329	1,146	8,706	9
10	Dietary	5,132			3,539	446		10
11	Cafeteria						150	11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	4,876			120		216	13.01
13.02	NURSING ADMINISTRATION	5,691			2,324		22	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	1,285			1,014		6	14.02
15	Pharmacy	8,223			641		11	15
16	Medical Records & Library	5,824			2,199		227	16
17	Social Service	13						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	30,664	544	983	11,944	10,558	1,199	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	23,530	913	1,651	7,243	1,074	3,201	50
53	Anesthesiology	341	126	228	67		61	53
54	Radiology-Diagnostic	20,234	2,178	3,982	4,110	1,478	1,004	54
54.01	ULTRA SOUND	3,240	404	730	248		6	54.01
56	Radioisotope	12,994	679	1,227	1,170		67	56
60	Laboratory	25,320	1,357	2,454	2,216		222	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,870	90	162	1,025		222	65
65.50	SLEEP LAB	2,686	162	293	314	269	44	65.50
66	Physical Therapy	23,240	730	1,319	4,811	1,939	350	66
67	Occupational Therapy	3,089	44	80				67
69	Electrocardiology	520	117	212				69
71	Medical Supplies Charged to Patients	1,742	292	529				71
73	Drugs Charged to Patients	9,092	520	939				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	33,046	1,157	2,092	6,312	2,414	1,698	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)	253,707	9,313	16,881	52,013	19,324	8,706	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB	23						192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	253,730	9,313	16,881	52,013	19,324	8,706	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	31,691						10
11	Cafeteria	19,775	19,925					11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT		542	7,658				13.01
13.02	NURSING ADMINISTRATION		616		21,512			13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY		404			8,790		14.02
15	Pharmacy					37	26,702	15
16	Medical Records & Library		1,101			34		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	9,740	4,941	7,658	9,444	732	257	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,176	1,920		5,279	2,540	55	50
53	Anesthesiology					92	70	53
54	Radiology-Diagnostic		1,590			613	738	54
54.01	ULTRA SOUND					28		54.01
56	Radioisotope		269			138	1,200	56
60	Laboratory		1,929			2,896		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		537		102			65
65.50	SLEEP LAB		223		106	1		65.50
66	Physical Therapy		2,667			124		66
67	Occupational Therapy		382			6		67
69	Electrocardiology					26		69
71	Medical Supplies Charged to Patients					960		71
73	Drugs Charged to Patients						24,257	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		2,804		6,581	563	125	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)	31,691	19,925	7,658	21,512	8,790	26,702	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)	31,691	19,925	7,658	21,512	8,790	26,702	202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	24,635						16
17	Social Service		16					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	9,547	16	197,613		197,613		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,917		179,027		179,027		50
53	Anesthesiology			3,738		3,738		53
54	Radiology-Diagnostic	1,740		283,235		283,235		54
54.01	ULTRA SOUND			7,016		7,016		54.01
56	Radioisotope			232,472		232,472		56
60	Laboratory	1,485		68,854		68,854		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	543		16,659		16,659		65
65.50	SLEEP LAB	591		7,516		7,516		65.50
66	Physical Therapy	527		82,207		82,207		66
67	Occupational Therapy	208		4,887		4,887		67
69	Electrocardiology			5,318		5,318		69
71	Medical Supplies Charged to Patients			3,958		3,958		71
73	Drugs Charged to Patients			37,077		37,077		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	5,077		129,860		129,860		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)	24,635	16	1,259,437		1,259,437		118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING			22,331		22,331		192.02
192.03	CARDIAC REHAB			320		320		192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,635	16	1,282,088		1,282,088		202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	7,504,599						1
2	Cap Rel Costs-Mvble Equip		998,483					2
4	Employee Benefits Department	26,545	233	6,961,792				4
5.01	ADMINISTRATION & ACCOUNTING	1,079,995	17,934	314,025	-1,181,642	16,185,013		5.01
5.02	GENERAL	1,079,995	218,106	198,659		920,575	-987,784	5.02
5.03	ADMITTING	76,800	901	121,528		185,305		5.03
5.04	PATIENT ACCOUNTING	115,300	589	205,415		431,837		5.04
6	Maintenance & Repairs							6
7	Operation of Plant	483,333	12,139	191,480		643,479		7
8	Laundry & Linen Service	213,033	2,547	56,580		130,988		8
9	Housekeeping	29,333	1,746	121,243		175,788		9
10	Dietary	315,900	4,538	136,034		276,831		10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	10,700	71	164,134		263,044		13.01
13.02	NURSING ADMINISTRATION	207,400	34	211,533		307,014		13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	90,500	908	45,155		69,305		14.02
15	Pharmacy	57,200	14,449			443,591		15
16	Medical Records & Library	196,265	3,444	182,267		314,159		16
17	Social Service					676		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	37,927	1,034,962		1,654,193		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	646,500	95,275	550,161		1,269,311		50
53	Anesthesiology	6,000	2,681			18,401		53
54	Radiology-Diagnostic	366,900	252,550	412,599		1,091,549		54
54.01	ULTRA SOUND	22,100	391			174,808		54.01
56	Radioisotope	104,400	235,846	71,824		700,975		56
60	Laboratory	197,800	15,725	440,089		1,365,904		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	91,500	4,699	133,915		208,743		65
65.50	SLEEP LAB	28,000	699	54,248		144,917		65.50
66	Physical Therapy	429,400	19,472	818,622		1,253,679		66
67	Occupational Therapy		320	119,090		166,612		67
69	Electrocardiology		4,944			28,077		69
71	Medical Supplies Charged to Patients					93,967		71
73	Drugs Charged to Patients					490,471		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	32,934	687,445		1,782,613		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)	7,504,599	981,102	6,271,008	-1,181,642	14,606,812	-987,784	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING		17,047	690,093		1,576,974	-1,692,106	192.02
192.03	CARDIAC REHAB		334	691		1,227		192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	411,019	871,069	2,469,678		1,181,642		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.054769	0.872392	0.354747		0.073008		203
204	Cost to be allocated (Per Wkst. B, Part II)			1,657		74,868		204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000238		0.004626		205

