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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 03/31/2015 TIME: 14:07 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [ ] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 01/01/2014 AND ENDING 12/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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		93,907	-82,607		94,133	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		184,631				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			561,493			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		278,538	478,886		94,133	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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS

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PARTS I, II & III

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.

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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: HOOPSETON	State: IL	ZIP Code: 60942	County: VERMILLION	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Prov-ider 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 / 2014	To: 12 / 31 / 2014	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	
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
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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

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

		1	2	

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.				

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)					62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)					62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N				63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

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

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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 Facilty 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.				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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.				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
	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable column.				N	92
93	Does this facility operate an ICF/MR 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	Column 1: 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. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'		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:		428,542			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 cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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COMPU-MAX

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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 SYSTEM	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 Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	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, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1		2	3	
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.		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)	484,229			168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional 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)		01/01/2014	12/31/2014	170

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
			Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT 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
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	03/03/2015	Y	03/03/2015	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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 COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED 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	WERE 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 REORT PREPARER INFORMATION				
41	FIRST NAME: GARY	LAST NAME: ZEMAN	TITLE: SENIOR MGR.	41
42	EMPLOYER: STRATEGIC REIMBURSMENT, INC.			42
43	PHONE NUMBER: 630-530-7100 EXT. 112	E-MAIL ADDRESS: GARY.ZEMAN@SRINC.ORG		43

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	22	8,030	39,334.00		565	46	1,128	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	39,334.00		861	46	1,591	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	39,334.00		861	46	1,591	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					21,747	6,718	127,898	26
27	TOTAL (sum of lines 14-26)		22							27
28	OBSERVATION BED DAYS								495	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					200	17	454	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)		96.65			200	17	454	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		118.17						26
27	TOTAL (sum of lines 14-26)		214.82						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	13,070,011			446,816.00		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		174,505			5,441.00		10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,209,603			117,329.00		14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		3,753,397					17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		38,462					19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		63,021			1,956.00		26
27	ADMINISTRATIVE & GENERAL		776,608	478,042		62,532.00		27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		216,844			10,919.00		30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		159,188			12,517.00		32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		147,968			9,706.00		34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		306,087			5,776.00		38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		80,047			4,766.00		41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		13,070,011		13,070,011	446,816.00	29.25	1
2	EXCLUDED AREA SALARIES (see instructions)		174,505		174,505	5,441.00	32.07	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		12,895,506		12,895,506	441,375.00	29.22	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		3,209,603		3,209,603	117,329.00	27.36	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		3,753,397		3,753,397		29.11%	5

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		19,858,506		19,858,506	558,704.00	35.54	6
7	TOTAL OVERHEAD COST (see instructions)		1,749,763	478,042	2,227,805	108,172.00	20.60	7

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	678,502	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,980,524	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	9,891	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	62,150	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	69,438	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	906,588	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	21,115	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	63,650	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	3,791,858	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL CONTRACT LABOR AND BENEFIT COST **WORKSHEET S-3 PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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 IN COLUMN 1 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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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	
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
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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA **COMPONENT CCN: 14-3448** **WORKSHEET S-8**

CHECK APPLICABLE BOX: **[XX] 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 HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

		1	2	
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)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	TYPE OPERATION	FROM	TO	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 SUBSCRIPTS 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.

		1	2	
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. 27, SECTION 508(D)?	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

		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 IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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)	0.470810	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	3,945,028	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	11,235,963	6
7	MEDICAID COST (line 1 times line 6)	5,290,004	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	1,344,976	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 AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	1,344,976	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	967,981		967,981	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	455,735		455,735	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	455,735		455,735	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,610,375	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	126,087	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,484,288	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	698,818	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,154,553	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	2,499,529	31

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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		641,633	641,633	612,562	1,254,195	1,952,282	3,206,477	1
2	00200	CAP REL COSTS-MVBLE EQUIP		888,217	888,217		888,217	-139,010	749,207	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	63,021	33,899	96,920		96,920		96,920	4
5	00500	ADMINISTRATIVE & GENERAL	776,608	6,678,230	7,454,838	352,383	7,807,221	490,775	8,297,996	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	216,844	1,023,854	1,240,698	-219,480	1,021,218		1,021,218	7
8	00800	LAUNDRY & LINEN SERVICE								8
9	00900	HOUSEKEEPING	159,188	127,067	286,255		286,255		286,255	9
10	01000	DIETARY	147,968	132,625	280,593		280,593	-44,002	236,591	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	306,087	109,212	415,299		415,299		415,299	13
14	01400	CENTRAL SERVICES & SUPPLY		106,660	106,660	-95,526	11,134		11,134	14
15	01500	PHARMACY								15
16	01600	MEDICAL RECORDS & LIBRARY	80,047	44,033	124,080		124,080		124,080	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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	779,638	559,539	1,339,177	6,435	1,345,612	-157,051	1,188,561	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	435,722	1,440,123	1,875,845	-619,377	1,256,468		1,256,468	50
54	05400	RADIOLOGY-DIAGNOSTIC	645,080	1,476,270	2,121,350		2,121,350	-444,862	1,676,488	54
60	06000	LABORATORY	434,367	561,892	996,259	326,133	1,322,392	-84,849	1,237,543	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	06600	PHYSICAL THERAPY	308,701	138,372	447,073		447,073		447,073	66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				95,526	95,526		95,526	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				532,516	532,516		532,516	72
73	07300	DRUGS CHARGED TO PATIENTS	155,072	535,735	690,807		690,807	366,576	1,057,383	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	7,493,032	9,725,685	17,218,717	-982,233	16,236,484	-777,037	15,459,447	88
91	09100	EMERGENCY	894,131	1,559,727	2,453,858	-8,939	2,444,919	-780,989	1,663,930	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)	12,895,506	25,782,773	38,678,279		38,678,279	381,833	39,060,112	118
		NONREIMBURSABLE COST CENTERS								
193.01	19301	MATTOON CLINIC	174,505	253,253	427,758		427,758		427,758	193.01
194	07950	FOUNDATION								194
200		TOTAL (sum of lines 118-199)	13,070,011	26,036,026	39,106,037		39,106,037	381,833	39,487,870	200

