

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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. <input checked="" type="checkbox"/> Electronically filed cost report Date: 05/27/2016 Time: 13:29 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> 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 HOOPESTON COMMUNITY MEMORIAL HOSPITA (14-1316) (Provider Name(s) and Number(s)) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015, 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)

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII						
		TITLE V	PART A	PART B	HIT	TITLE XIX		
		1	2	3	4	5		
1	HOSPITAL		553,336	-245,083		60,966	1	
2	SUBPROVIDER - IPF						2	
3	SUBPROVIDER - IRF						3	
4	SUBPROVIDER (OTHER)						4	
5	SWING BED - SNF		403,030				5	
6	SWING BED - NF						6	
7	SKILLED NURSING FACILITY						7	
8	NURSING FACILITY						8	
9	HOME HEALTH AGENCY						9	
10	HEALTH CLINIC - RHC			1,263,892			10	
11	HEALTH CLINIC - FQHC						11	
12	OUTPATIENT REHABILITATION PROVIDER						12	
200	TOTAL		956,366	1,018,809		60,966	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 respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete 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 applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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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: 701 EAST ORANGE	P.O. Box:		1
2	City: HOOPESTON	State: IL	ZIP Code: 60942 County: VERMILLION	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	HOOPESTON COMMUNITY MEMORIAL HOSPITA	14-1316	16974	1	11 / 01 / 2001	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	HOOPESTON CMH SWING BED	14-Z316	16974		11 / 01 / 2001	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	HOOPESTON MEDICAL CENTER RHC	14-3448	16974		04 / 01 / 1998	N	O	N	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: 01 / 01 / 2015	To: 12 / 31 / 2015	20
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21	Type of control (see instructions)	2		21
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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.	3	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
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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
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35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
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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
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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
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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
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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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
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	45
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	46
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	47
		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 as 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 osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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 received 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 column 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 Facility 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

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**WORKSHEET S-2
PART I**

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

Rural Providers

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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 elimination 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
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

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. 15-1, 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.	2			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	411,059			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.	Y			121

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified 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 certified 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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---	---------------------------------------	--	--

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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	14H077	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: CARLE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES Contractor's Number: 00450			141
142	Street: 611 WEST PARK STREET	P.O. Box:			142
143	City: URBANA	State: IL	ZIP Code: 61801		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		Title V	Title XIX	
		Part A	Part B			
		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	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)	88,768				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)	01 / 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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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	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	
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					
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.	N			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				
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 instructions.	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

		Y/N	
Bad Debts			
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					
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	03/24/2016	Y	03/24/2016
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	
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.	N		N	
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	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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 relieved 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.	Y	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.	Y	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	Y		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		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: GARY	Last name: ZEMAN	Title: VICE PRESIDENT
42	Employer: STRATEGIC REIMBURSEMENT, INC.		
43	Phone number: 630-530-7100 EXT. 112	E-mail Address: GARY.ZEMAN@SRINC.ORG	

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						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	22	8,030	36,821.00		511	23	987	1
2	HMO and other (see instructions)									2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						296		455	5
6	Hospital Adults & Peds. Swing Bed NF								8	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		22	8,030	36,821.00		807	23	1,450	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)		22	8,030	36,821.00		807	23	1,450	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					27,035	48,585	165,266	26
27	Total (sum of lines 14-26)		22							27
28	Observation Bed Days								591	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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		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)					198	8	425	1
2	HMO and other (see instructions)								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)		139.71			198	8	425	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		133.62						26
27	Total (sum of lines 14-26)		273.33						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

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

ESRD PPS

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

TRANSPLANT INFORMATION

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

EPOETIN

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

ARANESP

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

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

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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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	11/01/2001	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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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 category. 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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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**HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA**

COMPONENT CCN: 14-3448

WORKSHEET S-8

Check applicable box: RHC FQHC

Clinic Address and Identification:

1	Street: 801 EAST ORANGE STREET	1
2	City: HOOPESTON State: IL ZIP Code: 60452 County: VERMILLION	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

	Grant Award	Date	
	1	2	
4	Community Health Center (Section 330(d), PHS Act)		4
5	Migrant Health Center (Section 329(d), PHS Act)		5
6	Health Services for the Homeless (Section 340(d), PHS)		6
7	Appalachian Regional Commission		7
8	Look-alikes		8
9	OTHER		9

10	Does this facility operate as other than an RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10
----	--	---	--	----

Facility hours of operations (1)

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to			
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic	0900		0800	2000	0800	2000	0800	2000	0800	2000	0800	2000	0900	1700	11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripsts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	Y	7	13
14	Provider name: CHARLOTTE RUSSEL CCN number: 14-3448			14
14.01	Provider name: CISSNA PARK CCN number: 14-3485			14.01
14.02	Provider name: ROSSVILLE CCN number: 14-3496			14.02
14.03	Provider name: ROBERTS CLINIC CCN number: 14-8521			14.03
14.04	Provider name: MILFORD CLINIC CCN number: 14-8526			14.04
14.05	Provider name: DANVILLE CLINIC CCN number: 14-8531			14.05
14.06	Provider name: CARLE AT TUSCOLA CCN number: 14-8533			14.06
14.07	Provider name: CARLE MATTOON CCN number: 14-8544			14.07

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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)		0.548957	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		1,102,501	2
3	Did you receive DSH or supplemental payments from Medicaid?		N	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid			5
6	Medicaid charges		7,384,995	6
7	Medicaid cost (line 1 times line 6)		4,054,045	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.		2,951,544	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 fundng 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)		2,951,544	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	4,491,871		4,491,871	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,465,844		2,465,844	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	2,465,844		2,465,844	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)		370,351	26
27	Medicare bad debts for the entire hospital complex (see instructions)		116,269	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		254,082	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		139,480	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		2,605,324	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,556,868	31

