HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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: 05/30/2018 Time: 13:48 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 01/01/2017 and ending 12/31/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[_] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial 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		350,210	768,247		314,432	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		188,773				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			746,338			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		538,983	1,514,585		314,432	200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 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	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	HOOPESTON COMMUNITY MEMORIAL HOSPITA	14-1316	16974	1	11 / 01 / 2001	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	HOOPESTON CMH SWING BED	14-Z316	16974		11 / 01 / 2001	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	HOOPESTON MEDICAL CENTER RHC	14-3448	16974		04 / 01 / 1998	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2017	To: 12 / 31 / 2017	20
21	Type of control (see instructions)	2		21

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

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the GME FTE unweighted count.

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

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

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

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers		1	2	
105	Does this hospital qualify as a CAH?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.	N		111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	411,059			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	14H077	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: CARLE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES Contractor's Number: 00450				141
142	Street: 611 WEST PARK STREET	P.O. Box:				142
143	City: URBANA	State: IL	ZIP Code: 61801			143
144	Are provider based physicians' costs included in Worksheet A?			Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N		149

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	88,768			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		01 / 01 / 2015	12 / 31 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

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 in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/19/2018	Y	04/19/2018	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 Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	Y		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: GARY	Last name: ZEMAN	Title: VICE PRESIDENT	41
42	Employer: STRATEGIC REIMBURSMENT, INC.			42
43	Phone number: 630-530-7100 EXT. 112	E-mail Address: GARY.ZEMAN@SRINC.ORG		43

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	22	8,052	20,479.00		389	93	746	1
2	HMO and other (see instructions)						174			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						156	129	334	5
6	Hospital Adults & Peds. Swing Bed NF								109	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		22	8,052	20,479.00		545	222	1,189	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	8,052	20,479.00		545	222	1,189	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					32,587	48,585	175,513	26
27	Total (sum of lines 14-26)		22							27
28	Observation Bed Days								847	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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)					158	27	305	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)		85.41			158	27	305	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		151.03						26
27	Total (sum of lines 14-26)		236.44						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	11/01/2001	2

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

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	
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 catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3448** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

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

Source of Federal Funds:

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

		1	2	
10	Does this facility operate as other than a hospital-based 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. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	Y	8	13
14	RHC/FQHC name: CHARLOTTE RUSSEL CCN number: 14-3448			14
14.01	Provider name: CISSNA PARK CCN number: 14-3485			14.01
14.02	Provider name: ROSSVILLE CCN number: 14-3496			14.02
14.03	Provider name: ROBERTS CLINIC CCN number: 14-8521			14.03
14.04	Provider name: MILFORD CLINIC CCN number: 14-8526			14.04
14.05	Provider name: DANVILLE CLINIC CCN number: 14-8531			14.05
14.06	Provider name: CARLE AT TUSCOLA CCN number: 14-8533			14.06
14.07	Provider name: CARLE MATTOON CCN number: 14-8544			14.07

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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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)	0.504892	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	11,582,750	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 and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	30,882,324	6
7	Medicaid cost (line 1 times line 6)	15,592,238	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.	4,009,488	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,009,488	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,090,315		5,090,315	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,570,059		2,570,059	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	2,570,059		2,570,059	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,077,587	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	302,854	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	465,929	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,611,658	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	976,788	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,546,847	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,556,335	31

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		1,068,855	1,068,855	281,654	1,350,509	3,459,235	4,809,744	1
2	00200	Cap Rel Costs-Mvble Equip		977,446	977,446		977,446	-5,812	971,634	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department								4
5	00500	Administrative & General	721,286	9,828,755	10,550,041	1,634,347	12,184,388	4,672,839	16,857,227	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	329,992	617,370	947,362	19,463	966,825		966,825	7
8	00800	Laundry & Linen Service				81,366	81,366		81,366	8
9	00900	Housekeeping	178,387	198,070	376,457	-81,366	295,091		295,091	9
10	01000	Dietary	131,957	193,199	325,156		325,156	-40,236	284,920	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	255,277	79,760	335,037		335,037		335,037	13
14	01400	Central Services & Supply		125,927	125,927	-98,432	27,495		27,495	14
15	01500	Pharmacy								15
16	01600	Medical Records & Library								16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	887,074	608,744	1,495,818		1,495,818	-31,050	1,464,768	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	507,420	797,382	1,304,802	-336,138	968,664		968,664	50
54	05400	Radiology-Diagnostic	764,404	1,469,285	2,233,689		2,233,689	-374,553	1,859,136	54
60	06000	Laboratory	560,378	1,183,478	1,743,856		1,743,856	171,239	1,915,095	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	06600	Physical Therapy	383,078	146,364	529,442		529,442		529,442	66
71	07100	Medical Supplies Charged to Patients				98,432	98,432		98,432	71
72	07200	Impl. Dev. Charged to Patients				336,138	336,138		336,138	72
73	07300	Drugs Charged to Patients	155,340	606,418	761,758		761,758	255,688	1,017,446	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	9,190,679	19,472,905	28,663,584	-1,816,069	26,847,515	-216,746	26,630,769	88
90	09000	Clinic		2,962,241	2,962,241		2,962,241		2,962,241	90
91	09100	Emergency	1,148,103	1,778,701	2,926,804	-119,395	2,807,409	-1,070,107	1,737,302	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)	15,213,375	42,114,900	57,328,275		57,328,275	6,820,497	64,148,772	118
		NONREIMBURSABLE COST CENTERS								
192.01	19201	RETAIL PHARMACY								192.01
193.01	19301	MATTOON CLINIC								193.01
194	07950	FOUNDATION								194
200		TOTAL (sum of lines 118-199)	15,213,375	42,114,900	57,328,275		57,328,275	6,820,497	64,148,772	200