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		607,796	1
500	TOTAL RECLASSIFICATIONS					607,796	500
	CODE LETTER - A						
1	SURGERY SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		95,526	1
2			IMPL. DEV. CHARGED TO PATIENT	72		532,516	2
500	TOTAL RECLASSIFICATIONS					628,042	500
	CODE LETTER - B						
1	CAPITAL INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1		4,766	1
500	TOTAL RECLASSIFICATIONS					4,766	500
	CODE LETTER - C						
1	UTILITY EXPENSE	D	OPERATION OF PLANT	7		91,586	1
2			OPERATION OF PLANT	7		15,067	2
500	TOTAL RECLASSIFICATIONS					106,653	500
	CODE LETTER - D						
1	PHYSICIAN FEES	E	ADULTS & PEDIATRICS	30		6,435	1
2			LABORATORY	60		163,066	2
3			EMERGENCY	91		90,000	3
500	TOTAL RECLASSIFICATIONS					259,501	500
	CODE LETTER - E						
1	INSURANCE EXPENSE	F	ADMINISTRATIVE & GENERAL	5		54,784	1
2			ADMINISTRATIVE & GENERAL	5		180,566	2
3			ADMINISTRATIVE & GENERAL	5		92,504	3
500	TOTAL RECLASSIFICATIONS					327,854	500
	CODE LETTER - F						
1	RHC ADMIN	G	ADMINISTRATIVE & GENERAL	5	524,671	145,132	1
500	TOTAL RECLASSIFICATIONS				524,671	145,132	500
	CODE LETTER - G						
1	PURCHASED SERVICES FROM CARLE	H	LABORATORY	60		163,067	1
500	TOTAL RECLASSIFICATIONS					163,067	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	RHC SPECIALTY PHYSICIAN	J	RURAL HEALTH CLINIC	88	46,629	5,543	1
500	TOTAL RECLASSIFICATIONS				46,629	5,543	500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)				571,300	2,449,400	

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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	5		607,796	11	1
500	TOTAL RECLASSIFICATIONS					607,796		500
	CODE LETTER - A							
1	SURGERY SUPPLIES	B	CENTRAL SERVICES & SUPPLY	14		95,526		1
2			OPERATING ROOM	50		532,516		2
500	TOTAL RECLASSIFICATIONS					628,042		500
	CODE LETTER - B							
1	CAPITAL INSURANCE	C	ADMINISTRATIVE & GENERAL	5		4,766	11	1
500	TOTAL RECLASSIFICATIONS					4,766		500
	CODE LETTER - C							
1	UTILITY EXPENSE	D	ADMINISTRATIVE & GENERAL	5		91,586		1
2			RURAL HEALTH CLINIC	88		15,067		2
500	TOTAL RECLASSIFICATIONS					106,653		500
	CODE LETTER - D							
1	PHYSICIAN FEES	E	EMERGENCY	91		6,435		1
2			OPERATION OF PLANT	7		163,066		2
3			ADMINISTRATIVE & GENERAL	5		90,000		3
500	TOTAL RECLASSIFICATIONS					259,501		500
	CODE LETTER - E							
1	INSURANCE EXPENSE	F	OPERATING ROOM	50		54,784		1
2			RURAL HEALTH CLINIC	88		180,566		2
3			EMERGENCY	91		92,504		3
500	TOTAL RECLASSIFICATIONS					327,854		500
	CODE LETTER - F							
1	RHC ADMIN	G	RURAL HEALTH CLINIC	88	524,671	145,132		1
500	TOTAL RECLASSIFICATIONS				524,671	145,132		500
	CODE LETTER - G							
1	PURCHASED SERVICES FROM CARLE	H	OPERATION OF PLANT	7		163,067		1
500	TOTAL RECLASSIFICATIONS					163,067		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	RHC SPECIALTY PHYSICIAN	J	ADMINISTRATIVE & GENERAL	5	46,629	5,543		1
500	TOTAL RECLASSIFICATIONS				46,629	5,543		500
	CODE LETTER - J							
	GRAND TOTAL (DECREASES)				571,300	2,449,400		

