

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

**WORKSHEET S  
PARTS I, II & III**

**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 11/24/2015 Time: 16:55		
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report		
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)  
  
\_\_\_\_\_  
Title  
  
\_\_\_\_\_  
Date

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII					TITLE XIX	
		TITLE V	PART A	PART B	HIT			
		1	2	3	4	5		
1	HOSPITAL		-452,393	29,898	-102,535	-834,214	1	
2	SUBPROVIDER - IPF						2	
3	SUBPROVIDER - IRF						3	
4	SUBPROVIDER (OTHER)						4	
5	SWING BED - SNF						5	
6	SWING BED - NF						6	
7	SKILLED NURSING FACILITY						7	
8	NURSING FACILITY						8	
9	HOME HEALTH AGENCY						9	
10	HEALTH CLINIC - RHC						10	
11	HEALTH CLINIC - FQHC						11	
12	OUTPATIENT REHABILITATION PROVIDER						12	
200	TOTAL		-452,393	29,898	-102,535	-834,214	200	

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

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

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 850 WEST IRVING PARK ROAD	P.O. Box:									1
2	City: CHICAGO	State: IL	ZIP Code: 60613	County: COOK							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	THOREK MEMORIAL HOSPITAL	14-0115	16974	1	07 / 01 / 1966	N	P	O		3
4	Subprovider - IPF										4
5	Subprovider - IRF										5
6	Subprovider - (OTHER)										6
7	Swing Beds - SNF										7
8	Swing Beds - NF										8
9	Hospital-Based SNF										9
10	Hospital-Based NF										10
11	Hospital-Based OLTC										11
12	Hospital-Based HHA										12
13	Separately Certified ASC										13
14	Hospital-Based Hospice										14
15	Hospital-Based Health Clinic - RHC										15
16	Hospital-Based Health Clinic - FQHC										16
17	Hospital-Based (CMHC)										17
18	Renal Dialysis										18
19	Other										19

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

**Inpatient PPS Information**

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	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.	1	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.	6,477				1,334	3,073	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.	1						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.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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

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

**Teaching Hospitals that Claim Residents in Nonprovider Settings**

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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**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 column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
65	1	2	3	4	5		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))		
67	1	2	3	4	5		67

**Inpatient Psychiatric Facility PPS**

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

**Inpatient Rehabilitation Facility PPS**

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

**Long Term Care Hospital PPS**

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

**TEFRA Providers**

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

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

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

**Rural Providers**

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			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.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

**Miscellaneous Cost Reporting Information**

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	2,078,490	1,882,180		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121

**Transplant Center Information**

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

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**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)	N		140

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

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

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				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 transitional factor. (see instructions)	0.50			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10 / 01 / 2012	09 / 30 / 2013		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

**COMPLETED BY ALL HOSPITALS**

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

		Y/N	Type	Date	
<b>Financial Data and Reports</b>					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	12/31/2015	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	
<b>Approved Educational Activities</b>				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
<b>Bad Debts</b>			
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

<b>Bed Complement</b>			
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
<b>PS&amp;R Report Data</b>					
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)	N		N	
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)	Y	11/15/2015	Y	11/15/2015
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

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

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

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		35

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

Cost Report Preparer Contact Information			
41	First name: HATHUY	Last name: SHAH	Title: SR. REIMBURSEMENT CONSULTA
42	Employer: STRATEGIC REIMBURSEMENT GROUP LLC		
43	Phone number: 630-530-7100 EXT 107	E-mail Address: RAJ.SHAH@SRGROUP.LLC	

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	146	53,290			5,870	8,973	20,796	1
2	HMO and other (see instructions)						529	1,334		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)		146	53,290			5,870	8,973	20,796	7
8	Intensive Care Unit	31	10	3,650			623	577	1,584	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)		156	56,940			6,493	9,550	22,380	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		156							27
28	Observation Bed Days								828	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,258	2,543	4,785	1
2	HMO and other (see instructions)					73			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)		346.00			1,258	2,543	4,785	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		346.00						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**HOSPITAL WAGE INDEX INFORMATION**