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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		275,705	1
500	Total reclassifications					275,705	500
	Code Letter - A						
1	SURGERY SUPPLIES	B	Medical Supplies Charged to P	71		98,432	1
2			Impl. Dev. Charged to Patient	72		336,138	2
500	Total reclassifications					434,570	500
	Code Letter - B						
1	CAPITAL INSURANCE	C	Cap Rel Costs-Bldg & Fixt	1		5,949	1
500	Total reclassifications					5,949	500
	Code Letter - C						
1	UTILITY EXPENSE	D	Operation of Plant	7		19,463	1
500	Total reclassifications					19,463	500
	Code Letter - D						
1	INSURANCE EXPENSE	F	Administrative & General	5		119,395	1
500	Total reclassifications					119,395	500
	Code Letter - F						
1	RHC ADMIN	G	Administrative & General	5	1,179,081	617,525	1
500	Total reclassifications				1,179,081	617,525	500
	Code Letter - G						
1	LAUNDRY EXPENSE	H	Laundry & Linen Service	8		81,366	1
500	Total reclassifications					81,366	500
	Code Letter - H						
	GRAND TOTAL (Increases)				1,179,081	1,553,973	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	INTEREST EXPENSE	A	Administrative & General	5		275,705	11	1
500	Total reclassifications					275,705		500
	Code letter - A							
1	SURGERY SUPPLIES	B	Central Services & Supply	14		98,432		1
2			Operating Room	50		336,138		2
500	Total reclassifications					434,570		500
	Code letter - B							
1	CAPITAL INSURANCE	C	Administrative & General	5		5,949	11	1
500	Total reclassifications					5,949		500
	Code letter - C							
1	UTILITY EXPENSE	D	Rural Health Clinic	88		19,463		1
500	Total reclassifications					19,463		500
	Code letter - D							
1	INSURANCE EXPENSE	F	Emergency	91		119,395		1
500	Total reclassifications					119,395		500
	Code letter - F							
1	RHC ADMIN	G	Rural Health Clinic	88	1,179,081	617,525		1
500	Total reclassifications				1,179,081	617,525		500
	Code letter - G							
1	LAUNDRY EXPENSE	H	Housekeeping	9		81,366		1
500	Total reclassifications					81,366		500
	Code letter - H							
	GRAND TOTAL (Decreases)				1,179,081	1,553,973		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	104,595					104,595		1
2	Land Improvements	1,081,601					1,081,601		2
3	Buildings and Fixtures	11,314,594					11,314,594		3
4	Building Improvements								4
5	Fixed Equipment	1,735,646					1,735,646		5
6	Movable Equipment	9,381,391	485,344		485,344		9,866,735		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	23,617,827	485,344		485,344		24,103,171		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	23,617,827	485,344		485,344		24,103,171		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,068,855						1,068,855	1
2	Cap Rel Costs-Mvble Equip	977,446						977,446	2
3	Total (sum of lines 1-2)	2,046,301						2,046,301	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				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	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	4,543,840		265,904				4,809,744	1
2	Cap Rel Costs-Mvble Equip	971,634						971,634	2
3	Total (sum of lines 1-2)	5,515,474		265,904				5,781,378	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.)

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	-15,750	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,922,409				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	9,373,503				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-20,335	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 and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	CATERING	B	-27,532	Dietary	10		33
34							34
35	LOBBYING EXPENSE	A	-10,074	Administrative & General	5		35
36	OTHER REVENUE	B	-14,101	Rural Health Clinic	88		36
37							37
38							38
39	VENDING REVENUE	B	-819	Dietary	10		39
40	OTHER INCOME	B	-819	Administrative & General	5		40
41	PROVIDER TAX	A	-451,179	Administrative & General	5		41
42	WORKERS COMP EXPENSE	A	-52,987	Administrative & General	5		42
43	BILLING REVENUE	B	-31,189	Administrative & General	5		43
44							44
45	EHR ASSET DEPRECIATION	A	-5,812	Cap Rel Costs-Mvble Equip	2	9	45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		6,820,497				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	MANAGEMENT FEES	12,971,030	7,751,943	5,219,087		1
2	1	Cap Rel Costs-Bldg & Fixt	CAPITAL	3,474,985		3,474,985	9	2
3	54	Radiology-Diagnostic	CARLE SERVICES	732,930	542,431	190,499		3
3.01	60	Laboratory	CARLE SERVICES	792,078	586,206	205,872		3.01
3.02	54	Radiology-Diagnostic	CARLE CARDIOLOGY	72,800	53,878	18,922		3.02
3.03	10	Dietary	CARLE SERVICES	29,618	21,168	8,450		3.03
3.12	73	Drugs Charged to Patients	CARLE DRUG COSTS	794,824	588,239	206,585		3.12
3.13	73	Drugs Charged to Patients	CARLE PHARMACISTS	172,108	123,005	49,103		3.13
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			19,040,373	9,666,870	9,373,503		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:

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3	30	Adults & Pediatrics HOSPITALIST	299,850	31,050	268,800					3
4	91	Emergency AGGREGATE	1,251,640	1,070,107	181,533					4
5	54	Radiology-Diagnostic CARLE RADIOLOGY	542,432	542,432						5
6	88	Rural Health Clinic AGGREGATE	202,645	202,645						6
7	54	Radiology-Diagnostic CARLE CARDIOLO	53,878	41,542	12,336					7
8	60	Laboratory CARLE PATHOLOGI	34,633	34,633						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	2,385,078	1,922,409	462,669					200

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3	30	Adults & Pediatrics HOSPITALIST							31,050	3
4	91	Emergency AGGREGATE							1,070,107	4
5	54	Radiology-Diagnostic CARLE RADIOLOGY							542,432	5
6	88	Rural Health Clinic AGGREGATE							202,645	6
7	54	Radiology-Diagnostic CARLE CARDIOLO							41,542	7
8	60	Laboratory CARLE PATHOLOGI							34,633	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							1,922,409	200

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 excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	125,627	23

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

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

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

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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

		Therapists	Assistants	Aides	Trainees	Total	
		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 overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

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 excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	239,844	23

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

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

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

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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

		Therapists	Assistants	Aides	Trainees	Total	
		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 overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

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 excluding aides and trainees (line 2 times line 21)	55,559	22
23	Total salary equivalency (see instructions)	55,559	23