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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	391,970					391,970		1
2	LAND IMPROVEMENTS	758,510					758,510		2
3	BUILDINGS AND FIXTURES	13,171,844					13,171,844		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	3,212,615					3,212,615		5
6	MOVABLE EQUIPMENT	5,198,906					5,198,906		6
7	HIT DESIGNATED ASSETS		505,743		505,743		505,743		7
8	SUBTOTAL (sum of lines 1-7)	22,733,845	505,743		505,743		23,239,588		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	22,733,845	505,743		505,743		23,239,588		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	641,633						641,633	1
2	CAP REL COSTS-MVBLE EQUIP	888,217						888,217	2
3	TOTAL (sum of lines 1-2)	1,529,850						1,529,850	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	2,598,673		607,804				3,206,477	1
2	CAP REL COSTS-MVBLE EQUIP	749,207						749,207	2
3	TOTAL (sum of lines 1-2)	3,347,880		607,804				3,955,684	3

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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-4,758	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	3,318,212				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-19,139	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 AND						32
33	CATERING	B	-24,863	DIETARY	10		33
34	OTHER INCOME	B	-579	ADMINISTRATIVE & GENERAL	5		34
35	LOBBYING EXPENSE	A	-11,582	ADMINISTRATIVE & GENERAL	5		35
36	CLINIC MEDICAL RECORD REVENUE	B	-1,058	RURAL HEALTH CLINIC	88		36
37	MARKETING SALARIES	A	-36,406	ADMINISTRATIVE & GENERAL	5		37
38	MARKETING EXPENSE	A	-24,690	ADMINISTRATIVE & GENERAL	5		38
39	MARKETING BENEFITS	A	-19,769	ADMINISTRATIVE & GENERAL	5		39
40	MISCELLANEOUS REVENUE	B	-7,044	ADMINISTRATIVE & GENERAL	5		40
41	PROVIDER TAX	A	-382,629	ADMINISTRATIVE & GENERAL	5		41
42	MISC INCOME	B	-294	ADMINISTRATIVE & GENERAL	5		42
43	BILLING REVENUE	B	-600	RADIOLOGY-DIAGNOSTIC	54		43
44	NEGATIVE REAL ESTATE TAXES	A	49,229	ADMINISTRATIVE & GENERAL	5		44
45	EHR ASSET DEPRECIATION	A	-139,010	CAP REL COSTS-MVBLE EQUIP	2	9	45
45.01	RHC INPATIENT MD COSTS	A	-714,029	RURAL HEALTH CLINIC	88		45.01
45.02	POB LAPSING SCHEDULE	A	8,160	CAP REL COSTS-BLDG & FIXT	1	9	45.02
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		381,833				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

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

(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.

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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 ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	5,313,425	4,388,886	924,539		1
2	1	CAP REL COSTS-BLDG & FIXT	CAPITAL	1,948,880		1,948,880	9	2
3								3
3.01	60	LABORATORY	CARLE SERVICES	241,284	163,067	78,217		3.01
3.02	73	DRUGS CHARGED TO PATIENTS	CARLE SERVICES	748,067	381,491	366,576		3.02
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			8,251,656	4,933,444	3,318,212		5

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

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	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: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED 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: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATIO N	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT - ICE INSURANC E	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	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 HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] 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
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 VISITS(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		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
	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 EXCUDING 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.		

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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 HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME 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 OVERTIME 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 HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] 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
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 VISITS(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		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
	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 EXCUDING 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.		

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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 HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME 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 OVERTIME 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

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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 [XX] 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 VISITS(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
	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 EXCUDING 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.		

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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 [XX] SPEECH PATHOLOGY

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 HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME 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 OVERTIME 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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	3,206,477	3,206,477					1
2	CAP REL COSTS-MVBLE EQUIP	749,207		749,207				2
4	EMPLOYEE BENEFITS DEPARTMENT	96,920			96,920			4
5	ADMINISTRATIVE & GENERAL	8,297,996	656,645	153,428	9,348	9,117,417	9,117,417	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,021,218	908,478	212,268	1,616	2,143,580	643,518	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	286,255	20,358	4,757	1,186	312,556	93,831	9
10	DIETARY	236,591	116,759	27,281	1,103	381,734	114,599	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	415,299	70,657	16,509	2,281	504,746	151,528	13
14	CENTRAL SERVICES & SUPPLY	11,134	12,222	2,856		26,212	7,869	14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	124,080	34,140	7,977	596	166,793	50,072	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	1,188,561	444,785	103,926	5,809	1,743,081	523,285	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,256,468	244,440	57,115	3,247	1,561,270	468,704	50
54	RADIOLOGY-DIAGNOSTIC	1,676,488	118,691	27,733	4,806	1,827,718	548,694	54
60	LABORATORY	1,237,543	65,754	15,364	3,236	1,321,897	396,843	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	447,073	33,360	7,795	2,300	490,528	147,260	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,526				95,526	28,678	71
72	IMPL. DEV. CHARGED TO PATIENTS	532,516				532,516	159,865	72
73	DRUGS CHARGED TO PATIENTS	1,057,383	2,155	503	1,155	1,061,196	318,578	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	15,459,447	321,747	75,178	52,275	15,908,647	4,775,883	88
91	EMERGENCY	1,663,930	156,286	36,517	6,662	1,863,395	559,404	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)	39,060,112	3,206,477	749,207	95,620	39,058,812	8,988,611	118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC	427,758			1,300	429,058	128,806	193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	39,487,870	3,206,477	749,207	96,920	39,487,870	9,117,417	202