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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		666,695	666,695	576,948	1,243,643	2,628,534	3,872,177	1
2	00200	Cap Rel Costs-Mvble Equip		872,365	872,365		872,365	-88,768	783,597	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department						646,866	646,866	4
5	00500	Administrative & General	700,585	9,155,618	9,856,203	1,036,675	10,892,878	-7,827	10,885,051	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	308,568	726,600	1,035,168	61,164	1,096,332	253,635	1,349,967	7
8	00800	Laundry & Linen Service				26,087	26,087		26,087	8
9	00900	Housekeeping	153,044	146,159	299,203	-26,087	273,116		273,116	9
10	01000	Dietary	98,556	132,724	231,280		231,280	-43,367	187,913	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	342,943	111,569	454,512		454,512		454,512	13
14	01400	Central Services & Supply		112,558	112,558	-99,531	13,027	182,486	195,513	14
15	01500	Pharmacy								15
16	01600	Medical Records & Library						69,682	69,682	16
17	01700	Social Service								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	811,626	741,585	1,553,211	1	1,553,212	-157,051	1,396,161	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	419,766	911,617	1,331,383	-341,420	989,963		989,963	50
54	05400	Radiology-Diagnostic	674,460	1,465,891	2,140,351		2,140,351	-444,262	1,696,089	54
60	06000	Laboratory	459,286	1,086,478	1,545,764	1	1,545,765	-163,066	1,382,699	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	06600	Physical Therapy	338,256	133,433	471,689		471,689	86,948	558,637	66
71	07100	Medical Supplies Charged to Patients				99,531	99,531		99,531	71
72	07200	Impl. Dev. Charged to Patients				166,453	166,453		166,453	72
73	07300	Drugs Charged to Patients	147,653	683,700	831,353	-172,912	658,441	146,604	805,045	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								
88	08800	Rural Health Clinic	6,829,615	15,309,977	22,139,592	2,791,007	24,930,599	-390,107	24,540,492	88
91	09100	Emergency	992,286	1,688,594	2,680,880	-83,042	2,597,838	-780,989	1,816,849	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)	12,276,644	33,945,563	46,222,207	4,034,875	50,257,082	1,939,318	52,196,400	118
		NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY				172,912	172,912		172,912	192.01
193.01	19301	MATTOON CLINIC	1,961,426	4,072,374	6,033,800	-4,207,787	1,826,013		1,826,013	193.01
194	07950	FOUNDATION								194
200		TOTAL (sum of lines 118-199)	14,238,070	38,017,937	52,256,007		52,256,007	1,939,318	54,195,325	200

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1	2	3	4	5	6	7	
1	INTEREST EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		571,452	1
500	Total reclassifications					571,452	500
	Code Letter - A						
1	SURGERY SUPPLIES	B	Medical Supplies Charged to P	71		99,531	1
2			Impl. Dev. Charged to Patient	72		166,453	2
500	Total reclassifications					265,984	500
	Code Letter - B						
1	CAPITAL INSURANCE	C	Cap Rel Costs-Bldg & Fixt	1		5,496	1
500	Total reclassifications					5,496	500
	Code Letter - C						
1	UTILITY EXPENSE	D	Operation of Plant	7		44,556	1
2			Operation of Plant	7		16,609	2
500	Total reclassifications					61,165	500
	Code Letter - D						
1	PHYSICIAN FEES	E	Adults & Pediatrics	30		1	1
2			Laboratory	60		1	2
3			Emergency	91		1	3
500	Total reclassifications					3	500
	Code Letter - E						
1	INSURANCE EXPENSE	F	Administrative & General	5		71,445	1
2			Administrative & General	5		154,719	2
3			Administrative & General	5		83,042	3
4			Administrative & General	5		71,445	4
500	Total reclassifications					380,651	500
	Code Letter - F						
1	RHC ADMIN	G	Administrative & General	5	583,213	176,360	1
2			Administrative & General	5	246,706	70,204	2
500	Total reclassifications				829,919	246,564	500
	Code Letter - G						
1	LAUNDRY EXPENSE	H	Laundry & Linen Service	8		26,087	1
500	Total reclassifications					26,087	500
	Code Letter - H						
1	RECRUTINING EXPENSE	I	Administrative & General	5		201,046	1
2							2
3							3
4							4
500	Total reclassifications					201,046	500
	Code Letter - I						
1	MATTOON CERTIFIED COSTS	J	Rural Health Clinic	88	1,180,569	2,710,308	1
500	Total reclassifications				1,180,569	2,710,308	500
	Code Letter - J						
1	RETAIL PHARMACY	K	RETAIL PHARMACY	192.01		172,912	1
500	Total reclassifications					172,912	500
	Code Letter - K						
	GRAND TOTAL (Increases)					2,010,488	4,641,668

(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.

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9		
1	INTEREST EXPENSE	A	Administrative & General	5		571,452	11	1
500	Total reclassifications					571,452		500
	Code letter - A							
1	SURGERY SUPPLIES	B	Central Services & Supply	14		99,531		1
2			Operating Room	50		166,453		2
500	Total reclassifications					265,984		500
	Code letter - B							
1	CAPITAL INSURANCE	C	Administrative & General	5		5,496	11	1
500	Total reclassifications					5,496		500
	Code letter - C							
1	UTILITY EXPENSE	D	Administrative & General	5		44,556		1
2			Rural Health Clinic	88		16,609		2
500	Total reclassifications					61,165		500
	Code letter - D							
1	PHYSICIAN FEES	E	Emergency	91		1		1
2			Operation of Plant	7		1		2
3			Administrative & General	5		1		3
500	Total reclassifications					3		500
	Code letter - E							
1	INSURANCE EXPENSE	F	Operating Room	50		71,445		1
2			Rural Health Clinic	88		154,719		2
3			Emergency	91		83,042		3
4			Operating Room	50		71,445		4
500	Total reclassifications					380,651		500
	Code letter - F							
1	RHC ADMIN	G	Rural Health Clinic	88	583,213	176,360		1
2			MATTOON CLINIC	193.01	246,706	70,204		2
500	Total reclassifications				829,919	246,564		500
	Code letter - G							
1	LAUNDRY EXPENSE	H	Housekeeping	9		26,087		1
500	Total reclassifications					26,087		500
	Code letter - H							
1	RECRUTINING EXPENSE	I	Operating Room	50		32,077		1
2			Rural Health Clinic	88		121,068		2
3			Rural Health Clinic	88		15,000		3
4			Rural Health Clinic	88		32,901		4
500	Total reclassifications					201,046		500
	Code letter - I							
1	MATTOON CERTIFIED COSTS	J	MATTOON CLINIC	193.01	1,180,569	2,710,308		1
500	Total reclassifications				1,180,569	2,710,308		500
	Code letter - J							
1	RETAIL PHARMACY	K	Drugs Charged to Patients	73		172,912		1
500	Total reclassifications					172,912		500
	Code letter - K							
	GRAND TOTAL (Decreases)				2,010,488	4,641,668		

(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.