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

	COST CENTER DESCRIPTIONS	GENERAL ACCUM COST	ADMITTING GROSS CHARGES	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	14,686,765						5.02
5.03	ADMITTING	198,834	36,582,435					5.03
5.04	PATIENT ACCOUNTING	463,365		36,582,435				5.04
6	Maintenance & Repairs							6
7	Operation of Plant	690,458			4,642,631			7
8	Laundry & Linen Service	140,551			213,033	154,522		8
9	Housekeeping	188,622			29,333	9,160	1,569	9
10	Dietary	297,042			315,900	3,570		10
11	Cafeteria						27	11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT	282,248			10,700		39	13.01
13.02	NURSING ADMINISTRATION	329,428			207,400		4	13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY	74,365			90,500		1	14.02
15	Pharmacy	475,977			57,200		2	15
16	Medical Records & Library	337,095			196,265		41	16
17	Social Service	725						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	1,774,962	2,132,595	2,132,595	1,066,300	84,426	216	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,361,981	3,580,552	3,580,552	646,500	8,589	577	50
53	Anesthesiology	19,744	493,603	493,603	6,000		11	53
54	Radiology-Diagnostic	1,171,241	8,600,611	8,600,611	366,900	11,820	181	54
54.01	ULTRA SOUND	187,570	1,583,888	1,583,888	22,100		1	54.01
56	Radioisotope	752,152	2,662,662	2,662,662	104,400		12	56
60	Laboratory	1,465,626	5,322,714	5,322,714	197,800		40	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	223,983	352,280	352,280	91,500		40	65
65.50	SLEEP LAB	155,497	634,966	634,966	28,000	2,151	8	65.50
66	Physical Therapy	1,345,208	2,861,493	2,861,493	429,400	15,505	63	66
67	Occupational Therapy	178,776	174,293	174,293				67
69	Electrocardiology	30,127	459,629	459,629				69
71	Medical Supplies Charged to Patients	100,827	1,146,720	1,146,720				71
73	Drugs Charged to Patients	526,279	2,037,411	2,037,411				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	1,912,765	4,539,018	4,539,018	563,400	19,301	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)	14,685,448	36,582,435	36,582,435	4,642,631	154,522	1,569	118
	NONREIMBURSABLE COST CENTERS							
192.02	ASSISTED LIVING							192.02
192.03	CARDIAC REHAB	1,317						192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	987,784	212,207	494,530	736,896	183,817	216,861	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.067257	0.005801	0.013518	0.158724	1.189585	138.216061	203
204	Cost to be allocated (Per Wkst. B, Part II)	253,730	9,313	16,881	52,013	19,324	8,706	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.017276	0.000255	0.000461	0.011203	0.125057	5.548757	205