**WORKSHEET S-3  
PARTS II-III**

**Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)		
	1	2	3	4	5	6		
<b>SALARIES</b>								
1	Total salaries (see instructions)	200	21,296,739		21,296,739	720,395.00	29.56	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		163,609		163,609	1,196.00	136.80	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		1,776,731		1,776,731	13,601.00	130.63	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		2,050,606		2,050,606	50,688.25	40.46	10
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11	Contract labor (see instructions)		834,198		834,198	11,566.00	72.13	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		180,599		180,599	1,231.00	146.71	13
14	Home office salaries & wage-related costs							14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
<b>WAGE-RELATED COSTS</b>								
17	Wage-related costs (core)(see instructions)		2,446,279		2,446,279			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		289,866		289,866			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		23,127		23,127			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		251,152		251,152			23
24	Wage-related costs (RHC/FOHC)							24
25	Interns & residents (in an approved program)							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26	Employee Benefits Department		86,625		86,625	2,636.78	32.85	26
27	Administrative & General		3,966,000		3,966,000	121,063.47	32.76	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		451,579		451,579	17,205.00	26.25	30
31	Laundry & Linen Service							31
32	Housekeeping							32
33	Housekeeping under contract (see instructions)							33
34	Dietary		493,554	-108,833	384,721	33,396.00	11.52	34
35	Dietary under contract (see instructions)		240,557		240,557	5,672.00	42.41	35
36	Cafeteria			108,833	108,833	9,447.00	11.52	36
37	Maintenance of Personnel							37
38	Nursing Administration		503,696		503,696	11,338.75	44.42	38
39	Central Services and Supply		77,940		77,940	6,232.50	12.51	39
40	Pharmacy		749,442		749,442	21,144.00	35.44	40
41	Medical Records & Medical Records Library		516,964		516,964	23,793.00	21.73	41
42	Social Service		399,577		399,577	8,571.00	46.62	42
43	Other General Service							43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)		19,760,565		19,760,565	712,466.00	27.74	1
2	Excluded area salaries (see instructions)		2,050,606		2,050,606	50,688.25	40.46	2
3	Subtotal salaries (line 1 minus line 2)		17,709,959		17,709,959	661,777.75	26.76	3
4	Subtotal other wages & related costs (see instructions)		1,014,797		1,014,797	12,797.00	79.30	4
5	Subtotal wage-related costs (see instructions)		2,469,406		2,469,406		13.94%	5
6	Total (sum of lines 3 through 5)		21,194,162		21,194,162	674,574.75	31.42	6
7	Total overhead cost (see instructions)		7,485,934		7,485,934	260,499.50	28.74	7

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions	18,299	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)	1,121,470	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	47,096	10
11	Life Insurance (If employee is owner or beneficiary)	13,150	11
12	Accident Insurance (If employee is owner or beneficiary)	1,644	12
13	Disability Insurance (If employee is owner or beneficiary)	86,316	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	151,545	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	1,496,646	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	53,826	20
	<b>OTHER</b>		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	20,432	23
24	Total Wage Related cost (Sum of lines 1-23)	3,010,424	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	Supporting Exhibit for Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

<b>STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>			
1	Wage Index Fiscal Year Ending Date		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)		2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)		5
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)</b>			
6	Effective Date of Pension Plan		6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date		7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)		8

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

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable		9
10	Ending Date of Averaging Period from Line 5		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	<b>DEPOSIT DATE(S)</b>	<b>CONTRIBUTION(S)</b> 11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)		12
13	Total Contributions Made During Averaging Period		13
14	Average Monthly Contribution (Line 13 divided by Line 12)		14
15	Number of MOonths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	635,690	2,587,125	1
2	Hospital	635,690	2,587,125	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA**

**WORKSHEET S-5**

**RENAL DIALYSIS STATISTICS**

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

**ESRD PPS**

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

**TRANSPLANT INFORMATION**

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

**EPOETIN**

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

**ARANESP**

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

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

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

# KPMG LLP Compu-Max 2552-10

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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## HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

### Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.335763	1
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### Medicaid (see instructions for each line)

2	Net revenue from Medicaid		14,351,557	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid			5
6	Medicaid charges		22,620,650	6
7	Medicaid cost (line 1 times line 6)		7,595,177	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.			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)		1,569,575	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		3,317,393	14
15	State or local indigent care program cost (line 1 times line 14)		1,113,858	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16

### Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care			17
18	Government grants, appropriations of transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)
		1	2	3
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,117,581		2,117,581
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	711,005		711,005
22	Partial payment by patients approved for charity care			22
23	Cost of charity care (line 21 minus line 22)	711,005		711,005
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
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)			25
26	Total bad debt expense for the entire hospital complex (see instructions)			2,763,737
27	Medicare bad debts for the entire hospital complex (see instructions)			639,812
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			2,123,925
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			713,135
30	Cost of uncompensated care (line 23, column 3 plus line 29)			1,424,140
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,424,140