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

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

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

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

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

		Therapists	Assistants	Aides	Trainees	Total	
		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 overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	4A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	4,809,744	4,809,744					1
2	Cap Rel Costs-Mvble Equip	971,634		971,634				2
4	Employee Benefits Department							4
5	Administrative & General	16,857,227	350,376	70,781	17,278,384	17,278,384		5
6	Maintenance & Repairs							6
7	Operation of Plant	966,825	1,667,428	336,842	2,971,095	1,095,270	4,066,365	7
8	Laundry & Linen Service	81,366	7,379	1,491	90,236	33,265	10,748	8
9	Housekeeping	295,091	100,781	20,359	416,231	153,440	146,784	9
10	Dietary	284,920	134,534	27,178	446,632	164,647	195,944	10
11	Cafeteria		32,113	6,487	38,600	14,230	46,772	11
12	Maintenance of Personnel							12
13	Nursing Administration	335,037	118,067	23,851	476,955	175,826	171,961	13
14	Central Services & Supply	27,495			27,495	10,136		14
15	Pharmacy							15
16	Medical Records & Library		60,469	12,215	72,684	26,794	88,070	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	1,464,768	854,759	172,673	2,492,200	918,730	1,244,928	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	968,664	472,065	95,364	1,536,093	566,268	687,546	50
54	Radiology-Diagnostic	1,859,136	232,309	46,930	2,138,375	788,295	338,350	54
60	Laboratory	1,915,095	120,049	24,252	2,059,396	759,180	174,847	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	529,442	61,357	12,395	603,194	222,363	89,364	66
71	Medical Supplies Charged to Patients	98,432			98,432	36,286		71
72	Impl. Dev. Charged to Patients	336,138			336,138	123,915		72
73	Drugs Charged to Patients	1,017,446	3,963	801	1,022,210	376,830	5,772	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	26,630,769	322,909	65,232	27,018,910	9,960,295	470,306	88
90	Clinic	2,962,241			2,962,241	1,092,006		90
91	Emergency	1,737,302	271,186	54,783	2,063,271	760,608	394,973	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)	64,148,772	4,809,744	971,634	64,148,772	17,278,384	4,066,365	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	64,148,772	4,809,744	971,634	64,148,772	17,278,384	4,066,365	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	134,249						8
9	Housekeeping		716,455					9
10	Dietary		35,915	843,138				10
11	Cafeteria		8,573		108,175			11
12	Maintenance of Personnel							12
13	Nursing Administration		31,519			856,261		13
14	Central Services & Supply						37,631	14
15	Pharmacy							15
16	Medical Records & Library		16,143					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	134,249	228,183	843,138	19,041	599,687		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		126,021		5,927	186,667		50
54	Radiology-Diagnostic		62,017		14,233			54
60	Laboratory		32,048		12,166			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		16,380		7,863			66
71	Medical Supplies Charged to Patients						8,524	71
72	Impl. Dev. Charged to Patients						29,107	72
73	Drugs Charged to Patients		1,058		317			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		86,203		26,441			88
90	Clinic							90
91	Emergency		72,395		22,187	69,907		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)	134,249	716,455	843,138	108,175	856,261	37,631	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	134,249	716,455	843,138	108,175	856,261	37,631	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	203,691						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	47,811	6,527,967		6,527,967			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,899	3,124,421		3,124,421			50
54	Radiology-Diagnostic	37,803	3,379,073		3,379,073			54
60	Laboratory	26,684	3,064,321		3,064,321			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	11,674	950,838		950,838			66
71	Medical Supplies Charged to Patients		143,242		143,242			71
72	Impl. Dev. Charged to Patients		489,160		489,160			72
73	Drugs Charged to Patients		1,406,187		1,406,187			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	17,345	37,579,500		37,579,500			88
90	Clinic		4,054,247		4,054,247			90
91	Emergency	46,475	3,429,816		3,429,816			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	203,691	64,148,772		64,148,772			118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	203,691	64,148,772		64,148,772			202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	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		350,376	70,781	421,157	421,157		5
6	Maintenance & Repairs							6
7	Operation of Plant		1,667,428	336,842	2,004,270	26,698	2,030,968	7
8	Laundry & Linen Service		7,379	1,491	8,870	811	5,368	8
9	Housekeeping		100,781	20,359	121,140	3,740	73,312	9
10	Dietary		134,534	27,178	161,712	4,013	97,865	10
11	Cafeteria		32,113	6,487	38,600	347	23,360	11
12	Maintenance of Personnel							12
13	Nursing Administration		118,067	23,851	141,918	4,286	85,887	13
14	Central Services & Supply					247		14
15	Pharmacy							15
16	Medical Records & Library		60,469	12,215	72,684	653	43,987	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		854,759	172,673	1,027,432	22,395	621,786	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		472,065	95,364	567,429	13,803	343,399	50
54	Radiology-Diagnostic		232,309	46,930	279,239	19,215	168,991	54
60	Laboratory		120,049	24,252	144,301	18,506	87,328	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		61,357	12,395	73,752	5,420	44,633	66
71	Medical Supplies Charged to Patients					885		71
72	Impl. Dev. Charged to Patients					3,021		72
73	Drugs Charged to Patients		3,963	801	4,764	9,186	2,883	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		322,909	65,232	388,141	242,771	234,897	88
90	Clinic					26,619		90
91	Emergency		271,186	54,783	325,969	18,541	197,272	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)		4,809,744	971,634	5,781,378	421,157	2,030,968	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		4,809,744	971,634	5,781,378	421,157	2,030,968	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	15,049						8
9	Housekeeping		198,192					9
10	Dietary		9,935	273,525				10
11	Cafeteria		2,372		64,679			11
12	Maintenance of Personnel							12
13	Nursing Administration		8,719			240,810		13
14	Central Services & Supply						247	14
15	Pharmacy							15
16	Medical Records & Library		4,465					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,049	63,122	273,525	11,385	168,653		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		34,861		3,544	52,497		50
54	Radiology-Diagnostic		17,156		8,510			54
60	Laboratory		8,865		7,274			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		4,531		4,702			66
71	Medical Supplies Charged to Patients						56	71
72	Impl. Dev. Charged to Patients						191	72
73	Drugs Charged to Patients		293		190			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		23,846		15,808			88
90	Clinic							90
91	Emergency		20,027		13,266	19,660		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	15,049	198,192	273,525	64,679	240,810	247	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15,049	198,192	273,525	64,679	240,810	247	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		16	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	121,789						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	28,586	2,231,933		2,231,933			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,506	1,025,039		1,025,039			50
54	Radiology-Diagnostic	22,603	515,714		515,714			54
60	Laboratory	15,955	282,229		282,229			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	6,980	140,018		140,018			66
71	Medical Supplies Charged to Patients		941		941			71
72	Impl. Dev. Charged to Patients		3,212		3,212			72
73	Drugs Charged to Patients		17,316		17,316			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	10,371	915,834		915,834			88
90	Clinic		26,619		26,619			90
91	Emergency	27,788	622,523		622,523			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)	121,789	5,781,378		5,781,378			118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	121,789	5,781,378		5,781,378			202