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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

	COST CENTER DESCRIPTIONS	DIETARY MEALS SERVED	CAFETERIA FTE'S SERVED	UR/QUALITY IMPROVEMENT DIRECT NRSING HRS	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		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	28,924						10
11	Cafeteria	18,048	9,123					11
12	Maintenance of Personnel							12
13	Nursing Administration							13
13.01	UR/QUALITY IMPROVEMENT		248	2,681				13.01
13.02	NURSING ADMINISTRATION		282		52,848			13.02
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY		185			828,251		14.02
15	Pharmacy					3,449	539,939	15
16	Medical Records & Library		504			3,191		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	8,890	2,263	2,681	23,202	69,012	5,194	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,986	879		12,968	239,342	1,121	50
53	Anesthesiology					8,701	1,421	53
54	Radiology-Diagnostic		728			57,784	14,924	54
54.01	ULTRA SOUND					2,682		54.01
56	Radioisotope		123			12,977	24,272	56
60	Laboratory		883			272,642		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		246		250			65
65.50	SLEEP LAB		102		260	100		65.50
66	Physical Therapy		1,221			11,700	1	66
67	Occupational Therapy		175			609		67
69	Electrocardiology					2,487		69
71	Medical Supplies Charged to Patients					90,487		71
73	Drugs Charged to Patients						490,471	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		1,284		16,168	53,088	2,535	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)	28,924	9,123	2,681	52,848	828,251	539,939	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)	371,408	235,483	314,720	392,335	98,645	517,756	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.840824	25.812014	117.389034	7.423838	0.119100	0.958916	203
204	Cost to be allocated (Per Wkst. B, Part II)	31,691	19,925	7,658	21,512	8,790	26,702	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.095665	2.184040	2.856397	0.407054	0.010613	0.049454	205

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	1,543						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	598	100					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	308						50
53	Anesthesiology							53
54	Radiology-Diagnostic	109						54
54.01	ULTRA SOUND							54.01
56	Radioisotope							56
60	Laboratory	93						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	34						65
65.50	SLEEP LAB	37						65.50
66	Physical Therapy	33						66
67	Occupational Therapy	13						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	318						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)	1,543	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)	409,975	774					202
203	Unit Cost Multiplier (Wkst. B, Part I)	265.699935	7.740000					203
204	Cost to be allocated (Per Wkst. B, Part II)	24,635	16					204
205	Unit Cost Multiplier (Wkst. B, Part II)	15.965651	0.160000					205