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COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		7	9	10	13	14	16	
	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	2,787,098						7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	34,568	440,955					9
10	DIETARY	198,263	31,762	726,358				10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	119,980	19,221		795,475			13
14	CENTRAL SERVICES & SUPPLY	20,754	3,325			58,160		14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	57,971	9,287				284,123	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	755,264	120,993	726,358	317,634		66,689	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	415,072	66,494		139,006		22,178	50
54	RADIOLOGY-DIAGNOSTIC	201,543	32,287				52,730	54
60	LABORATORY	111,653	17,887				37,221	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	56,647	9,075				16,284	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					9,413		71
72	IMPL. DEV. CHARGED TO PATIENTS					48,747		72
73	DRUGS CHARGED TO PATIENTS	3,659	586					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	546,343	87,524				24,194	88
91	EMERGENCY	265,381	42,514		338,835		64,827	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)	2,787,098	440,955	726,358	795,475	58,160	284,123	118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,787,098	440,955	726,358	795,475	58,160	284,123	202

KPMG LLP

COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		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 SERV COST CENTERS							
30	ADULTS & PEDIATRICS	4,253,304		4,253,304				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,672,724		2,672,724				50
54	RADIOLOGY-DIAGNOSTIC	2,662,972		2,662,972				54
60	LABORATORY	1,885,501		1,885,501				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	719,794		719,794				66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,617		133,617				71
72	IMPL. DEV. CHARGED TO PATIENTS	741,128		741,128				72
73	DRUGS CHARGED TO PATIENTS	1,384,019		1,384,019				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	21,342,591		21,342,591				88
91	EMERGENCY	3,134,356		3,134,356				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)	38,930,006		38,930,006				118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC	557,864		557,864				193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	39,487,870		39,487,870				202

KPMG LLP

COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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		656,645	153,428	810,073	810,073		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		908,478	212,268	1,120,746	57,176	1,177,922	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		20,358	4,757	25,115	8,337	14,610	9
10	DIETARY		116,759	27,281	144,040	10,182	83,793	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		70,657	16,509	87,166	13,463	50,707	13
14	CENTRAL SERVICES & SUPPLY		12,222	2,856	15,078	699	8,771	14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY		34,140	7,977	42,117	4,449	24,501	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		444,785	103,926	548,711	46,493	319,201	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		244,440	57,115	301,555	41,644	175,423	50
54	RADIOLOGY-DIAGNOSTIC		118,691	27,733	146,424	48,751	85,179	54
60	LABORATORY		65,754	15,364	81,118	35,259	47,188	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY		33,360	7,795	41,155	13,084	23,941	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					2,548		71
72	IMPL. DEV. CHARGED TO PATIENTS					14,204		72
73	DRUGS CHARGED TO PATIENTS		2,155	503	2,658	28,305	1,546	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		321,747	75,178	396,925	424,333	230,903	88
91	EMERGENCY		156,286	36,517	192,803	49,702	112,159	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)		3,206,477	749,207	3,955,684	798,629	1,177,922	118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC					11,444		193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		3,206,477	749,207	3,955,684	810,073	1,177,922	202

KPMG LLP

COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		9	10	13	14	16	24	
	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	48,062						9
10	DIETARY	3,462	241,477					10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,095		153,431				13
14	CENTRAL SERVICES & SUPPLY	362			24,910			14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	1,012				72,079		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	13,187	241,477	61,265		16,918	1,247,252	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	7,248		26,812		5,626	558,308	50
54	RADIOLOGY-DIAGNOSTIC	3,519				13,377	297,250	54
60	LABORATORY	1,950				9,443	174,958	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	989				4,131	83,300	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				4,032		6,580	71
72	IMPL. DEV. CHARGED TO PATIENTS				20,878		35,082	72
73	DRUGS CHARGED TO PATIENTS	64					32,573	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	9,540				6,138	1,067,839	88
91	EMERGENCY	4,634		65,354		16,446	441,098	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)	48,062	241,477	153,431	24,910	72,079	3,944,240	118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC						11,444	193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	48,062	241,477	153,431	24,910	72,079	3,955,684	202

KPMG LLP

COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		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 SERV COST CENTERS							
30	ADULTS & PEDIATRICS		1,247,252					30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		558,308					50
54	RADIOLOGY-DIAGNOSTIC		297,250					54
60	LABORATORY		174,958					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY		83,300					66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		6,580					71
72	IMPL. DEV. CHARGED TO PATIENTS		35,082					72
73	DRUGS CHARGED TO PATIENTS		32,573					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		1,067,839					88
91	EMERGENCY		441,098					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)		3,944,240					118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC		11,444					193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		3,955,684					202