**KPMG LLP Compu-Max 2552-10**

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

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		4,917,508	4,917,508	-1,572,217	3,345,291	-799,009	2,546,282	1
2	00200	Cap Rel Costs-Mvble Equip				2,701,987	2,701,987		2,701,987	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	86,625	3,055,561	3,142,186		3,142,186		3,142,186	4
5	00500	Administrative & General	3,966,000	9,191,393	13,157,393	-252,967	12,904,426	-375,288	12,529,138	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	451,579	1,647,804	2,099,383		2,099,383	-109	2,099,274	7
8	00800	Laundry & Linen Service				195,199	195,199		195,199	8
9	00900	Housekeeping		674,909	674,909		674,909		674,909	9
10	01000	Dietary	493,554	851,605	1,345,159	-296,619	1,048,540		1,048,540	10
11	01100	Cafeteria				296,619	296,619	-100,464	196,155	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	503,696	44,237	547,933		547,933	-5,108	542,825	13
14	01400	Central Services & Supply	77,940	205,807	283,747	-144,037	139,710		139,710	14
15	01500	Pharmacy	749,442	4,510,969	5,260,411	-4,238,365	1,022,046		1,022,046	15
16	01600	Medical Records & Library	516,964	455,354	972,318		972,318	-5,135	967,183	16
17	01700	Social Service	399,577	32,655	432,232		432,232	-59,732	372,500	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
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	4,048,150	889,848	4,937,998	-209,786	4,728,212	-21,415	4,706,797	30
31	03100	Intensive Care Unit	750,990	176,316	927,306	-52,366	874,940	-6,080	868,860	31
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	881,595	2,303,534	3,185,129	-1,043,941	2,141,188	-153,976	1,987,212	50
53	05300	Anesthesiology		580,310	580,310	-35,419	544,891	-526,650	18,241	53
54	05400	Radiology-Diagnostic	769,543	694,001	1,463,544	-82,967	1,380,577		1,380,577	54
54.01	03630	ULTRASOUND	163,493	9,290	172,783	-2,988	169,795		169,795	54.01
60	06000	Laboratory	1,128,792	1,962,747	3,091,539	-7,289	3,084,250	-18,849	3,065,401	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	642,621	120,262	762,883	-41,036	721,847	-15,729	706,118	65
66	06600	Physical Therapy		153,926	153,926		153,926		153,926	66
69	06900	Electrocardiology	77,181	20,831	98,012	-2,584	95,428		95,428	69
69.01	03140	CARDIAC CATH LAB	6,706	82,009	88,715	-48,222	40,493		40,493	69.01
70.01	07001	SLEEP LAB								70.01
71	07100	Medical Supplies Charged to Patients				1,509,219	1,509,219		1,509,219	71
72	07200	Impl. Dev. Charged to Patients				518,211	518,211		518,211	72
73	07300	Drugs Charged to Patients				4,197,061	4,197,061		4,197,061	73
74	07400	Renal Dialysis		207,807	207,807		207,807		207,807	74
75	07500	ASC (Non-Distinct Part)	448,345	57,445	505,790	-22,647	483,143	-1,098	482,045	75
75.01	03480	ONCOLOGY	276,878	121,953	398,831	-37,578	361,253		361,253	75.01
75.02	03340	GI LAB		197,980	197,980	-117,372	80,608		80,608	75.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	09000	Clinic	1,275,752	95,456	1,371,208	-7,738	1,363,470	-774,342	589,128	90
90.01	09001	WOUND CARE CENTER	68,868	30,270	99,138	-27,970	71,168		71,168	90.01
91	09100	Emergency	1,461,842	757,116	2,218,958	-102,186	2,116,772	-1,472,834	643,938	91
92	09200	Observation Beds (Non-Distinct Part)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
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
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	Interest Expense		1,072,002	1,072,002	-1,072,002				113
118		SUBTOTALS (sum of lines 1-117)	19,246,133	35,120,905	54,367,038		54,367,038	-4,335,818	50,031,220	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190.01	19001	SENIOR HEALTH								190.01
192	19200	Physicians' Private Offices	1,507,909	1,726,395	3,234,304		3,234,304		3,234,304	192
192.01	19201	RETAIL PHARMACY	143,543	1,156,477	1,300,020		1,300,020		1,300,020	192.01
192.02	19202	CHA SITES	247,890	24,183	272,073		272,073		272,073	192.02
192.03	19203	OTHER NON REIMBURSABLE		59,948	59,948		59,948		59,948	192.03
194	07950	SENIOR HEALTH	151,264	1,478	152,742		152,742		152,742	194
200		TOTAL (sum of lines 118-199)	21,296,739	38,089,386	59,386,125		59,386,125	-4,335,818	55,050,307	200