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	3,067,471		3,067,471			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,971,219		1,971,219			50
53	Anesthesiology	35,479		35,479			53
54	Radiology-Diagnostic	1,582,432		1,582,432			54
54.01	ULTRA SOUND	234,749		234,749			54.01
56	Radioisotope	900,405		900,405			56
60	Laboratory	1,783,928		1,783,928			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	283,145		283,145			65
65.50	SLEEP LAB	200,736		200,736			65.50
66	Physical Therapy	1,627,952		1,627,952			66
67	Occupational Therapy	202,211		202,211			67
69	Electrocardiology	41,328		41,328			69
71	Medical Supplies Charged to Patients	140,538		140,538			71
73	Drugs Charged to Patients	1,071,355		1,071,355			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	2,530,195		2,530,195			91
92	Observation Beds (Non-Distinct Part)	484,337		484,337			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)	16,157,480		16,157,480			200
201	Less Observation Beds	484,337		484,337			201
202	Total (line 200 minus line 201)	15,673,143		15,673,143			202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	2,132,595		2,132,595				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	65,763	3,514,789	3,580,552	0.550535			50
53	Anesthesiology	10,730	482,873	493,603	0.071878			53
54	Radiology-Diagnostic	266,354	8,334,257	8,600,611	0.183991			54
54.01	ULTRA SOUND	113,729	1,470,159	1,583,888	0.148211			54.01
56	Radioisotope	42,905	2,619,757	2,662,662	0.338160			56
60	Laboratory	612,929	4,709,785	5,322,714	0.335154			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	113,854	238,426	352,280	0.803750			65
65.50	SLEEP LAB		634,966	634,966	0.316137			65.50
66	Physical Therapy	275,765	2,585,728	2,861,493	0.568917			66
67	Occupational Therapy	94,724	79,569	174,293	1.160179			67
69	Electrocardiology	19,883	439,746	459,629	0.089916			69
71	Medical Supplies Charged to Patients	421,491	725,229	1,146,720	0.122557			71
73	Drugs Charged to Patients	471,881	1,565,530	2,037,411	0.525841			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	1,763	4,537,255	4,539,018	0.557432			91
92	Observation Beds (Non-Distinct Part)	109,370	928,337	1,037,707	0.466738			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)	4,753,736	32,866,406	37,620,142				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	4,753,736	32,866,406	37,620,142				202

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed 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	0.550535		1,626,447			895,416		50
53	Anesthesiology	0.071878		199,384			14,331		53
54	Radiology-Diagnostic	0.183991		3,164,838			582,302		54
54.01	ULTRA SOUND	0.148211		547,960			81,214		54.01
56	Radioisotope	0.338160		969,901			327,982		56
60	Laboratory	0.335154		2,045,173			685,448		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.803750		88,394			71,047		65
65.50	SLEEP LAB	0.316137		206,835			65,388		65.50
66	Physical Therapy	0.568917		800,580			455,464		66
67	Occupational Therapy	1.160179		24,456			28,373		67
69	Electrocardiology	0.089916		217,015			19,513		69
71	Medical Supplies Charged to Pat	0.122557		417,007			51,107		71
73	Drugs Charged to Patients	0.525841		1,243,739			654,009		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	0.557432		1,647,538			918,390		91
92	Observation Beds (Non-Distinct	0.466738		308,407			143,945		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			13,507,674			4,993,929		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			13,507,674			4,993,929		202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	0.550535							50
53	Anesthesiology	0.071878							53
54	Radiology-Diagnostic	0.183991							54
54.01	ULTRA SOUND	0.148211							54.01
56	Radioisotope	0.338160							56
60	Laboratory	0.335154							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.803750							65
65.50	SLEEP LAB	0.316137							65.50
66	Physical Therapy	0.568917							66
67	Occupational Therapy	1.160179							67
69	Electrocardiology	0.089916							69
71	Medical Supplies Charged to Pat	0.122557							71
73	Drugs Charged to Patients	0.525841							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	0.557432							91
92	Observation Beds (Non-Distinct	0.466738							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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	197,613	93,756	103,857	1,388	74.82	89	6,659	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)	197,613		103,857	1,388		89	6,659	200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	179,027	3,580,552	0.050000			50
53	Anesthesiology	3,738	493,603	0.007573			53
54	Radiology-Diagnostic	283,235	8,600,611	0.032932			54
54.01	ULTRA SOUND	7,016	1,583,888	0.004430			54.01
56	Radioisotope	232,472	2,662,662	0.087308			56
60	Laboratory	68,854	5,322,714	0.012936			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	16,659	352,280	0.047289			65
65.50	SLEEP LAB	7,516	634,966	0.011837			65.50
66	Physical Therapy	82,207	2,861,493	0.028729			66
67	Occupational Therapy	4,887	174,293	0.028039			67
69	Electrocardiology	5,318	459,629	0.011570			69
71	Medical Supplies Charged to Pat	3,958	1,146,720	0.003452			71
73	Drugs Charged to Patients	37,077	2,037,411	0.018198			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	129,860	4,539,018	0.028610			91
92	Observation Beds (Non-Distinct	31,202	1,037,707	0.030068			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,093,026	35,487,547				200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	1,388		89		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)	1,388		89		200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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