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	391,970				307,740	84,230		1
2	Land Improvements	758,510	323,091		323,091		1,081,601		2
3	Buildings and Fixtures	13,171,844				795,241	12,376,603		3
4	Building Improvements								4
5	Fixed Equipment	3,212,615	43,450		43,450		3,256,065		5
6	Movable Equipment	5,198,906	310,430		310,430		5,509,336		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	22,733,845	676,971		676,971	1,102,981	22,307,835		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	22,733,845	676,971		676,971	1,102,981	22,307,835		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	666,695						666,695	1	
2	Cap Rel Costs-Mvble Equip	872,365						872,365	2	
3	Total (sum of lines 1-2)	1,539,060						1,539,060	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 line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		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				0.000000					1
2	Cap Rel Costs-Mvble Equip				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	3,310,979		561,198				3,872,177	1	
2	Cap Rel Costs-Mvble Equip	783,597						783,597	2	
3	Total (sum of lines 1-2)	4,094,576		561,198				4,655,774	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.)

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.	
				COST CENTER		LINE#		
				1	2	3		4
1	Investment income-buildings & fixtures (chapter 2)	B	-15,750	Cap Rel Costs-Bldg & Fixt		1	11	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)							4
5	Refunds and rebates of expenses (chapter 8)							5
6	Rental of provider space by suppliers (chapter 8)							6
7	Telephone services (pay stations excl) (chapter 21)							7
8	Television and radio service (chapter 21)							8
9	Parking lot (chapter 21)							9
10	Provider-based physician adjustment	Wkst A-8-2	-1,607,318					10
11	Sale of scrap, waste, etc. (chapter 23)							11
12	Related organization transactions (chapter 10)	Wkst A-8-1	4,444,947					12
13	Laundry and linen service							13
14	Cafeteria - employees and guests	B	-20,144	Dietary		10		14
15	Rental of quarters to employees & others							15
16	Sale of medical and surgical supplies to other than patients							16
17	Sale of drugs to other than patients							17
18	Sale of medical records and abstracts							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							32
33	CATERING	B	-23,223	Dietary		10		33
34								34
35	LOBBYING EXPENSE	A	-11,827	Administrative & General		5		35
36								36
37								37
38								38
39								39
40	MISCELLANEOUS REVENUE	B	-397	Administrative & General		5		40
41	PROVIDER TAX	A	-393,038	Administrative & General		5		41
42								42
43	BILLING REVENUE	B	-17,007	Administrative & General		5		43
44								44
45	EHR ASSET DEPRECIATION	A	-88,768	Cap Rel Costs-Mvble Equip		2	9	45
45.01	RHC INPATIENT MD COSTS	A	-328,157	Rural Health Clinic		88		45.01
46								46
47								47
48								48
49								49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		1,939,318					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.

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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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	5	Administrative & General	MANAGEMENT FEES	7,343,885	6,929,443	414,442		1
2	1	Cap Rel Costs-Bldg & Fixt	CAPITAL	2,644,284		2,644,284	9	2
3								3
3.01	60	Laboratory	CARLE SERVICES	457,666	457,666			3.01
3.02	73	Drugs Charged to Patients	CARLE SERVICES	513,747	513,747			3.02
3.03	10	Dietary	CARLE SERVICES	21,335	21,335			3.03
3.04	54	Radiology-Diagnostic	CARLE SERVICES	491,457	491,457			3.04
3.06	4	Employee Benefits Department	HOME OFFICE ALLOCATIONS	646,866		646,866		3.06
3.07	7	Operation of Plant	HOME OFFICE ALLOCATIONS	253,635		253,635		3.07
3.08	14	Central Services & Supply	HOME OFFICE ALLOCATIONS	182,486		182,486		3.08
3.09	16	Medical Records & Library	HOME OFFICE ALLOCATIONS	69,682		69,682		3.09
3.11	66	Physical Therapy	CARLE THERPAY SERVICES	401,633	314,685	86,948		3.11
3.12	73	Drugs Charged to Patients	CARLE DRUG COSTS	512,243	401,349	110,894		3.12
3.13	73	Drugs Charged to Patients	CARLE PHARMACISTS	148,107	112,397	35,710		3.13
4								4
5		TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12		13,687,026	9,242,079	4,444,947		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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		Type of Business	
				Name	Percentage of Ownership		
	1	2	3	4	5	6	
6	B			CARLE HEALTH SYSTEM	100.00	HOME OFFICE	6
7							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:

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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										1
2										2
3	30	Adults & Pediatrics HOSPITALIST	279,266	157,051	122,215					3
4	91	Emergency AGGREGATE	1,201,521	780,989	420,532					4
5	54	Radiology-Diagnostic AGGREGATE	444,262	444,262						5
6	88	Rural Health Clinic AGGREGATE	61,950	61,950						6
7	60	Laboratory AGGREGATE	163,066	163,066						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	2,150,065	1,607,318	542,747					200

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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										1
2										2
3	30	Adults & Pediatrics HOSPITALIST							157,051	3
4	91	Emergency AGGREGATE							780,989	4
5	54	Radiology-Diagnostic AGGREGATE							444,262	5
6	88	Rural Health Clinic AGGREGATE							61,950	6
7	60	Laboratory AGGREGATE							163,066	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							1,607,318	200

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HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS I-IV**

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					320	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					45	4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					5	5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					6	6
7	Standard travel expense rate					7	7
8	Optional travel expense rate					8	8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		415.00	1,798.00			9
10	AHSEA (see instructions)		71.23	53.43			10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.62	35.62	26.72			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)						14
15	Therapists (column 2, line 9 times column 2, line 10)					29,560	15
16	Assistants (column 3, line 9 times column 3, line 10)					96,067	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					125,627	17
18	Aides (column 4, line 9 times column 4, line 10)						18
19	Trainees (column 5, line 9 times column 5, line 10)						19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					125,627	20
21	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.						
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)						22
23	Total salary equivalency (see instructions)					125,627	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance							
24	Therapists (line 3 times column 2, line 11)					11,398	24
25	Assistants (line 4 times column 3, line 11)					1,202	25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,600	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,600	28
Optional Travel Allowance and Optional Travel Expense							
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	Assistants (column 3, line 10 times column 3, line 12)						30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	Standard travel allowance and standard travel expense (line 28)					12,600	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13)						43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.							
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)						44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)						45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)						46

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HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS V-VI**