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	DEPRECIATION GL CC 8850-8581	1		3			
			2				
500	Total reclassifications	A	Cap Rel Costs-Mvble Equip	2		2,701,987	1
	Code Letter - A						500
1	INSURANCE	B	Cap Rel Costs-Bldg & Fixt	1		57,768	1
500	Total reclassifications					57,768	500
	Code Letter - B						
1	DRUGS CHARGED	C	Drugs Charged to Patients	73		4,197,061	1
500	Total reclassifications					4,197,061	500
	Code Letter - C						
1	SUPPLIES CHARGED	D	Medical Supplies Charged to P	71		1,509,219	1
2			Impl. Dev. Charged to Patient	72		518,211	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
500	Total reclassifications					2,027,430	500
	Code Letter - D						
1	CAFETERIA COSTS	E	Cafeteria	11	108,833	187,786	1
500	Total reclassifications				108,833	187,786	500
	Code Letter - E						
1	INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		1,072,002	1
500	Total reclassifications					1,072,002	500
	Code Letter - F						
1	LAUNDRY EXP	I	Laundry & Linen Service	8		195,199	1
500	Total reclassifications					195,199	500
	Code Letter - I						
	<b>GRAND TOTAL (Increases)</b>				108,833	10,439,233	

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

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION GL CC 8850-8581	A	Cap Rel Costs-Bldg & Fixt	1		2,701,987	9	1
500	Total reclassifications					2,701,987		500
	Code letter - A							
1	INSURANCE	B	Administrative & General	5		57,768	12	1
500	Total reclassifications					57,768		500
	Code letter - B							
1	DRUGS CHARGED	C	Pharmacy	15		4,197,061		1
500	Total reclassifications					4,197,061		500
	Code letter - C							
1	SUPPLIES CHARGED	D	Central Services & Supply	14		144,037		1
2			Pharmacy	15		41,304		2
3			Adults & Pediatrics	30		209,786		3
4			Intensive Care Unit	31		52,366		4
5			Operating Room	50		1,043,941		5
6			Anesthesiology	53		35,419		6
7			Radiology-Diagnostic	54		82,967		7
8			ULTRASOUND	54.01		2,988		8
9			Laboratory	60		7,289		9
10			Respiratory Therapy	65		41,036		10
11			Electrocardiology	69		2,584		11
12			CARDIAC CATH LAB	69.01		48,222		12
13			ASC (Non-Distinct Part)	75		22,647		13
14			ONCOLOGY	75.01		37,578		14
15			GI LAB	75.02		117,372		15
16			Clinic	90		7,738		16
17			WOUND CARE CENTER	90.01		27,970		17
18			Emergency	91		102,186		18
500	Total reclassifications					2,027,430		500
	Code letter - D							
1	CAFETERIA COSTS	E	Dietary	10	108,833	187,786		1
500	Total reclassifications				108,833	187,786		500
	Code letter - E							
1	INTEREST	F	Interest Expense	113		1,072,002	11	1
500	Total reclassifications					1,072,002		500
	Code letter - F							
1	LAUNDRY EXP	I	Administrative & General	5		195,199		1
500	Total reclassifications					195,199		500
	Code letter - I							
	GRAND TOTAL (Decreases)				108,833	10,439,233		

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

**KPMG LLP Compu-Max 2552-10**

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**RECONCILIATION OF CAPITAL COST CENTERS**

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

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	13,334,216					13,334,216		1
2	Land Improvements	1,464,958	56,850		56,850		1,521,808		2
3	Buildings and Fixtures	42,094,840				5,729,409	36,365,431		3
4	Building Improvements	22,315,136	1,739,795		1,739,795		24,054,931		4
5	Fixed Equipment	5,807,685	4,216,449		4,216,449		10,024,134		5
6	Movable Equipment	24,593,886	346,014		346,014		24,939,900		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	109,610,721	6,359,108		6,359,108	5,729,409	110,240,420		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	109,610,721	6,359,108		6,359,108	5,729,409	110,240,420		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	4,917,508						4,917,508	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	4,917,508						4,917,508	3	

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

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

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	71,682,620		71,682,620	0.744549					1
2	Cap Rel Costs-Mvble Equip	24,593,886		24,593,886	0.255451					2
3	Total (sum of lines 1-2)	96,276,506		96,276,506	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	2,215,521		272,993	57,768			2,546,282	1	
2	Cap Rel Costs-Mvble Equip	2,701,987						2,701,987	2	
3	Total (sum of lines 1-2)	4,917,508		272,993	57,768			5,248,269	3	