		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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	3,580,552							50
53	Anesthesiology	493,603							53
54	Radiology-Diagnostic	8,600,611							54
54.01	ULTRA SOUND	1,583,888							54.01
56	Radioisotope	2,662,662							56
60	Laboratory	5,322,714							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	352,280							65
65.50	SLEEP LAB	634,966							65.50
66	Physical Therapy	2,861,493							66
67	Occupational Therapy	174,293							67
69	Electrocardiology	459,629							69
71	Medical Supplies Charged to Pat	1,146,720							71
73	Drugs Charged to Patients	2,037,411							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	4,539,018							91
92	Observation Beds (Non-Distinct	1,037,707							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	35,487,547							200

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	0.550535							50
53	Anesthesiology	0.071878							53
54	Radiology-Diagnostic	0.183991							54
54.01	ULTRA SOUND	0.148211							54.01
56	Radioisotope	0.338160							56
60	Laboratory	0.335154							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.803750							65
65.50	SLEEP LAB	0.316137							65.50
66	Physical Therapy	0.568917							66
67	Occupational Therapy	1.160179							67
69	Electrocardiology	0.089916							69
71	Medical Supplies Charged to Pat	0.122557							71
73	Drugs Charged to Patients	0.525841							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	0.557432							91
92	Observation Beds (Non-Distinct	0.466738							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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	2,641	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,388	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)	971	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,253	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)	719	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)	1,253	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)	3,067,471	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)	1,455,334	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,612,137	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)	1,612,137	37

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] PPS [ ] TEFRA [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)	1,161.48	38
39	Program general inpatient routine service cost (line 9 x line 38)	835,104	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)	835,104	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)	383,915	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,219,019	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)	1,455,334	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)	1,455,334	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)					417	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,161.48	88
89	Observation bed cost (line 87 x line 88) (see instructions)					484,337	89
		Cost	Routine Cost (from line 21)	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	197,613	3,067,471	0.064422	484,337	31,202	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	2,641	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,388	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)	971	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,253	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)	89	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)	3,067,471	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)	1,455,334	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,612,137	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)	1,612,137	37