KPMG LLP

COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	86,314						1
2	CAP REL COSTS-MVBLE EQUIP		86,314					2
4	EMPLOYEE BENEFITS DEPARTMENT			13,006,990				4
5	ADMINISTRATIVE & GENERAL	17,676	17,676	1,254,650	-9,117,417	30,370,453		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	24,455	24,455	216,844		2,143,580	44,183	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	548	548	159,188		312,556	548	9
10	DIETARY	3,143	3,143	147,968		381,734	3,143	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,902	1,902	306,087		504,746	1,902	13
14	CENTRAL SERVICES & SUPPLY	329	329			26,212	329	14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	919	919	80,047		166,793	919	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	779,638		1,743,081	11,973	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,580	6,580	435,722		1,561,270	6,580	50
54	RADIOLOGY-DIAGNOSTIC	3,195	3,195	645,080		1,827,718	3,195	54
60	LABORATORY	1,770	1,770	434,367		1,321,897	1,770	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	898	898	308,701		490,528	898	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					95,526		71
72	IMPL. DEV. CHARGED TO PATIENTS					532,516		72
73	DRUGS CHARGED TO PATIENTS	58	58	155,072		1,061,196	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	8,661	8,661	7,014,990		15,908,647	8,661	88
91	EMERGENCY	4,207	4,207	894,131		1,863,395	4,207	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)	86,314	86,314	12,832,485	-9,117,417	29,941,395	44,183	118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC			174,505		429,058		193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,206,477	749,207	96,920		9,117,417	2,787,098	202
203	UNIT COST MULT-WS B PT I	37.148979	8.680017	0.007451		0.300207	63.080778	203
204	COST TO BE ALLOC PER B PT II					810,073	1,177,922	204
205	UNIT COST MULT-WS B PT II					0.026673	26.660073	205

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	
		9	10	13	14	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	43,635						9
10	DIETARY	3,143	100					10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,902		71,475				13
14	CENTRAL SERVICES & SUPPLY	329			528,309			14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY	919				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	11,973	100	28,540		2,150	100	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,580		12,490		715		50
54	RADIOLOGY-DIAGNOSTIC	3,195				1,700		54
60	LABORATORY	1,770				1,200		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	898				525		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				85,507			71
72	IMPL. DEV. CHARGED TO PATIENTS				442,802			72
73	DRUGS CHARGED TO PATIENTS	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	8,661				780		88
91	EMERGENCY	4,207		30,445		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)	43,635	100	71,475	528,309	9,160	100	118
	NONREIMBURSABLE COST CENTERS							
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	440,955	726,358	795,475	58,160	284,123		202
203	UNIT COST MULT-WS B PT I	10.105535	7,263.580000	11.129416	0.110087	31.017795		203
204	COST TO BE ALLOC PER B PT II	48,062	241,477	153,431	24,910	72,079		204
205	UNIT COST MULT-WS B PT II	1.101455	2,414.770000	2.146639	0.047150	7.868886		205

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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

	COST CENTER DESCRIPTIONS							

	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 SERV 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							
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I							202
203	UNIT COST MULT-WS B PT I							203
204	COST TO BE ALLOC PER B PT II							204
205	UNIT COST MULT-WS B PT II							205

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	4,253,304		4,253,304			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,672,724		2,672,724			50
54	RADIOLOGY-DIAGNOSTIC	2,662,972		2,662,972			54
60	LABORATORY	1,885,501		1,885,501			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	719,794		719,794			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,617		133,617			71
72	IMPL. DEV. CHARGED TO PATIENTS	741,128		741,128			72
73	DRUGS CHARGED TO PATIENTS	1,384,019		1,384,019			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	21,342,591		21,342,591			88
91	EMERGENCY	3,134,356		3,134,356			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,012,958		1,012,958			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 (SEE INSTRUCTIONS)	39,942,964		39,942,964			200
201	LESS OBSERVATION BEDS	1,012,958		1,012,958			201
202	TOTAL (SEE INSTRUCTIONS)	38,930,006		38,930,006			202

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,312,641		3,312,641				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	196,529	4,057,055	4,253,584	0.628346			50
54	RADIOLOGY-DIAGNOSTIC	1,203,348	14,091,651	15,294,999	0.174107			54
60	LABORATORY	1,105,375	10,343,836	11,449,211	0.164684			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	PHYSICAL THERAPY	266,821	1,223,220	1,490,041	0.483070			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	272,025	1,328,932	1,600,957	0.083461			71
72	IMPL. DEV. CHARGED TO PATIENTS	369,784	401,083	770,867	0.961421			72
73	DRUGS CHARGED TO PATIENTS	643,418	2,474,914	3,118,332	0.443833			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		30,758,263	30,758,263				88
91	EMERGENCY	607,885	8,433,536	9,041,421	0.346666			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		1,596,964	1,596,964	0.634302			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 (SEE INSTRUCTIONS)	7,977,826	74,709,454	82,687,280				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		74,709,454	82,687,280				202

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1316** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.628346		1,108,262			696,372		50
54	RADIOLOGY-DIAGNOSTIC	0.174107		3,493,521			608,246		54
60	LABORATORY	0.164684		2,395,792			394,549		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	0.483070		291,097			140,620		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083461		472,340			39,422		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.961421		124,788			119,974		72
73	DRUGS CHARGED TO PATIENTS	0.443833		793,821	2,604		352,324	1,156	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	0.346666		1,850,879			641,637		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.634302		587,906			372,910		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			11,118,406	2,604		3,366,054	1,156	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			11,118,406	2,604		3,366,054	1,156	202