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists 1	Assistants 2	Aides 3	Trainees 4	Total 5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	125,627	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	12,600	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	138,227	63
64	Total cost of outside supplier services (from provider records)	101,666	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS I-IV**

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					140	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					225	4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					5	5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					6	6
7	Standard travel expense rate					7	7
8	Optional travel expense rate					8	8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		2,095.00	1,696.00			9
10	AHSEA (see instructions)		71.23	53.43	35.62		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.62	35.62	26.72			11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)						14
15	Therapists (column 2, line 9 times column 2, line 10)					149,227	15
16	Assistants (column 3, line 9 times column 3, line 10)					90,617	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					239,844	17
18	Aides (column 4, line 9 times column 4, line 10)						18
19	Trainees (column 5, line 9 times column 5, line 10)						19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					239,844	20
21	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.						
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)						22
23	Total salary equivalency (see instructions)					239,844	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance							
24	Therapists (line 3 times column 2, line 11)					4,987	24
25	Assistants (line 4 times column 3, line 11)					6,012	25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,999	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,999	28
Optional Travel Allowance and Optional Travel Expense							
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	Assistants (column 3, line 10 times column 3, line 12)						30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	Standard travel allowance and standard travel expense (line 28)					10,999	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13)						43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.							
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)						44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)						45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)						46

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS V-VI**

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists 1	Assistants 2	Aides 3	Trainees 4	Total 5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	239,844	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	10,999	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	250,843	63
64	Total cost of outside supplier services (from provider records)	203,154	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS I-IV**

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		153.00				9
10	AHSEA (see instructions)		71.23				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.62	35.62				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)						14
15	Therapists (column 2, line 9 times column 2, line 10)					10,898	15
16	Assistants (column 3, line 9 times column 3, line 10)						16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					10,898	17
18	Aides (column 4, line 9 times column 4, line 10)						18
19	Trainees (column 5, line 9 times column 5, line 10)						19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					10,898	20
21	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.						
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)					71.23	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)					55,559	22
23	Total salary equivalency (see instructions)					55,559	23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance							
24	Therapists (line 3 times column 2, line 11)						24
25	Assistants (line 4 times column 3, line 11)						25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						28
Optional Travel Allowance and Optional Travel Expense							
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	Assistants (column 3, line 10 times column 3, line 12)						30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	Standard travel allowance and standard travel expense (line 28)						33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13)						43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.							
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)						44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)						45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)						46

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

**WORKSHEET A-8-3
PARTS V-VI**

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists 1	Assistants 2	Aides 3	Trainees 4	Total 5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)					55,559	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)						58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)						59
60	Overtime allowance (from column 5, line 56)						60
61	Equipment cost (see instructions)						61
62	Supplies (see instructions)						62
63	Total allowance (sum of lines 57-62)					55,559	63
64	Total cost of outside supplier services (from provider records)					9,686	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)						65