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

**KPMG LLP Compu-Max 2552-10**

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
1	Investment income-buildings & fixtures (chapter 2)	B	-766,587	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)	B	-153	Administrative & General	5		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)	A	-17,488	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-3,062,993				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-98,537	Cafeteria	11		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	B	-5,135	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-1,927	Cafeteria	11		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							33
34	PHY PRACTICE REIMB INCOME	B	-1,159	Administrative & General	5		34
35							35
36							36
37							37
38							38
39							39
40	1985 SERIES E BOND INTEREST	A	-32,422	Cap Rel Costs-Bldg & Fixt	1	11	40
41	HOSPITALITY EXP	A	-94,639	Administrative & General	5		41
41.01	HOSPITALITY EXP	A	-2,554	Nursing Administration	13		41.01
41.03	HOSPITALITY EXP	A	-125	Laboratory	60		41.03
41.05	HOSPITALITY EXP	A	-477	Clinic	90		41.05
41.06	HOSPITALITY EXP	A	-109	Operation of Plant	7		41.06
41.07	HOSPITALITY EXP	A	-2,554	Nursing Administration	13		41.07
41.08	HOSPITALITY EXP	A	-1,098	ASC (Non-Distinct Part)	75		41.08
42							42
42.01	LDUES -LOBBYING PORTION	A	-17,790	Administrative & General	5		42.01
42.02	MARKETING EXP	A	-154,718	Administrative & General	5		42.02
42.03	MEDICARE PREMIUM FOR RETIRED EM	A	-3,776	Administrative & General	5		42.03
43	DONATION	A	-2,500	Administrative & General	5		43
44	ADVERTISING EXP	A	-67,729	Administrative & General	5		44
44.02	ADVERTISING EXP	A	-1,348	Adults & Pediatrics	30		44.02
45							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)		-4,335,818				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1  
(2) Basis for adjustment (see instructions)

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

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

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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**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								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

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

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

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

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

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

(1) Use the following symbols to indicate the interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial Or non-financial) specify:

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**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	4	Employee Benefits De								1
2	5	Administrative & Gen	40,042	44	39,998	177,200	290	24,706	1,235	2
3										3
4	16	Medical Records & Li								4
5										5
6	17	Social Service	159,066		159,066	177,200	1,166	99,334	4,967	6
7										7
8	30	Adults & Pediatrics	54,400		54,400	177,200	403	34,333	1,717	8
9	31	Intensive Care Unit	14,088		14,088	177,200	94	8,008	400	9
10	50	Operating Room	156,958	152,240	4,718	177,200	35	2,982	149	10
11										11
12	53	Anesthesiology	526,650	526,650						12
13										13
14										14
15										15
16	60	Laboratory	43,345		43,345	177,200	289	24,621	1,231	16
17										17
18	65	Respiratory Therapy	28,593		28,593	177,200	151	12,864	643	18
19										19
20	75	ASC (Non-Distinct Pa								20
22	90	Clinic	773,865	773,865						22
24	91	Emergency	1,472,834	1,472,834						24
200		TOTAL	3,269,841	2,925,633	344,208		2,428	206,848	10,342	200

**KPMG LLP Compu-Max 2552-10**

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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	4	Employee Benefits De	AGGREGATE							1
2	5	Administrative & Gen	AGGREGATE				24,706	15,292	15,336	2
3										3
4	16	Medical Records & Li	AGGREGATE							4
5										5
6	17	Social Service	AGGREGATE				99,334	59,732	59,732	6
7										7
8	30	Adults & Pediatrics	AGGREGATE				34,333	20,067	20,067	8
9	31	Intensive Care Unit	AGGREGATE				8,008	6,080	6,080	9
10	50	Operating Room	AGGREGATE				2,982	1,736	153,976	10
11										11
12	53	Anesthesiology	AGGREGATE						526,650	12
13										13
14										14
15										15
16	60	Laboratory	AGGREGATE				24,621	18,724	18,724	16
17										17
18	65	Respiratory Therapy	AGGREGATE				12,864	15,729	15,729	18
19										19
20	75	ASC (Non-Distinct Pa	AGGREGATE							20
22	90	Clinic	AGGREGATE						773,865	22
24	91	Emergency	AGGREGATE						1,472,834	24
200		TOTAL					206,848	137,360	3,062,993	200