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z316** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XVIII, PART B [ ] TITLE XIX - O/P | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [XX] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.628346							50
54	RADIOLOGY-DIAGNOSTIC	0.174107							54
60	LABORATORY	0.164684							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	0.483070							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083461							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.961421							72
73	DRUGS CHARGED TO PATIENTS	0.443833							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	0.346666							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.634302							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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,247,252	273,313	973,939	1,623	600.09	46	27,604	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)	1,247,252		973,939	1,623		46	27,604	200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1316** **WORKSHEET D PART II**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] HOSPITAL** **[ ] SUB (OTHER)** **[ ] TITLE XVIII, PART A** **[ ] IPF** **[XX] 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	558,308	4,253,584	0.131256			50
54	RADIOLOGY-DIAGNOSTIC	297,250	15,294,999	0.019434			54
60	LABORATORY	174,958	11,449,211	0.015281			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	83,300	1,490,041	0.055905			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,580	1,600,957	0.004110			71
72	IMPL. DEV. CHARGED TO PATIENTS	35,082	770,867	0.045510			72
73	DRUGS CHARGED TO PATIENTS	32,573	3,118,332	0.010446			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	1,067,839	30,758,263	0.034717			88
91	EMERGENCY	441,098	9,041,421	0.048786			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	380,401	1,596,964	0.238203			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	3,077,389	79,374,639				200

(A) Worksheet A line numbers

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[ ] TITLE XVIII, PART A** **[XX] TITLE XIX**

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV 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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK APPLICABLE BOXES:
[ ] TITLE V
[ ] TITLE XVIII, PART A
[XX] TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	1,623		46		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)	1,623		46		200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1316** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR
[ ] TITLE XVIII, PART A [ ] IPF [ ] SNF
[XX] TITLE XIX [ ] IRF [ ] NF

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
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							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1316** | **WORKSHEET D PART IV**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR; [ ] TITLE XVIII, PART A [ ] IPF [ ] SNF; [XX] TITLE XIX [ ] IRF [ ] NF

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	4,253,584							50
54	RADIOLOGY-DIAGNOSTIC	15,294,999							54
60	LABORATORY	11,449,211							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	1,490,041							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,600,957							71
72	IMPL. DEV. CHARGED TO PATIENTS	770,867							72
73	DRUGS CHARGED TO PATIENTS	3,118,332							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	30,758,263							88
91	EMERGENCY	9,041,421							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,596,964							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	79,374,639							200

(A) Worksheet A line numbers

KPMG LLP COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1316** **WORKSHEET D PART V**

CHECK APPLICABLE BOXES: [ ] TITLE V - O/P [XX] TITLE XIX - O/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.628346							50
54	RADIOLOGY-DIAGNOSTIC	0.174107							54
60	LABORATORY	0.164684							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	0.483070							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083461							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.961421							72
73	DRUGS CHARGED TO PATIENTS	0.443833							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	0.346666							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.634302							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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1316** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] PPS**	
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] OTHER**	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	2,086	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,623	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)	1,128	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	565	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	4,253,304	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)	932,037	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,321,267	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 - line 36)	3,321,267	37

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1316** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [ ] PPS [ ] TEFRA [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					2,046.37	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,156,199	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)					1,156,199	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 (Worksheet D-3, column 3, line 200)					372,545	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,528,744	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)		50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet 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)	605,726	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)	605,726	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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1316** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] PPS**
	[XX] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] OTHER**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)	495	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)	2,046.38	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)	1,012,958	89

		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,247,252	3,321,267	0.375535	1,012,958	380,401	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1316** **WORKSHEET D-1 PART I**

CHECK APPLICABLE BOXES:	**[ ] TITLE V - I/P**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] ICF/MR**	**[ ] PPS**	
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] TITLE XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] OTHER**	

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	2,086	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,623	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)	1,128	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	46	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	4,253,304	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)	932,037	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,321,267	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 - line 36)	3,321,267	37

KPMG LLP COMPU-MAX

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1316** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] PPS
[ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA
[XX] TITLE XIX - I/P [ ] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					2,046.37	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					94,133	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)					94,133	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 (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					94,133	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	27,604	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	27,604	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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1316** **WORKSHEET D-1 PARTS III & IV**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					495	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)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1316** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,502,820		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.628346	87,658	55,080	50
54	RADIOLOGY-DIAGNOSTIC	0.174107	323,098	56,254	54
60	LABORATORY	0.164684	363,491	59,861	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	PHYSICAL THERAPY	0.483070	36,969	17,859	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083461	152,715	12,746	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.961421	59,732	57,428	72
73	DRUGS CHARGED TO PATIENTS	0.443833	229,402	101,816	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	0.346666	33,175	11,501	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.634302			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,286,240	372,545	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,286,240		202

(A) Worksheet A line numbers

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z316** **WORKSHEET D-3**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [ ] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [XX] SWING BED SNF [ ] SWING BED NF [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.628346			50
54	RADIOLOGY-DIAGNOSTIC	0.174107	48,080	8,371	54
60	LABORATORY	0.164684	54,090	8,908	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	PHYSICAL THERAPY	0.483070	125,444	60,598	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083461	25,651	2,141	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.961421			72
73	DRUGS CHARGED TO PATIENTS	0.443833	50,419	22,378	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	0.346666			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.634302			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		303,684	102,396	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		303,684		202