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,872,177	3,872,177					1
2	Cap Rel Costs-Mvble Equip	783,597		783,597				2
4	Employee Benefits Department	646,866			646,866			4
5	Administrative & General	10,885,051	163,282	33,043	69,534	11,150,910	11,150,910	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,349,967	1,400,614	283,435	14,019	3,048,035	789,612	7
8	Laundry & Linen Service	26,087				26,087	6,758	8
9	Housekeeping	273,116	29,443	5,958	6,953	315,470	81,724	9
10	Dietary	187,913	107,267	21,707	4,478	321,365	83,252	10
11	Cafeteria		25,942	5,250		31,192	8,080	11
12	Maintenance of Personnel							12
13	Nursing Administration	454,512	109,161	22,090	15,581	601,344	155,782	13
14	Central Services & Supply	195,513	42,298	8,560		246,371	63,824	14
15	Pharmacy							15
16	Medical Records & Library	69,682	53,605	10,848		134,135	34,748	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	1,396,161	687,164	139,059	36,874	2,259,258	585,274	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	989,963	396,527	80,244	19,071	1,485,805	384,907	50
54	Radiology-Diagnostic	1,696,089	183,370	37,108	30,642	1,947,209	504,436	54
60	Laboratory	1,382,699	105,201	21,289	20,866	1,530,055	396,370	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	558,637	37,305	7,549	15,368	618,859	160,319	66
71	Medical Supplies Charged to Patients	99,531				99,531	25,784	71
72	Impl. Dev. Charged to Patients	166,453				166,453	43,121	72
73	Drugs Charged to Patients	805,045	3,329	674	6,708	815,756	211,326	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	24,540,492	286,218	57,921	337,422	25,222,053	6,533,921	88
91	Emergency	1,816,849	241,451	48,862	45,082	2,152,244	557,552	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORE							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)	52,196,400	3,872,177	783,597	622,598	52,172,132	10,626,790	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY	172,912				172,912	44,794	192.01
193.01	MATTOON CLINIC	1,826,013			24,268	1,850,281	479,326	193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	54,195,325	3,872,177	783,597	646,866	54,195,325	11,150,910	202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	3,837,647						7
8	Laundry & Linen Service		32,845					8
9	Housekeeping	54,668		451,862				9
10	Dietary	199,171		21,270	625,058			10
11	Cafeteria	48,168		5,144		92,584		11
12	Maintenance of Personnel							12
13	Nursing Administration	202,688		21,645			981,459	13
14	Central Services & Supply	78,539		8,387				14
15	Pharmacy							15
16	Medical Records & Library	99,532		10,629				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	1,275,912	32,845	136,255	625,058	19,276	390,387	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	736,263		78,626		6,718	136,058	50
54	Radiology-Diagnostic	340,478		36,360		11,637		54
60	Laboratory	195,335		20,860		10,070		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	69,268		7,397		3,785		66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients	6,181		660		241		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	531,444		56,753		18,390		88
91	Emergency			47,876		22,467	455,014	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)	3,837,647	32,845	451,862	625,058	92,584	981,459	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,837,647	32,845	451,862	625,058	92,584	981,459	202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY 14	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 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	Administrative & General							5
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
14	Central Services & Supply	397,121						14
15	Pharmacy							15
16	Medical Records & Library		279,044					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		65,497	5,389,762		5,389,762		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		21,781	2,850,158		2,850,158		50
54	Radiology-Diagnostic		51,788	2,891,908		2,891,908		54
60	Laboratory		36,556	2,189,246		2,189,246		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		15,993	875,621		875,621		66
71	Medical Supplies Charged to Patients	148,602		273,917		273,917		71
72	Impl. Dev. Charged to Patients	248,519		458,093		458,093		72
73	Drugs Charged to Patients			1,034,164		1,034,164		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		23,761	32,386,322		32,386,322		88
91	Emergency		63,668	3,298,821		3,298,821		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)	397,121	279,044	51,648,012		51,648,012		118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY			217,706		217,706		192.01
193.01	MATTOON CLINIC			2,329,607		2,329,607		193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	397,121	279,044	54,195,325		54,195,325		202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		163,282	33,043	196,325	196,325		5
6	Maintenance & Repairs							6
7	Operation of Plant		1,400,614	283,435	1,684,049	13,902	1,697,951	7
8	Laundry & Linen Service					119		8
9	Housekeeping		29,443	5,958	35,401	1,439	24,188	9
10	Dietary		107,267	21,707	128,974	1,466	88,123	10
11	Cafeteria		25,942	5,250	31,192	142	21,312	11
12	Maintenance of Personnel							12
13	Nursing Administration		109,161	22,090	131,251	2,743	89,679	13
14	Central Services & Supply		42,298	8,560	50,858	1,124	34,749	14
15	Pharmacy							15
16	Medical Records & Library		53,605	10,848	64,453	612	44,038	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		687,164	139,059	826,223	10,304	564,520	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		396,527	80,244	476,771	6,777	325,757	50
54	Radiology-Diagnostic		183,370	37,108	220,478	8,881	150,643	54
60	Laboratory		105,201	21,289	126,490	6,979	86,425	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		37,305	7,549	44,854	2,823	30,647	66
71	Medical Supplies Charged to Patients					454		71
72	Impl. Dev. Charged to Patients					759		72
73	Drugs Charged to Patients		3,329	674	4,003	3,721	2,735	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		286,218	57,921	344,139	115,036	235,135	88
91	Emergency		241,451	48,862	290,313	9,816		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)		3,872,177	783,597	4,655,774	187,097	1,697,951	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY					789		192.01
193.01	MATTOON CLINIC					8,439		193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,872,177	783,597	4,655,774	196,325	1,697,951	202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	119						8
9	Housekeeping		61,028					9
10	Dietary		2,873	221,436				10
11	Cafeteria		695		53,341			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,923			226,596		13
14	Central Services & Supply		1,133				87,864	14
15	Pharmacy							15
16	Medical Records & Library		1,436					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	119	18,402	221,436	11,105	90,131		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		10,619		3,870	31,413		50
54	Radiology-Diagnostic		4,911		6,705			54
60	Laboratory		2,817		5,802			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		999		2,181			66
71	Medical Supplies Charged to Patients						32,879	71
72	Impl. Dev. Charged to Patients						54,985	72
73	Drugs Charged to Patients		89		139			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		7,665		10,595			88
91	Emergency		6,466		12,944	105,052		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)	119	61,028	221,436	53,341	226,596	87,864	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	119	61,028	221,436	53,341	226,596	87,864	202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	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	Administrative & General						5
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
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	110,539					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	25,946	1,768,186		1,768,186		30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	8,628	863,835		863,835		50
54	Radiology-Diagnostic	20,515	412,133		412,133		54
60	Laboratory	14,481	242,994		242,994		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	Physical Therapy	6,335	87,839		87,839		66
71	Medical Supplies Charged to Patients		33,333		33,333		71
72	Impl. Dev. Charged to Patients		55,744		55,744		72
73	Drugs Charged to Patients		10,687		10,687		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	9,413	721,983		721,983		88
91	Emergency	25,221	449,812		449,812		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)	110,539	4,646,546		4,646,546		118
	NONREIMBURSABLE COST CENTERS						
192.01	RETAIL PHARMACY		789		789		192.01
193.01	MATTOON CLINIC		8,439		8,439		193.01
194	FOUNDATION						194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	110,539	4,655,774		4,655,774		202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	67,468						1
2	Cap Rel Costs-Mvble Equip		67,468					2
4	Employee Benefits Department			14,238,070				4
5	Administrative & General	2,845	2,845	1,530,504	-11,150,910	43,044,415		5
6	Maintenance & Repairs							6
7	Operation of Plant	24,404	24,404	308,568		3,048,035	36,012	7
8	Laundry & Linen Service					26,087		8
9	Housekeeping	513	513	153,044		315,470	513	9
10	Dietary	1,869	1,869	98,556		321,365	1,869	10
11	Cafeteria	452	452			31,192	452	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,902	1,902	342,943		601,344	1,902	13
14	Central Services & Supply	737	737			246,371	737	14
15	Pharmacy							15
16	Medical Records & Library	934	934			134,135	934	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	11,973	11,973	811,626		2,259,258	11,973	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,909	6,909	419,766		1,485,805	6,909	50
54	Radiology-Diagnostic	3,195	3,195	674,460		1,947,209	3,195	54
60	Laboratory	1,833	1,833	459,286		1,530,055	1,833	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	650	650	338,256		618,859	650	66
71	Medical Supplies Charged to Patients					99,531		71
72	Impl. Dev. Charged to Patients					166,453		72
73	Drugs Charged to Patients	58	58	147,653		815,756	58	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,987	4,987	7,426,971		25,222,053	4,987	88
91	Emergency	4,207	4,207	992,286		2,152,244		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)	67,468	67,468	13,703,919	-11,150,910	41,021,222	36,012	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY					172,912		192.01
193.01	MATTOON CLINIC			534,151		1,850,281		193.01
194	FOUNDATION							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,872,177	783,597	646,866		11,150,910	3,837,647	202
203	Unit Cost Multiplier (Wkst. B, Part I)	57.392794	11.614351	0.045432		0.259056	106.565784	203
204	Cost to be allocated (Per Wkst. B, Part II)					196,325	1,697,951	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.004561	47.149589	205