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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	70,394						1
2	Cap Rel Costs-Mvble Equip		70,394					2
4	Employee Benefits Department			15,213,375				4
5	Administrative & General	5,128	5,128	1,900,367	-17,278,384	46,870,388		5
6	Maintenance & Repairs							6
7	Operation of Plant	24,404	24,404	329,992		2,971,095	40,862	7
8	Laundry & Linen Service	108	108			90,236	108	8
9	Housekeeping	1,475	1,475	178,387		416,231	1,475	9
10	Dietary	1,969	1,969	131,957		446,632	1,969	10
11	Cafeteria	470	470			38,600	470	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,728	1,728	255,277		476,955	1,728	13
14	Central Services & Supply					27,495		14
15	Pharmacy							15
16	Medical Records & Library	885	885			72,684	885	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	12,510	12,510	887,074		2,492,200	12,510	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,909	6,909	507,420		1,536,093	6,909	50
54	Radiology-Diagnostic	3,400	3,400	764,404		2,138,375	3,400	54
60	Laboratory	1,757	1,757	560,378		2,059,396	1,757	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	898	898	383,078		603,194	898	66
71	Medical Supplies Charged to Patients					98,432		71
72	Impl. Dev. Charged to Patients					336,138		72
73	Drugs Charged to Patients	58	58	155,340		1,022,210	58	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,726	4,726	8,011,598		27,018,910	4,726	88
90	Clinic					2,962,241		90
91	Emergency	3,969	3,969	1,148,103		2,063,271	3,969	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)	70,394	70,394	15,213,375	-17,278,384	46,870,388	40,862	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,809,744	971,634			17,278,384	4,066,365	202
203	Unit Cost Multiplier (Wkst. B, Part I)	68.326051	13.802796			0.368642	99.514586	203
204	Cost to be allocated (Per Wkst. B, Part II)					421,157	2,030,968	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.008986	49.703098	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	100						8
9	Housekeeping		39,279					9
10	Dietary		1,969	100				10
11	Cafeteria		470		164,477			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,728			41,339		13
14	Central Services & Supply						434,570	14
15	Pharmacy							15
16	Medical Records & Library		885					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	100	12,510	100	28,952	28,952		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		6,909		9,012	9,012		50
54	Radiology-Diagnostic		3,400		21,641			54
60	Laboratory		1,757		18,498			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy		898		11,956			66
71	Medical Supplies Charged to Patients						98,432	71
72	Impl. Dev. Charged to Patients						336,138	72
73	Drugs Charged to Patients		58		482			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		4,726		40,201			88
90	Clinic							90
91	Emergency		3,969		33,735	3,375		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	39,279	100	164,477	41,339	434,570	118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	134,249	716,455	843,138	108,175	856,261	37,631	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1,342.490000	18.240154	8,431.380000	0.657691	20.713152	0.086594	203
204	Cost to be allocated (Per Wkst. B, Part II)	15,049	198,192	273,525	64,679	240,810	247	204
205	Unit Cost Multiplier (Wkst. B, Part II)	150.490000	5.045750	2,735.250000	0.393240	5.825250	0.000568	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT					
		16	17					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	9,160						16
17	Social Service		100					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,150	100					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	715						50
54	Radiology-Diagnostic	1,700						54
60	Laboratory	1,200						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	525						66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	780						88
90	Clinic							90
91	Emergency	2,090						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	9,160	100					118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	203,691						202
203	Unit Cost Multiplier (Wkst. B, Part I)	22.237009						203
204	Cost to be allocated (Per Wkst. B, Part II)	121,789						204
205	Unit Cost Multiplier (Wkst. B, Part II)	13.295742						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	6,527,967		6,527,967			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,124,421		3,124,421			50
54	Radiology-Diagnostic	3,379,073		3,379,073			54
60	Laboratory	3,064,321		3,064,321			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	Physical Therapy	950,838		950,838			66
71	Medical Supplies Charged to Patients	143,242		143,242			71
72	Impl. Dev. Charged to Patients	489,160		489,160			72
73	Drugs Charged to Patients	1,406,187		1,406,187			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	37,579,500		37,579,500			88
90	Clinic	4,054,247		4,054,247			90
91	Emergency	3,429,816		3,429,816			91
92	Observation Beds (Non-Distinct Part)	2,863,699		2,863,699			92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	67,012,471		67,012,471			200
201	Less Observation Beds	2,863,699		2,863,699			201
202	Total (line 200 minus line 201)	64,148,772		64,148,772			202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	2,379,577		2,379,577				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	235,194	3,105,368	3,340,562	0.935298			50
54	Radiology-Diagnostic	846,807	19,885,328	20,732,135	0.162987			54
60	Laboratory	1,092,310	19,356,611	20,448,921	0.149852			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy	222,922	1,491,550	1,714,472	0.554595			66
71	Medical Supplies Charged to Patients	290,273	821,108	1,111,381	0.128886			71
72	Impl. Dev. Charged to Patients	151,556	170,464	322,020	1.519036			72
73	Drugs Charged to Patients	1,052,078	3,777,856	4,829,934	0.291140			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		50,637,958	50,637,958				88
90	Clinic		8,747,908	8,747,908	0.463453			90
91	Emergency	463,089	9,447,047	9,910,136	0.346092			91
92	Observation Beds (Non-Distinct Part)	300,731	2,578,752	2,879,483	0.994518			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	7,034,537	120,019,950	127,054,487				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,034,537	120,019,950	127,054,487				202