(A) Worksheet A line numbers

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1316** **WORKSHEET D-3**

CHECK APPLICABLE BOXES:	**[ ] TITLE V**	**[XX] HOSPITAL**	**[ ] SUB (OTHER)**	**[ ] SWING BED SNF**	**[ ] PPS**
	[ ] TITLE XVIII, PART A	**[ ] IPF**	**[ ] SNF**	**[ ] SWING BED NF**	**[ ] TEFRA**
	[XX] TITLE XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] OTHER**

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.628346			50
54	RADIOLOGY-DIAGNOSTIC	0.174107			54
60	LABORATORY	0.164684			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	PHYSICAL THERAPY	0.483070			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.083461			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.961421			72
73	DRUGS CHARGED TO PATIENTS	0.443833			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	0.346666			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.634302			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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1316** **WORKSHEET E PART B**

CHECK APPLICABLE BOX: [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	3,367,210			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 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	3,367,210			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, line 69, col. 4)				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)	3,400,882			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	10,820			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,744,201			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,645,861			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)	1,645,861			30
31	PRIMARY PAYER PAYMENTS	227			31
32	SUBTOTAL (line 30 minus line 31)	1,645,634			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)	103,529			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	78,682			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	8,743			36
37	SUBTOTAL (see instructions)	1,724,316			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,724,316			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	34,486			40.01
41	INTERIM PAYMENTS	1,772,437			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-82,607			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	46,566			44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (sse instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1316** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[XX] HOSPITAL [ ] SUB (OTHER) [ ] IPF [ ] SNF [ ] IRF [ ] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,113,559		1,349,873	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				33,204		301,417	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	12/18/2014	63,926	12/18/2014	105,724	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	05/21/2014	59,637	05/21/2014	15,423	3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		123,563		121,147	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)				1,270,326		1,772,437	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		121,748			6.01
	BASED ON THE COST REPORT (1)		.02				-48,121	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,392,074		1,724,316	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.

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z316** **WORKSHEET E-1 PART I**

CHECK APPLICABLE BOXES: **[ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [XX] SWING BED SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				469,725			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		.01	12/18/2014	23,445			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	05/21/2014	25,226			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	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		41,279			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)				511,004			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		198,828			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				709,832			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.

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1**
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	454	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	565	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,128	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	82,687,280	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	967,981	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	484,229	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	342,253	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	6,845	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	335,408	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	335,408	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z316** **WORKSHEET E-2**

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX** **[XX] SWING BED - SNF** **[ ] SWING BED - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	611,783		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, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)	103,420		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 1-3 plus lines 6 and 7)	715,203		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	715,203		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	715,203		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	5,371		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)	709,832		15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
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)	709,832		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	14,197		19.01
20	INTERIM PAYMENTS	511,004		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	184,631		22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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	1,528,744	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	1,528,744	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	1,544,031	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 TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	1,544,031	19
20	DEDUCTIBLES (exclude professional component)	168,992	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	1,375,039	22
23	COINSURANCE		23
24	SUBTOTAL (line 22 minus line 23)	1,375,039	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	22,414	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	17,035	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	3,322	27
28	SUBTOTAL (sum of lines 24 and 26)	1,392,074	28
29	OTHER ADJUSTMENTS (LOSS ON SALE OF ASSETS)		29
30	SUBTOTAL (line 28 plus or minus line 29)	1,392,074	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	27,841	30.01
31	INTERIM PAYMENTS	1,270,326	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	93,907	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	670,873	34

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1316** **WORKSHEET E-3 PART VII**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XIX [XX] HOSPITAL [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] OTHER

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	94,133		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	94,133		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	94,133		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)	94,133		21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	94,133		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	94,133		31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	94,133		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	94,133		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	94,133		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	94,133		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	4,175,666				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	20,935,586				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-14,078,862				6
7	INVENTORY					7
8	PREPAID EXPENSES	297,498				8
9	OTHER CURRENT ASSETS	-1,015,914				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	10,313,974				11
	FIXED ASSETS					
12	LAND	84,230				12
13	LAND IMPROVEMENTS	1,081,601				13
14	ACCUMULATED DEPRECIATION	-148,468				14
15	BUILDINGS	10,893,768				15
16	ACCUMULATED DEPRECIATION	-1,388,268				16
17	LEASEHOLD IMPROVEMENTS	25,947				17
18	ACCUMULATED AMORTIZATION	-6,305				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS	43,450				21
22	ACCUMULATED DEPRECIATION	-20,422				22
23	MAJOR MOVABLE EQUIPMENT	7,832,036				23
24	ACCUMULATED DEPRECIATION	-2,355,738				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)	16,041,831				30
	OTHER ASSETS					
31	INVESTMENTS	3,586,661				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	4,999,678				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	8,586,339				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	34,942,144				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	419,818				37
38	SALARIES, WAGES & FEES PAYABLE	493,148				38
39	PAYROLL TAXES PAYABLE	26,931				39
40	NOTES & LOANS PAYABLE (short term)	201,811				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	23,163,599				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	24,305,307				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE	10,611,349				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)	10,611,349				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	34,916,656				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	25,488				52
53	SPECIFIC PURPOSE FUND BALANCE					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

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
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 52-58)	25,488				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	34,942,144				60