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINISTRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	100						8
9	Housekeeping		39,706					9
10	Dietary		1,869	100				10
11	Cafeteria		452		313,119			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,902			163,892		13
14	Central Services & Supply		737				265,984	14
15	Pharmacy							15
16	Medical Records & Library		934					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	100	11,973	100	65,190	65,190		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		6,909		22,720	22,720		50
54	Radiology-Diagnostic		3,195		39,358			54
60	Laboratory		1,833		34,058			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		650		12,802			66
71	Medical Supplies Charged to Patients						99,531	71
72	Impl. Dev. Charged to Patients						166,453	72
73	Drugs Charged to Patients		58		815			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		4,987		62,194			88
91	Emergency		4,207		75,982	75,982		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)	100	39,706	100	313,119	163,892	265,984	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	32,845	451,862	625,058	92,584	981,459	397,121	202
203	Unit Cost Multiplier (Wkst. B, Part I)	328.450000	11.380194	6,250.580000	0.295683	5.988450	1.493026	203
204	Cost to be allocated (Per Wkst. B, Part II)	119	61,028	221,436	53,341	226,596	87,864	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.190000	1.536997	2,214.360000	0.170354	1.382593	0.330336	205

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	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	Administrative & General						5
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
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	9,160					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	2,150	100				30
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	715					50
54	Radiology-Diagnostic	1,700					54
60	Laboratory	1,200					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	Physical Therapy	525					66
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
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							
88	Rural Health Clinic	780					88
91	Emergency	2,090					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)	9,160	100				118
NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY						192.01
193.01	MATTOON CLINIC						193.01
194	FOUNDATION						194
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	279,044					202
203	Unit Cost Multiplier (Wkst. B, Part I)	30,463319					203
204	Cost to be allocated (Per Wkst. B, Part II)	110,539					204
205	Unit Cost Multiplier (Wkst. B, Part II)	12,067576					205

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	WORKSHEET			
DESCRIPTION	PART	LINE NO.	AMOUNT	
1	2	3	4	

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		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	5,389,762		5,389,762			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,850,158		2,850,158			50
54	Radiology-Diagnostic	2,891,908		2,891,908			54
60	Laboratory	2,189,246		2,189,246			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	Physical Therapy	875,621		875,621			66
71	Medical Supplies Charged to Patients	273,917		273,917			71
72	Impl. Dev. Charged to Patients	458,093		458,093			72
73	Drugs Charged to Patients	1,034,164		1,034,164			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	32,386,322		32,386,322			88
91	Emergency	3,298,821		3,298,821			91
92	Observation Beds (Non-Distinct Part)	1,566,546		1,566,546			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)	53,214,558		53,214,558			200
201	Less Observation Beds	1,566,546		1,566,546			201
202	Total (line 200 minus line 201)	51,648,012		51,648,012			202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	2,555,306		2,555,306				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	257,212	2,644,908	2,902,120	0.982095			50
54	Radiology-Diagnostic	1,130,513	15,901,062	17,031,575	0.169797			54
60	Laboratory	1,100,636	15,768,031	16,868,667	0.129782			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	205,061	1,474,618	1,679,679	0.521303			66
71	Medical Supplies Charged to Patients	422,212	860,931	1,283,143	0.213473			71
72	Impl. Dev. Charged to Patients	294,288	196,112	490,400	0.934121			72
73	Drugs Charged to Patients	897,608	3,389,301	4,286,909	0.241238			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		35,470,609	35,470,609				88
91	Emergency	561,182	9,034,582	9,595,764	0.343779			91
92	Observation Beds (Non-Distinct Part)	116,152	1,803,588	1,919,740	0.816020			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)	7,540,170	86,543,742	94,083,912				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,540,170	86,543,742	94,083,912				202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1316

WORKSHEET D
PART V

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

(A)	Cost Center Description	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.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.982095		857,743			842,385	50
54	Radiology-Diagnostic	0.169797		3,680,812			624,991	54
60	Laboratory	0.129782		4,203,707			545,566	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	0.521303		373,985			194,960	66
71	Medical Supplies Charged to Pat	0.213473		269,041			57,433	71
72	Impl. Dev. Charged to Patients	0.934121		89,680			83,772	72
73	Drugs Charged to Patients	0.241238		851,787			205,483	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency	0.343779		1,659,980			570,666	91
92	Observation Beds (Non-Distinct	0.816020		660,021			538,590	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)			12,646,756			3,663,846	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			12,646,756			3,663,846	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z316

WORKSHEET D
PART V

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

(A)	Cost Center Description	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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.982095							50
54	Radiology-Diagnostic	0.169797							54
60	Laboratory	0.129782							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	Physical Therapy	0.521303							66
71	Medical Supplies Charged to Pat	0.213473							71
72	Impl. Dev. Charged to Patients	0.934121							72
73	Drugs Charged to Patients	0.241238							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.343779							91
92	Observation Beds (Non-Distinct)	0.816020							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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjustment	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,768,186	395,973	1,372,213	1,578	869.59	23	20,001	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)	1,768,186		1,372,213	1,578		23	20,001	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1316

WORKSHEET D
PART II

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

(A)	Cost Center Description	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)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	863,835	2,902,120	0.297657			50
54	Radiology-Diagnostic	412,133	17,031,575	0.024198			54
60	Laboratory	242,994	16,868,667	0.014405			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	Physical Therapy	87,839	1,679,679	0.052295			66
71	Medical Supplies Charged to Pat	33,333	1,283,143	0.025978			71
72	Impl. Dev. Charged to Patients	55,744	490,400	0.113670			72
73	Drugs Charged to Patients	10,687	4,286,909	0.002493			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	721,983	35,470,609	0.020354			88
91	Emergency	449,812	9,595,764	0.046876			91
92	Observation Beds (Non-Distinct	662,228	1,919,740	0.344957			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,540,588	91,528,606				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,578		23		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)	1,578		23		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1316

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy							66
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
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							
88	Rural Health Clinic							88
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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1316

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	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)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,902,120							50
54	Radiology-Diagnostic	17,031,575							54
60	Laboratory	16,868,667							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	Physical Therapy	1,679,679							66
71	Medical Supplies Charged to Pat	1,283,143							71
72	Impl. Dev. Charged to Patients	490,400							72
73	Drugs Charged to Patients	4,286,909							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	35,470,609							88
91	Emergency	9,595,764							91
92	Observation Beds (Non-Distinct)	1,919,740							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	91,528,606							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1316

WORKSHEET D
PART V

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

(A)	Cost Center Description	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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.982095							50
54	Radiology-Diagnostic	0.169797							54
60	Laboratory	0.129782							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	Physical Therapy	0.521303							66
71	Medical Supplies Charged to Pat	0.213473							71
72	Impl. Dev. Charged to Patients	0.934121							72
73	Drugs Charged to Patients	0.241238							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.343779							91
92	Observation Beds (Non-Distinct)	0.816020							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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1316