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/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.935298		1,186,899			1,110,104		50
54	Radiology-Diagnostic	0.162987		4,562,722			743,664		54
60	Laboratory	0.149852		5,748,647			861,446		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	Physical Therapy	0.554595		352,634			195,569		66
71	Medical Supplies Charged to Pat	0.128886		323,994			41,758		71
72	Impl. Dev. Charged to Patients	1.519036		83,277			126,501		72
73	Drugs Charged to Patients	0.291140		922,369			268,539		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
90	Clinic	0.463453							90
91	Emergency	0.346092		3,118,626	345		1,079,332	119	91
92	Observation Beds (Non-Distinct	0.994518		1,093,311			1,087,317		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			17,392,479	345		5,514,230	119	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			17,392,479	345		5,514,230	119	202

(A) Worksheet A line numbers

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.935298							50
54	Radiology-Diagnostic	0.162987							54
60	Laboratory	0.149852							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	Physical Therapy	0.554595							66
71	Medical Supplies Charged to Pat	0.128886							71
72	Impl. Dev. Charged to Patients	1.519036							72
73	Drugs Charged to Patients	0.291140							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
90	Clinic	0.463453							90
91	Emergency	0.346092							91
92	Observation Beds (Non-Distinct	0.994518							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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,231,933	390,470	1,841,463	1,593	1,155.97	93	107,505	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)	2,231,933		1,841,463	1,593		93	107,505	200

(A) Worksheet A line numbers

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	1,025,039	3,340,562	0.306846			50
54	Radiology-Diagnostic	515,714	20,732,135	0.024875			54
60	Laboratory	282,229	20,448,921	0.013802			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	Physical Therapy	140,018	1,714,472	0.081668			66
71	Medical Supplies Charged to Pat	941	1,111,381	0.000847			71
72	Impl. Dev. Charged to Patients	3,212	322,020	0.009975			72
73	Drugs Charged to Patients	17,316	4,829,934	0.003585			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	915,834	50,637,958	0.018086			88
90	Clinic	26,619	8,747,908	0.003043			90
91	Emergency	622,523	9,910,136	0.062817			91
92	Observation Beds (Non-Distinct	979,107	2,879,483	0.340029			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	4,528,552	124,674,910				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,593		93		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)	1,593		93		200

(A) Worksheet A line numbers

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	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 Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	3,340,562							50
54	Radiology-Diagnostic	20,732,135							54
60	Laboratory	20,448,921							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	Physical Therapy	1,714,472							66
71	Medical Supplies Charged to Pat	1,111,381							71
72	Impl. Dev. Charged to Patients	322,020							72
73	Drugs Charged to Patients	4,829,934							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	50,637,958							88
90	Clinic	8,747,908							90
91	Emergency	9,910,136							91
92	Observation Beds (Non-Distinct	2,879,483							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	124,674,910							200

(A) Worksheet A line numbers

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.935298							50
54	Radiology-Diagnostic	0.162987							54
60	Laboratory	0.149852							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	Physical Therapy	0.554595							66
71	Medical Supplies Charged to Pat	0.128886							71
72	Impl. Dev. Charged to Patients	1.519036							72
73	Drugs Charged to Patients	0.291140							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
90	Clinic	0.463453							90
91	Emergency	0.346092							91
92	Observation Beds (Non-Distinct	0.994518							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

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

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[ ] 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)	2,036	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,593	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)	746	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	334	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	109	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	389	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)	156	10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	117.40	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.40	20
21	Total general inpatient routine service cost (see instructions)	6,527,967	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)	12,797	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	1,142,048	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,385,919	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,385,919	37

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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)					3,380.99	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,315,205	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)					1,315,205	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					623,563	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,938,768	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					527,434	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)					527,434	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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					847	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,380.99	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,863,699	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,231,933	6,527,967	0.341903	2,863,699	979,107	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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/IID**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,036	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,593	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)	746	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	334	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	109	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	93	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	117.40	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.40	20
21	Total general inpatient routine service cost (see instructions)	6,527,967	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)	12,797	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	1,142,048	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,385,919	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,385,919	37

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					3,380.99	38
39	Program general inpatient routine service cost (line 9 x line 38)					314,432	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)					314,432	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					314,432	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					107,505	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					107,505	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					847	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,380.99	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,863,699	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,231,933	6,527,967	0.341903	2,863,699	979,107	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,046,530		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.935298	104,949	98,159	50
54	Radiology-Diagnostic	0.162987	443,890	72,348	54
60	Laboratory	0.149852	529,754	79,385	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	Physical Therapy	0.554595	29,600	16,416	66
71	Medical Supplies Charged to Patients	0.128886	119,655	15,422	71
72	Impl. Dev. Charged to Patients	1.519036	34,051	51,725	72
73	Drugs Charged to Patients	0.291140	403,106	117,360	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
90	Clinic	0.463453			90
91	Emergency	0.346092	390	135	91
92	Observation Beds (Non-Distinct Part)	0.994518	173,564	172,613	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,838,959	623,563	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,838,959		202