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt	2,546,282	2,546,282					1
2	Cap Rel Costs-Mvble Equip	2,701,987		2,701,987				2
4	Employee Benefits Department	3,142,186	4,270	4,531	3,150,987			4
5	Administrative & General	12,529,138	139,939	148,496	596,736	13,414,309	13,414,309	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,099,274	1,002,521	1,063,829	67,628	4,233,252	1,363,873	7
8	Laundry & Linen Service	195,199				195,199	62,889	8
9	Housekeeping	674,909	6,656	7,063	422	689,050	221,999	9
10	Dietary	1,048,540	62,138	65,938	56,532	1,233,148	397,297	10
11	Cafeteria	196,155	19,658	20,860	17,882	254,555	82,013	11
12	Maintenance of Personnel							12
13	Nursing Administration	542,825	3,264	3,464	77,860	627,413	202,141	13
14	Central Services & Supply	139,710	65,613	69,625	11,967	286,915	92,439	14
15	Pharmacy	1,022,046	10,058	10,673	87,615	1,130,392	364,191	15
16	Medical Records & Library	967,183	25,098	26,633	83,094	1,102,008	355,046	16
17	Social Service	372,500			70,121	442,621	142,604	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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	Adults & Pediatrics	4,706,797	260,887	276,840	656,421	5,900,945	1,901,155	30
31	Intensive Care Unit	868,860	29,131	30,912	112,234	1,041,137	335,435	31
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	1,987,212	68,136	72,303	149,126	2,276,777	733,534	50
53	Anesthesiology	18,241	2,953	3,134		24,328	7,838	53
54	Radiology-Diagnostic	1,380,577	73,768	78,279	121,699	1,654,323	532,991	54
54.01	ULTRASOUND	169,795	2,057	2,183	26,075	200,110	64,472	54.01
60	Laboratory	3,065,401	39,783	42,215	154,975	3,302,374	1,063,962	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	706,118	27,457	29,136	87,941	850,652	274,064	65
66	Physical Therapy	153,926	23,718	25,168		202,812	65,342	66
69	Electrocardiology	95,428			16,426	111,854	36,037	69
69.01	CARDIAC CATH LAB	40,493	14,172	15,039	10,698	80,402	25,904	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	1,509,219				1,509,219	486,242	71
72	Impl. Dev. Charged to Patients	518,211				518,211	166,958	72
73	Drugs Charged to Patients	4,197,061				4,197,061	1,352,213	73
74	Renal Dialysis	207,807	640	679		209,126	67,376	74
75	ASC (Non-Distinct Part)	482,045	74,902	79,482	71,850	708,279	228,194	75
75.01	ONCOLOGY	361,253	27,430	29,107	42,176	459,966	148,192	75.01
75.02	GI LAB	80,608	16,440	17,445		114,493	36,887	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	589,128	63,537	67,422	185,202	905,289	291,667	90
90.01	WOUND CARE CENTER	71,168	7,772	8,247	11,507	98,694	31,797	90.01
91	Emergency	643,938	45,900	48,706	216,015	954,559	307,541	91
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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
<b>SPECIAL PURPOSE COST CENTERS</b>								
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	50,031,220	2,117,898	2,247,409	2,932,202	48,929,473	11,442,293	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	3,234,304	24,815	26,332	157,134	3,442,585	1,109,135	192
192.01	RETAIL PHARMACY	1,300,020	12,435	13,195	12,878	1,338,528	431,248	192.01
192.02	CHA SITES	272,073	391,134	415,051	23,327	1,101,585	354,910	192.02
192.03	OTHER NON REIMBURSABLE	59,948				59,948	19,314	192.03
194	SENIOR HEALTH	152,742			25,446	178,188	57,409	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	55,050,307	2,546,282	2,701,987	3,150,987	55,050,307	13,414,309	202

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	5,597,125						7
8	Laundry & Linen Service		258,088					8
9	Housekeeping	26,620		937,669				9
10	Dietary	248,504		38,408	1,917,357			10
11	Cafeteria	78,617		12,151		427,336		11
12	Maintenance of Personnel							12
13	Nursing Administration	13,054		2,018		9,027	853,653	13
14	Central Services & Supply	262,400		40,556		4,969		14
15	Pharmacy	40,223		6,217		16,845		15
16	Medical Records & Library	100,374		15,514		18,949		16
17	Social Service					6,824	24,999	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	1,043,345	184,642	237,965	1,884,901	137,442	503,491	30
31	Intensive Care Unit	116,500	7,295	18,006	32,456	18,700	68,503	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	272,492	35,557	42,115		21,615	79,182	50
53	Anesthesiology	11,811		1,825				53
54	Radiology-Diagnostic	295,017	20,047	45,597		18,982		54
54.01	ULTRASOUND	8,227		1,272		6,062		54.01
60	Laboratory	159,100		24,590		33,723		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	109,808		16,972		19,909		65
66	Physical Therapy	94,853		14,660				66
69	Electrocardiology					2,021		69
69.01	CARDIAC CATH LAB	56,678		8,760		215		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	2,560		396				74
75	ASC (Non-Distinct Part)	299,551	9,980	46,298		10,253	37,559	75
75.01	ONCOLOGY	109,699		16,955		8,365	30,641	75.01
75.02	GI LAB	65,746		10,162				75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	254,099		39,273		28,688		90
90.01	WOUND CARE CENTER	31,081		4,804		1,971	7,220	90.01
91	Emergency	183,563	567	28,371		22,427	82,156	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	3,883,922	258,088	672,885	1,917,357	386,987	833,751	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	99,241		15,338		26,700		192
192.01	RETAIL PHARMACY	49,730		7,686		4,572		192.01
192.02	CHA SITES	1,564,232		241,760		6,957	19,902	192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					2,120		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,597,125	258,088	937,669	1,917,357	427,336	853,653	202