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[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)					1,161.48	38
39	Program general inpatient routine service cost (line 9 x line 38)					103,372	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)					103,372	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)					103,372	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					6,659	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)					6,659	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)					417	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 21)	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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		849,986		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.550535	33,668	18,535	50
53	Anesthesiology	0.071878	5,891	423	53
54	Radiology-Diagnostic	0.183991	160,968	29,617	54
54.01	ULTRA SOUND	0.148211	77,391	11,470	54.01
56	Radioisotope	0.338160	21,208	7,172	56
60	Laboratory	0.335154	296,186	99,268	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.803750	62,241	50,026	65
65.50	SLEEP LAB	0.316137			65.50
66	Physical Therapy	0.568917	42,508	24,184	66
67	Occupational Therapy	1.160179	10,102	11,720	67
69	Electrocardiology	0.089916	13,793	1,240	69
71	Medical Supplies Charged to Patients	0.122557	212,643	26,061	71
73	Drugs Charged to Patients	0.525841	198,157	104,199	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	0.557432			91
92	Observation Beds (Non-Distinct Part)	0.466738			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,134,756	383,915	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,134,756		202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	0.550535	4,184	2,303	50
53	Anesthesiology	0.071878	970	70	53
54	Radiology-Diagnostic	0.183991	60,097	11,057	54
54.01	ULTRA SOUND	0.148211	12,420	1,841	54.01
56	Radioisotope	0.338160	9,683	3,274	56
60	Laboratory	0.335154	221,677	74,296	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.803750	34,485	27,717	65
65.50	SLEEP LAB	0.316137			65.50
66	Physical Therapy	0.568917	227,395	129,369	66
67	Occupational Therapy	1.160179	82,845	96,115	67
69	Electrocardiology	0.089916	3,358	302	69
71	Medical Supplies Charged to Patients	0.122557	150,123	18,399	71
73	Drugs Charged to Patients	0.525841	213,964	112,511	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	0.557432	1,763	983	91
92	Observation Beds (Non-Distinct Part)	0.466738			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,022,964	478,237	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,022,964		202

(A) Worksheet A line numbers

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.550535			50
53	Anesthesiology	0.071878			53
54	Radiology-Diagnostic	0.183991			54
54.01	ULTRA SOUND	0.148211			54.01
56	Radioisotope	0.338160			56
60	Laboratory	0.335154			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.803750			65
65.50	SLEEP LAB	0.316137			65.50
66	Physical Therapy	0.568917			66
67	Occupational Therapy	1.160179			67
69	Electrocardiology	0.089916			69
71	Medical Supplies Charged to Patients	0.122557			71
73	Drugs Charged to Patients	0.525841			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	0.557432			91
92	Observation Beds (Non-Distinct Part)	0.466738			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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	4,993,929			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)	4,993,929			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)	5,043,868			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)	42,681			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,315,313			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)	2,685,874			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)	2,685,874			30
31	Primary payer payments	1,775			31
32	Subtotal (line 30 minus line 31)	2,684,099			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)	328,556			34
35	Adjusted reimbursable bad debts (see instructions)	213,561			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	328,556			36
37	Subtotal (see instructions)	2,897,660			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)	2,897,660			40
40.01	Sequestration adjustment (see instructions)	57,953			40.01
41	Interim payments	2,709,197			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	130,510			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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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				819,006		3,351,157	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	02/12/2016	23,191			3.01
	amount based on subsequent revision of the interim		.02	06/16/2016	174,171			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			02/12/2016	121,687	3.51
		Provider	.52			06/16/2016	520,273	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		197,362		-641,960	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)				1,016,368		2,709,197	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				130,510	6.01
	based on the cost report (1)		.02		-18,571			6.02
7	Total Medicare program liability (see instructions)				997,797		2,839,707	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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				1,602,117			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	02/12/2016	61,095			3.01
	amount based on subsequent revision of the interim		.02	06/16/2016	167,737			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					3.51
		Provider	.52					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		228,832			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)				1,830,949			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		21,560			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,852,509			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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	336	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	719	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	76	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	971	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	37,620,142	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	659,637	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	106,398	7
8	Calculation of the HIT incentive payment (see instructions)	106,398	8
9	Sequestration adjustment amount (see instructions)	2,128	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	104,270	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)	104,270	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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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)	1,469,887		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)	483,019		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,253		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)	1,952,906		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,952,906		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,952,906		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	62,591		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)	1,890,315		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)	1,890,315		19
19.01	Sequestration adjustment (see instructions)	37,806		19.01
20	Interim payments	1,830,949		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	21,560		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	1,219,019	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,219,019	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,231,209	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)	1,231,209	19
20	Deductibles (exclude professional component)	227,270	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,003,939	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,003,939	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,879	25
26	Adjusted reimbursable bad debts (see instructions)	14,221	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,879	27
28	Subtotal (sum of lines 24 and 26)	1,018,160	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,018,160	30
30.01	Sequestration adjustment (see instructions)	20,363	30.01
31	Interim payments	1,016,368	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-18,571	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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	103,372		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	103,372		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	103,372		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)	103,372		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)	103,372		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)	103,372		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)	103,372		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	103,372		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)	103,372		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	103,372		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	991,465				1
2	Temporary investments	7,333,022				2
3	Notes receivable					3
4	Accounts receivable	4,007,261				4
5	Other receivables	31,396				5
6	Allowances for uncollectible notes and accounts receivable	-1,482,000				6
7	Inventory	419,918				7
8	Prepaid expenses	284,012				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	11,585,074				11
	FIXED ASSETS					
12	Land	265,746				12
13	Land improvements	1,687,647				13
14	Accumulated depreciation	-846,852				14
15	Buildings	16,506,790				15
16	Accumulated depreciation	-7,739,471				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	164,333				19
20	Accumulated depreciation	-161,960				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	12,080,366				23
24	Accumulated depreciation	-9,627,683				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)	12,328,916				30
	OTHER ASSETS					
31	Investments	2,695,000				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	7,750,877				34
35	Total other assets (sum of lines 31-34)	10,445,877				35
36	Total assets (sum of lines 11, 30 and 35)	34,359,867				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	1,183,794				37
38	Salaries, wages and fees payable	620,479				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	281,929				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	536,281				43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	2,622,483				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	5,590,820				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	5,590,820				50
51	Total liabilities (sum of lines 45 and 50)	8,213,303				51
	CAPITAL ACCOUNTS					
52	General fund balance	26,146,564				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)	26,146,564				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	34,359,867				60