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,041	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,578	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)	987	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	455	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	8	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)	511	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)	296	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	117.40	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.40	20
21	Total general inpatient routine service cost (see instructions)	5,389,762	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)	939	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)	1,206,998	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,182,764	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)	4,182,764	37

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1316

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					2,650.68	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,354,497	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)					1,354,497	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)					571,595	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,926,092	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 enter 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)					784,601	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)					784,601	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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1316

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					591	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,650.67	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,566,546	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,768,186	4,182,764	0.422731	1,566,546	662,228	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1316

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,041	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,578	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)	987	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	455	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	8	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)	23	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	117.40	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.40	20
21	Total general inpatient routine service cost (see instructions)	5,389,762	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)	939	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)	1,206,998	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,182,764	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)	4,182,764	37

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1316

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF 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)						2,650.68	38	
39	Program general inpatient routine service cost (line 9 x line 38)						60,966	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)						60,966	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)						60,966	49	
	PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						20,001	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)						20,001	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 enter 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	

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1316

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					591	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1316

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,293,220		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.982095	110,857	108,872	50
54	Radiology-Diagnostic	0.169797	480,125	81,524	54
60	Laboratory	0.129782	468,405	60,791	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	Physical Therapy	0.521303	36,825	19,197	66
71	Medical Supplies Charged to Patients	0.213473	170,760	36,453	71
72	Impl. Dev. Charged to Patients	0.934121	111,292	103,960	72
73	Drugs Charged to Patients	0.241238	406,078	97,961	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.343779	67,360	23,157	91
92	Observation Beds (Non-Distinct Part)	0.816020	48,626	39,680	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,900,328	571,595	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,900,328		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z316

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.982095			50
54	Radiology-Diagnostic	0.169797	39,645	6,732	54
60	Laboratory	0.129782	48,772	6,330	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	Physical Therapy	0.521303	94,125	49,068	66
71	Medical Supplies Charged to Patients	0.213473	21,880	4,671	71
72	Impl. Dev. Charged to Patients	0.934121			72
73	Drugs Charged to Patients	0.241238	53,124	12,816	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.343779			91
92	Observation Beds (Non-Distinct Part)	0.816020			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		257,546	79,617	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		257,546		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1316

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.982095			50
54	Radiology-Diagnostic	0.169797			54
60	Laboratory	0.129782			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	Physical Therapy	0.521303			66
71	Medical Supplies Charged to Patients	0.213473			71
72	Impl. Dev. Charged to Patients	0.934121			72
73	Drugs Charged to Patients	0.241238			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.343779			91
92	Observation Beds (Non-Distinct Part)	0.816020			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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1316

**WORKSHEET E
PART B**

Check applicable box: 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)	3,663,846			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)	3,663,846			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 reasonable 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)	3,700,484			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)	8,456			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,711,529			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)	1,980,499			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)	1,980,499			30
31	Primary payer payments	1,139			31
32	Subtotal (line 30 minus line 31)	1,979,360			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)	125,628			34
35	Adjusted reimbursable bad debts (see instructions)	81,658			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,413			36
37	Subtotal (see instructions)	2,061,018			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)	2,061,018			40
40.01	Sequestration adjustment (see instructions)	41,220			40.01
41	Interim payments	2,264,881			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-245,083			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	46,566			44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see 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

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1316

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT		
		1	2	3	4		
1	Total interim payments paid to provider		1,143,906		2,128,345	1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero		19,304		107,348	2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01	11/19/2015	25,535	11/19/2015	29,188	3.01
		.02					3.02
		.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
		.51					3.51
		.52					3.52
		.53					3.53
		.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		25,535		29,188	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)			1,188,745		2,264,881	4
TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01					5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.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) based on the cost report (1)	.01		553,336			6.01
		.02				-245,083	6.02
7	Total Medicare program liability (see instructions)			1,742,081		2,019,798	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.

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z316

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		458,530		1
2	Interim payments payable on individual bills, either 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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50	03/12/2010	7,392	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		-7,392	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)		451,138		4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	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) based on the cost report (1)	.01		403,030	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			854,168	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.

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: 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)	425	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	511	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	987	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	94,083,912	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	4,491,871	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	88,768	7
8	Calculation of the HIT incentive payment (see instructions)	66,017	8
9	Sequestration adjustment amount (see instructions)	1,320	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	64,697	10

INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH

30	Initial/interim HIT payment(s)	64,697	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		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.

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z316

WORKSHEET E-2

Check Title V Swing Bed - SNF
 Applicable Title XVIII Swing Bed - NF
 Boxes: Title XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

	PART A	PART B	
	1	2	
1 Inpatient routine services - swing bed-SNF (see instructions)	792,447		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)	80,413		3
4 Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5 Program days	296		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)	872,860		8
9 Primary payer payments (see instructions)			9
10 Subtotal (line 8 minus line 9)	872,860		10
11 Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12 Subtotal (line 10 minus line 11)	872,860		12
13 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,260		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)	871,600		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)	871,600		19
19.01 Sequestration adjustment (see instructions)	17,432		19.01
20 Interim payments	451,138		20
21 Tentative settlement (for contractor use only)			21
22 Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	403,030		22
23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			23

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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	1,926,092	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,926,092	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,945,353	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)	1,945,353	19
20	Deductibles (exclude professional component)	176,356	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,768,997	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,768,997	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,287	25
26	Adjusted reimbursable bad debts (see instructions)	8,637	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (sum of lines 24 and 26)	1,777,634	28
29	Other adjustments (LOSS ON SALE OF ASSETS)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,777,634	30
30.01	Sequestration adjustment (see instructions)	35,553	30.01
31	Interim payments	1,188,745	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	553,336	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	670,873	34

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HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1316

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	60,966		1
2			2
3			3
4	60,966		4
5			5
6			6
7	60,966		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18			18
19			19
20			20
21	60,966		21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	60,966		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	60,966		31
32			32
33			33
34			34
35			35
36	60,966		36
37			37
38	60,966		38
39			39
40	60,966		40
41			41
42	60,966		42
43			43