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS
		14	15	16	17	24	25
	<b>GENERAL SERVICE COST CENTERS</b>						
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	687,279					14
15	Pharmacy		1,557,868				15
16	Medical Records & Library			1,591,891			16
17	Social Service				617,048		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics		9,168	295,772	370,228	12,469,054	30
31	Intensive Care Unit		2,918	37,021	123,410	1,801,381	31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room		9,241	35,883		3,506,396	50
53	Anesthesiology		4,633	19,424		69,859	53
54	Radiology-Diagnostic		17,521	200,885		2,785,363	54
54.01	ULTRASOUND			31,956		312,099	54.01
60	Laboratory			259,805		4,843,554	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy			39,998		1,311,403	65
66	Physical Therapy			2,798		380,465	66
69	Electrocardiology		151	29,735		179,798	69
69.01	CARDIAC CATH LAB		1,734	6,753		180,446	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	511,611		71,572		2,578,644	71
72	Impl. Dev. Charged to Patients	175,668		34,596		895,433	72
73	Drugs Charged to Patients		1,174,530	355,371		7,079,175	73
74	Renal Dialysis			6,002		285,460	74
75	ASC (Non-Distinct Part)		710	21,501		1,362,325	75
75.01	ONCOLOGY		1,650	41,887	61,705	879,060	75.01
75.02	GI LAB		75	17,361		244,724	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic		6,140	31,876		1,557,032	90
90.01	WOUND CARE CENTER		123	5,265		180,955	90.01
91	Emergency		1,892	46,430	61,705	1,689,211	91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	687,279	1,230,486	1,591,891	617,048	44,591,837	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices		42,818			4,735,817	192
192.01	RETAIL PHARMACY		284,179			2,115,943	192.01
192.02	CHA SITES		385			3,289,731	192.02
192.03	OTHER NON REIMBURSABLE					79,262	192.03
194	SENIOR HEALTH					237,717	194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	687,279	1,557,868	1,591,891	617,048	55,050,307	202

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	<b>GENERAL SERVICE COST CENTERS</b>						
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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	12,469,054					30
31	Intensive Care Unit	1,801,381					31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	3,506,396					50
53	Anesthesiology	69,859					53
54	Radiology-Diagnostic	2,785,363					54
54.01	ULTRASOUND	312,099					54.01
60	Laboratory	4,843,554					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,311,403					65
66	Physical Therapy	380,465					66
69	Electrocardiology	179,798					69
69.01	CARDIAC CATH LAB	180,446					69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	2,578,644					71
72	Impl. Dev. Charged to Patients	895,433					72
73	Drugs Charged to Patients	7,079,175					73
74	Renal Dialysis	285,460					74
75	ASC (Non-Distinct Part)	1,362,325					75
75.01	ONCOLOGY	879,060					75.01
75.02	GI LAB	244,724					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	1,557,032					90
90.01	WOUND CARE CENTER	180,955					90.01
91	Emergency	1,689,211					91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	44,591,837					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	4,735,817					192
192.01	RETAIL PHARMACY	2,115,943					192.01
192.02	CHA SITES	3,289,731					192.02
192.03	OTHER NON REIMBURSABLE	79,262					192.03
194	SENIOR HEALTH	237,717					194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	55,050,307					202