(A) Worksheet A line numbers

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

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

		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	0.935298			50
54	Radiology-Diagnostic	0.162987	18,137	2,956	54
60	Laboratory	0.149852	43,103	6,459	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	Physical Therapy	0.554595	57,815	32,064	66
71	Medical Supplies Charged to Patients	0.128886	20,452	2,636	71
72	Impl. Dev. Charged to Patients	1.519036			72
73	Drugs Charged to Patients	0.291140	241,037	70,176	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
90	Clinic	0.463453			90
91	Emergency	0.346092			91
92	Observation Beds (Non-Distinct Part)	0.994518			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		380,544	114,291	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		380,544		202

(A) Worksheet A line numbers

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.935298			50
54	Radiology-Diagnostic	0.162987			54
60	Laboratory	0.149852			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	Physical Therapy	0.554595			66
71	Medical Supplies Charged to Patients	0.128886			71
72	Impl. Dev. Charged to Patients	1.519036			72
73	Drugs Charged to Patients	0.291140			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
90	Clinic	0.463453			90
91	Emergency	0.346092			91
92	Observation Beds (Non-Distinct Part)	0.994518			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

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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)	5,514,349			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,514,349			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	5,569,492			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	28,708			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,337,855			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,202,929			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)	3,202,929			30
31	Primary payer payments	1,955			31
32	Subtotal (line 30 minus line 31)	3,200,974			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)	186,456			34
35	Adjusted reimbursable bad debts (see instructions)	121,196			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	186,456			36
37	Subtotal (see instructions)	3,322,170			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,322,170			40
40.01	Sequestration adjustment (see instructions)	66,443			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,487,480			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	768,247			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,424,912		2,621,615	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				11,812		71,407	2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51			08/23/2016	115,500	3.51
		Provider	.52			12/01/2016	90,042	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				-205,542	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)				1,436,724		2,487,480	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		350,210		768,247	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,786,934		3,255,727	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.

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [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				453,798			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	08/23/2016	7,392			3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-7,392			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				446,406			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		188,773			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				635,179			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.

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)	532,708		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	115,434		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	156		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	648,142		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	648,142		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	648,142		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			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)	648,142		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	648,142		19
19.01	Sequestration adjustment (see instructions)	12,963		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	446,406		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	188,773		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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

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

1	Inpatient services	1,938,768	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,938,768	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,958,156	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,958,156	19
20	Deductibles (exclude professional component)	138,180	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,819,976	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,819,976	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5,270	25
26	Adjusted reimbursable bad debts (see instructions)	3,426	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,270	27
28	Subtotal (sum of lines 24 and 26)	1,823,402	28
29	Other adjustments (LOSS ON SALE OF ASSETS)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,823,402	30
30.01	Sequestration adjustment (see instructions)	36,468	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	1,436,724	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	350,210	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	314,432		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	314,432		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	314,432		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	314,432		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	314,432		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)	314,432		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)	314,432		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	314,432		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	314,432		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	314,432		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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	-85,377				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	13,539,087				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-10,569,898				6
7	Inventory					7
8	Prepaid expenses	125,894				8
9	Other current assets	121,567				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	3,131,273				11
	FIXED ASSETS					
12	Land	104,595				12
13	Land improvements	1,081,601				13
14	Accumulated depreciation	-372,372				14
15	Buildings	11,308,433				15
16	Accumulated depreciation	-3,441,914				16
17	Leasehold improvements	1,735,646				17
18	Accumulated depreciation	-905,372				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks	69,131				21
22	Accumulated depreciation	-41,160				22
23	Major movable equipment	9,803,761				23
24	Accumulated depreciation	-5,119,098				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)	14,223,251				30
	OTHER ASSETS					
31	Investments	3,601,914				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,444,690				34
35	Total other assets (sum of lines 31-34)	8,046,604				35
36	Total assets (sum of lines 11, 30 and 35)	25,401,128				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	220,960				37
38	Salaries, wages and fees payable	1,578,025				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	17,546,763				44
45	Total current liabilities (sum of lines 37 thru 44)	19,345,748				45
	LONG TERM LIABILITIES					
46	Mortgage payable	9,122,387				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)	9,122,387				50
51	Total liabilities (sum of lines 45 and 50)	28,468,135				51
	CAPITAL ACCOUNTS					
52	General fund balance	-3,067,007				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	-3,067,007				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	25,401,128				60

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		-6,580,549			1
2	Net income (loss) (from Worksheet G-3, line 29)		3,513,542			2
3	Total (sum of line 1 and line 2)		-3,067,007			3
4	Additions (credit adjustments) (specify)					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)		-3,067,007			11
12	Deductions (debit adjustments) (specify)					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)		-3,067,007			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						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) (specify)					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