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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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)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	4,090,011				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	13,801,750				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-9,872,012				6
7	Inventory					7
8	Prepaid expenses	168,398				8
9	Other current assets	-1,018,490				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	7,169,657				11
FIXED ASSETS						
12	Land	84,230				12
13	Land improvements	1,081,601				13
14	Accumulated depreciation	-224,361				14
15	Buildings	10,924,704				15
16	Accumulated depreciation	-2,059,721				16
17	Leasehold improvements	1,720,249				17
18	Accumulated depreciation	-216,871				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks	43,450				21
22	Accumulated depreciation	-29,910				22
23	Major movable equipment	8,721,951				23
24	Accumulated depreciation	-3,431,270				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)	16,614,052				30
OTHER ASSETS						
31	Investments	4,101,173				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,444,690				34
35	Total other assets (sum of lines 31-34)	8,545,863				35
36	Total assets (sum of lines 11, 30 and 35)	32,329,572				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	359,565				37
38	Salaries, wages and fees payable	520,135				38
39	Payroll taxes payable	17,995				39
40	Notes and loans payable (short term)	154,700				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	26,816,458				44
45	Total current liabilities (sum of lines 37 thru 44)	27,868,853				45
LONG TERM LIABILITIES						
46	Mortgage payable	10,013,108				46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	10,013,108				50
51	Total liabilities (sum of lines 45 and 50)	37,881,961				51
CAPITAL ACCOUNTS						
52	General fund balance	-5,552,389				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)	-5,552,389				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	32,329,572				60

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		28,704		
2	Net income (loss) (from Worksheet G-3, line 29)		-5,581,093		
3	Total (sum of line 1 and line 2)		-5,552,389		
4	Additions (credit adjustments) (specify)				
5					
6					
7					
8					
9					
10	Total additions (sum of lines 4-9)				
11	Subtotal (line 3 plus line 10)		-5,552,389		
12	Deductions (debit adjustments) (specify)				
13					
14					
15					
16					
17					
18	Total deductions (sum of lines 12-17)				
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-5,552,389		

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				
2	Net income (loss) (from Worksheet G-3, line 29)				
3	Total (sum of line 1 and line 2)				
4	Additions (credit adjustments) (specify)				
5					
6					
7					
8					
9					
10	Total additions (sum of lines 4-9)				
11	Subtotal (line 3 plus line 10)				
12	Deductions (debit adjustments) (specify)				
13					
14					
15					
16					
17					
18	Total deductions (sum of lines 12-17)				
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,255,306		2,255,306	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)	2,255,306		2,255,306	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)	2,255,306		2,255,306	17
18	Ancillary services	5,284,864		5,284,864	18
19	Outpatient services		51,053,133	51,053,133	19
20	Rural Health Clinic (RHC)		35,470,609	35,470,609	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
27.01	RHC NON CERTIFIED		10,452,213	10,452,213	27.01
27.02	PROFESSIONAL FEES	530,200	3,296,768	3,826,968	27.02
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	8,070,370	100,272,723	108,343,093	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		52,256,007	29
30	Add (specify)			30
31	TAXES	1,250		31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		1,250	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)		52,257,257	43

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	108,343,093	1
2	Less contractual allowances and discounts on patients' accounts	62,221,651	2
3	Net patient revenues (line 1 minus line 2)	46,121,442	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	52,257,257	4
5	Net income from service to patients (line 3 minus line 4)	-6,135,815	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		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		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
23	Governmental appropriations	20,452	23
24	Other (TRUST INCOME)		24
24.01	Other (MISCELLANEOUS INCOME)	515,860	24.01
24.02	Other (UNREALIZED GAINS)		24.02
24.03	Other (GRANTS)		24.03
24.04	Other (RESTRICTED REVENUE)	2,500	24.04
24.05	Other (DIVIDEND INCOME)	160	24.05
24.06	Other (BOND PROCEED INCOME)	15,750	24.06
24.07	Other (INCOME TAX)		24.07
25	Total other income (sum of lines 6-24)	554,722	25
26	Total (line 5 plus line 25)	-5,581,093	26
29	Net income (or loss) for the period (line 26 minus line 28)	-5,581,093	29

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
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
14	Central Services & Supply							14
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
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy							66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
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							
88	Rural Health Clinic							88
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							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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**ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS**

COMPONENT CCN: 14-3448

WORKSHEET M-1

Check applicable box: RHC I FQHC

		COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician		8,326,759	8,326,759	-393,831	7,932,928		7,932,928	1
2	Physician Assistant	1,373,553		1,373,553		1,373,553		1,373,553	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs	4,359,026		4,359,026	-524,671	3,834,355	-390,107	3,444,248	9
10	Subtotal (sum of lines 1 through 9)	5,732,579	8,326,759	14,059,338	-918,502	13,140,836	-390,107	12,750,729	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		272,479	272,479		272,479		272,479	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment		192,788	192,788		192,788		192,788	17
18	Professional Liability Insurance		154,719	154,719	-180,566	-25,847		-25,847	18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		619,986	619,986	-180,566	439,420		439,420	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,732,579	8,946,745	14,679,324	-1,099,068	13,580,256	-390,107	13,190,149	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	1,097,036	6,363,232	7,460,268	3,890,075	11,350,343		11,350,343	30
31	Total Facility Overhead (sum of lines 29 and 30)	1,097,036	6,363,232	7,460,268	3,890,075	11,350,343		11,350,343	31
32	Total facility costs (sum of lines 22, 28 and 31)	6,829,615	15,309,977	22,139,592	2,791,007	24,930,599	-390,107	24,540,492	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITAL Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3448

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	5.94	88,074	4,200	24,948		1
2	Physician Assistants	24.41	77,192	2,100	51,261		2
3	Nurse Practitioners			2,100			3
4	Subtotal (sum of lines 1 through 3)	30.35	165,266		76,209	165,266	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	30.35	165,266			165,266	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					13,190,149	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)					13,190,149	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)					11,350,343	14
15	Parent provider overhead allocated to facility (see instructions)					7,845,830	15
16	Total overhead (sum of lines 14 and 15)					19,196,173	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					19,196,173	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					19,196,173	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)					32,386,322	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

KPMG LLP Compu-Max 2552-10

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form CMS-2552-10	Period : From: 01/01/2015 To: 12/31/2015	Run Date: 05/27/2016 Run Time: 13:29 Version: 2015.10 (05/05/2016)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3448

WORKSHEET M-5

Check applicable box: RHC I FQHC

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider		2,657,660	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero			2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01 11/18/2015	252,766	3.01
		.02		3.02
	Program	.03		3.03
	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	252,766	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		2,910,426	
TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01		5.01
		.02		5.02
	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	Determine net settlement amount (balance due) based on the cost report (1)	.01	1,263,892	6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		4,174,318	
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 you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.