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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		24,797,117			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,921,631			2
3	Total (sum of line 1 and line 2)		26,718,748			3
4	Additions (credit adjustments) (specify)					4
5	RETURN ON INVESTMENTS	4,071				5
6	CONTRIBUTIONS OF EQUIPTMENT	29,881				6
7	TRANSFERS FROM FOUNDATION	29,881				7
8	CHANGE IN INTEREST OF FOUNDATION	6,789				8
9						9
10	Total additions (sum of lines 4-9)		70,622			10
11	Subtotal (line 3 plus line 10)		26,789,370			11
12	Deductions (debit adjustments) (specify)					12
13	RELEASED CONTRIBUTIONS	54,435				13
14	TRANSFERS TO HILLSBORO AREA HEALTH	500,000				14
15	UNREALIZED CHANGE IN INVESTMENTS	88,371				15
16						16
17						17
18	Total deductions (sum of lines 12-17)		642,806			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,146,564			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: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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	3,510,950		3,510,950	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)	3,510,950		3,510,950	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)	3,510,950		3,510,950	17
18	Ancillary services	2,510,008	27,753,889	30,263,897	18
19	Outpatient services		6,349,615	6,349,615	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 PATIENT REVENUES	1,557,961		1,557,961	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,578,919	34,103,504	41,682,423	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		19,475,902	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)		19,475,902	43

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	41,682,423	1
2	Less contractual allowances and discounts on patients' accounts	20,729,434	2
3	Net patient revenues (line 1 minus line 2)	20,952,989	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	19,475,902	4
5	Net income from service to patients (line 3 minus line 4)	1,477,087	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	245,608	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	3,861	10
11	Rebates and refunds of expenses	3,861	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	40,875	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	3,822	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	22,466	22
23	Governmental appropriations		23
24	Other (MISC. INCOME/ADJUSTMENTS)	122,603	24
24.01	Other (GAIN ON DISPOSAL OF ASSETS)	1,448	24.01
25	Total other income (sum of lines 6-24)	444,544	25
26	Total (line 5 plus line 25)	1,921,631	26
29	Net income (or loss) for the period (line 26 minus line 28)	1,921,631	29

HILLSBORO AREA HOSPITAL Provider CCN: 14-1332	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/14/2016 Run Time: 13:22 Version: 2016.05 (09/08/2016)

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