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	2,355,737		2,355,737	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	2,355,737		2,355,737	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	2,355,737		2,355,737	17
18	Ancillary services	4,941,501	77,231,210	82,172,711	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)		50,226,687	50,226,687	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,297,238	127,457,897	134,755,135	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		57,328,275	29
30	Add (specify)			30
31	BAD DEBT EXPENSE			31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		57,328,275	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	134,755,135	1
2	Less contractual allowances and discounts on patients' accounts	74,537,790	2
3	Net patient revenues (line 1 minus line 2)	60,217,345	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	57,328,275	4
5	Net income from service to patients (line 3 minus line 4)	2,889,070	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	42,971	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	13,836	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (TRUST INCOME)	15,750	24
24.01	Other (MISCELLANEOUS INCOME)		24.01
24.02	Other (UNREALIZED GAINS)		24.02
24.03	Other (GRANTS)	384,415	24.03
24.04	Other (RESTRICTED REVENUE)	17,500	24.04
24.05	Other (UNRESTRICTED REVENUE)	150,000	24.05
24.06	Other (BOND PROCEED INCOME)		24.06
24.07	Other (INCOME TAX)		24.07
25	Total other income (sum of lines 6-24)	624,472	25
26	Total (line 5 plus line 25)	3,513,542	26
29	Net income (or loss) for the period (line 26 minus line 28)	3,513,542	29

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
66	Physical Therapy							66
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192.01	RETAIL PHARMACY							192.01
193.01	MATTOON CLINIC							193.01
194	FOUNDATION							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

ANALYSIS OF HOSPITAL-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		11,294,926	11,294,926		11,294,926		11,294,926	1
2	Physician Assistant	1,126,319		1,126,319		1,126,319		1,126,319	2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse	2,344,756		2,344,756		2,344,756		2,344,756	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	3,725,174		3,725,174		3,725,174		3,725,174	9
10	Subtotal (sum of lines 1 through 9)	7,196,249	11,294,926	18,491,175		18,491,175		18,491,175	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		1,635,205	1,635,205		1,635,205		1,635,205	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		1,635,205	1,635,205		1,635,205		1,635,205	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	7,196,249	12,930,131	20,126,380		20,126,380		20,126,380	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	1,994,430	6,542,774	8,537,204	-1,816,069	6,721,135	-216,746	6,504,389	30
31	Total Facility Overhead (sum of lines 29 and 30)	1,994,430	6,542,774	8,537,204	-1,816,069	6,721,135	-216,746	6,504,389	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	9,190,679	19,472,905	28,663,584	-1,816,069	26,847,515	-216,746	26,630,769	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.

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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	39.20	99,698	4,200	164,640		1
2	Physician Assistants	9.63	75,815	2,100	20,223		2
3	Nurse Practitioners			2,100			3
4	Subtotal (sum of lines 1 through 3)	48.83	175,513		184,863	184,863	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	48.83	175,513			184,863	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	20,126,380	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	20,126,380	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	6,504,389	14
15	Parent provider overhead allocated to facility (see instructions)	10,948,731	15
16	Total overhead (sum of lines 14 and 15)	17,453,120	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	17,453,120	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	17,453,120	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	37,579,500	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.

HOOPESTON COMMUNITY MEMORIAL HOSPITA Provider CCN: 14-1316	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2017 To: 12/31/2017	Run Date: 05/30/2018 Run Time: 13:48 Version: 2018.04 (05/22/2018)

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 Wkst. M-2, line 20)	37,579,500	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	2,562,205	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	35,017,295	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	184,863	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	184,863	6
7	Adjusted cost per visit (line 3 divided by line 6)	189.42	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)	189.42	189.42	189.42	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		32,820		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		6,216,764		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 (see instructions)		6,216,764		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)		4,529,999		16.04
16.05	Total program cost (see instructions)		4,529,999		16.05
17	Primary payer payments		3,212		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		554,265		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,383,062		19
20	Net Medicare cost excluding vaccines (see instructions)		4,526,787		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		584,025		21
22	Total reimbursable Program cost (line 20 plus line 21)		5,110,812		22
23	Allowable bad debts (see instructions)		274,203		23
23.01	Adjusted reimbursable bad debts (see instructions)		178,232		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		274,203		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		5,289,044		26
26.01	Sequestration adjustment (see instructions)		105,781		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		4,436,925		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		746,338		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

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 Wkst. M-1, col. 7, line 10)	18,491,175	18,491,175	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.006500	0.012600	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	120,193	232,989	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	702,364	316,688	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	822,557	549,677	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	20,126,380	20,126,380	6
7	Total overhead (from Wkst. M-2, line 16)	17,453,120	17,453,120	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.040870	0.027311	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	713,309	476,662	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	1,535,866	1,026,339	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	4,411	8,542	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	348.19	120.15	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	884	2,299	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	307,800	276,225	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		2,562,205	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		584,025	16

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				4,436,925	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter 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			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				4,436,925	
	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 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	Determine net settlement amount (balance due)		.01		746,338	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				5,183,263	

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.