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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		3,489,588			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-3,464,102			2
3	TOTAL (sun of line 1 and line 2)		25,486			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		25,486			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		25,486			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	8,863,384		8,863,384	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)	8,863,384		8,863,384	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)	8,863,384		8,863,384	17
18	ANCILLARY SERVICES				18
19	OUTPATIENT SERVICES		48,258,422	48,258,422	19
20	RHC		30,758,263	30,758,263	20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	8,863,384	79,016,685	87,880,069	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		39,106,037	29
30	ADD (SPECIFY)			30
31	BAD DEBTS	1,528,757		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		1,528,757	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)		40,634,794	43

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	87,880,069	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	51,734,161	2
3	NET PATIENT REVENUES (line 1 minus line 2)	36,145,908	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	40,634,794	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-4,488,886	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	43,224	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER 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, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	778	21
22	RENTAL OF HOSPITAL SPACE	19,416	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (TRUST INCOME)		24
24.01	OTHER (MISCELLANEOUS INCOME)		24.01
24.02	OTHER (UNREALIZED GAINS)		24.02
24.03	OTHER (GRANTS)	669,373	24.03
24.04	OTHER (UNRESTRICTED REVENUE)	178,710	24.04
24.05	OTHER (LOSS ON DISPOSAL)		24.05
24.06	OTHER (COUNTY TERRACE)		24.06
24.07	OTHER (NET OTHER INCOME)		24.07
24.08		113,283	24.08
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,024,784	25
26	TOTAL (line 5 plus line 25)	-3,464,102	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-3,464,102	29

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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 SERV 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							
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-3448

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC I [ ] FQHC

		COMPENS-ATION	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	1,932,672		1,932,672		1,932,672		1,932,672	1
2	PHYSICIAN ASSISTANT	2,655,180		2,655,180		2,655,180		2,655,180	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	1,352,353		1,352,353	-524,671	827,682	-715,087	112,595	9
10	SUBTOTAL (sum of lines 1-9)	5,940,205		5,940,205	-524,671	5,415,534	-715,087	4,700,447	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 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		969,187	969,187		969,187		969,187	15
16	TRANSPORTATION (Health Care Staff)								16
17	DEPRECIATION-MEDICAL EQUIPMENT		228,567	228,567		228,567		228,567	17
18	PROFESSIONAL LIABILITY INSURANCE		180,566	180,566	-180,566				18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		1,378,320	1,378,320	-180,566	1,197,754		1,197,754	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	5,940,205	1,378,320	7,318,525	-705,237	6,613,288	-715,087	5,898,201	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 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	1,552,827	8,347,365	9,900,192	-276,996	9,623,196	-61,950	9,561,246	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	1,552,827	8,347,365	9,900,192	-276,996	9,623,196	-61,950	9,561,246	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	7,493,032	9,725,685	17,218,717	-982,233	16,236,484	-777,037	15,459,447	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.

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3448** **WORKSHEET M-2**

CHECK APPLICABLE BOX: [XX] 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	57,147	4,200	24,948		1
2	PHYSICIAN ASSISTANTS	24.41	70,751	2,100	51,261		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (sum of lines 1-3)	30.35	127,898		76,209	127,898	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 4-7)	30.35	127,898			127,898	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)	5,898,201	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)		11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)	5,898,201	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)	1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)	9,561,246	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)	5,883,144	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)	15,444,390	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)		17
18	SUBTRACT LINE 17 FROM LINE 16	15,444,390	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)	15,444,390	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)	21,342,591	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 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3448** **WORKSHEET M-3**

CHECK APPLICABLE BOXES: **[XX] RHC I** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	21,342,591	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	1,705,679	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	19,636,912	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	127,898	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	127,898	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	153.54	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	153.54	153.54	153.54	9
	CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		21,747		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		3,339,034		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		3,339,034		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		2,494,031		16.04
16.05	TOTAL PROGRAM COST (see instructions)		2,494,031		16.05
17	PRIMARY PAYER PAYMENTS		265		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		221,495		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		781,605		19
20	NET MEDICARE COST EXCUDING VACCINES (see instructions)		2,493,766		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		465,562		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		2,959,328		22
23	ALLOWABLE BAD DEBTS (see instructions)		39,960		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		30,370		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		7,122		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		2,989,698		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		59,794		26.01
27	INTERIM PAYMENTS		2,368,411		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		561,493		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3448** **WORKSHEET M-4**

CHECK APPLICABLE BOXES: **[XX] RHC I** **[ ] FQHC** **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	4,700,447	4,700,447	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.005190	0.008400	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	24,395	39,484	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	271,900	135,600	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	296,295	175,084	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	5,898,201	5,898,201	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	15,444,390	15,444,390	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.050235	0.029684	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	775,849	458,451	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	1,072,144	633,535	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	5,438	9,040	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	197.16	70.08	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	1,504	2,412	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	296,529	169,033	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		1,705,679	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		465,562	16

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HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 03/31/2015 Run Time: 14:07 Version: 2014.10

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: [XX] RHC I [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,583,787	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		.01	12/18/2014	728,996	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	05/21/2014	55,628	3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		784,624	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)				2,368,411	
	TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01			5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02			5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03			5.03
		TO	.04			5.04
		PROVIDER	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		PROVIDER	.52			5.52
		TO	.53			5.53
		PROGRAM	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		621,287	6.01
	BASED ON THE COST REPORT (1)		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				2,989,698	
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.