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		4,270	4,531	8,801	8,801		4
5	Administrative & General		139,939	148,496	288,435	1,669	290,104	5
6	Maintenance & Repairs							6
7	Operation of Plant		1,002,521	1,063,829	2,066,350	189	29,497	7
8	Laundry & Linen Service						1,360	8
9	Housekeeping		6,656	7,063	13,719	1	4,801	9
10	Dietary		62,138	65,938	128,076	158	8,593	10
11	Cafeteria		19,658	20,860	40,518	50	1,774	11
12	Maintenance of Personnel							12
13	Nursing Administration		3,264	3,464	6,728	218	4,372	13
14	Central Services & Supply		65,613	69,625	135,238	33	1,999	14
15	Pharmacy		10,058	10,673	20,731	245	7,877	15
16	Medical Records & Library		25,098	26,633	51,731	232	7,679	16
17	Social Service					196	3,084	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics		260,887	276,840	537,727	1,827	41,102	30
31	Intensive Care Unit		29,131	30,912	60,043	314	7,255	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		68,136	72,303	140,439	417	15,865	50
53	Anesthesiology		2,953	3,134	6,087		170	53
54	Radiology-Diagnostic		73,768	78,279	152,047	340	11,527	54
54.01	ULTRASOUND		2,057	2,183	4,240	73	1,394	54.01
60	Laboratory		39,783	42,215	81,998	433	23,011	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		27,457	29,136	56,593	246	5,927	65
66	Physical Therapy		23,718	25,168	48,886		1,413	66
69	Electrocardiology					46	779	69
69.01	CARDIAC CATH LAB		14,172	15,039	29,211	30	560	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients						10,516	71
72	Impl. Dev. Charged to Patients						3,611	72
73	Drugs Charged to Patients						29,245	73
74	Renal Dialysis		640	679	1,319		1,457	74
75	ASC (Non-Distinct Part)		74,902	79,482	154,384	201	4,935	75
75.01	ONCOLOGY		27,430	29,107	56,537	118	3,205	75.01
75.02	GI LAB		16,440	17,445	33,885		798	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		63,537	67,422	130,959	518	6,308	90
90.01	WOUND CARE CENTER		7,772	8,247	16,019	32	688	90.01
91	Emergency		45,900	48,706	94,606	604	6,651	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		2,117,898	2,247,409	4,365,307	8,190	247,453	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		24,815	26,332	51,147	439	23,988	192
192.01	RETAIL PHARMACY		12,435	13,195	25,630	36	9,327	192.01
192.02	CHA SITES		391,134	415,051	806,185	65	7,676	192.02
192.03	OTHER NON REIMBURSABLE						418	192.03
194	SENIOR HEALTH					71	1,242	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,546,282	2,701,987	5,248,269	8,801	290,104	202

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	2,096,036						7
8	Laundry & Linen Service		1,360					8
9	Housekeeping	9,969		28,490				9
10	Dietary	93,061		1,167	231,055			10
11	Cafeteria	29,441		369		72,152		11
12	Maintenance of Personnel							12
13	Nursing Administration	4,889		61		1,524	17,792	13
14	Central Services & Supply	98,265		1,232		839		14
15	Pharmacy	15,063		189		2,844		15
16	Medical Records & Library	37,589		471		3,199		16
17	Social Service					1,152	521	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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	390,717	973	7,230	227,144	23,206	10,494	30
31	Intensive Care Unit	43,627	38	547	3,911	3,157	1,428	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	102,044	187	1,280		3,650	1,650	50
53	Anesthesiology	4,423		55				53
54	Radiology-Diagnostic	110,479	106	1,385		3,205		54
54.01	ULTRASOUND	3,081		39		1,024		54.01
60	Laboratory	59,580		747		5,694		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41,122		516		3,361		65
66	Physical Therapy	35,521		445				66
69	Electrocardiology					341		69
69.01	CARDIAC CATH LAB	21,225		266		36		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	959		12				74
75	ASC (Non-Distinct Part)	112,177	53	1,407		1,731	783	75
75.01	ONCOLOGY	41,080		515		1,412	639	75.01
75.02	GI LAB	24,621		309				75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	95,156		1,193		4,844		90
90.01	WOUND CARE CENTER	11,639		146		333	150	90.01
91	Emergency	68,741	3	862		3,787	1,712	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,454,469	1,360	20,443	231,055	65,339	17,377	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	37,164		466		4,508		192
192.01	RETAIL PHARMACY	18,623		234		772		192.01
192.02	CHA SITES	585,780		7,347		1,175	415	192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					358		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,096,036	1,360	28,490	231,055	72,152	17,792	202

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	237,606						14
15	Pharmacy		46,949					15
16	Medical Records & Library			100,901				16
17	Social Service				4,953			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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics		276	18,744	2,972	1,262,412		30
31	Intensive Care Unit		88	2,346	991	123,745		31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		278	2,274		268,084		50
53	Anesthesiology		140	1,231		12,106		53
54	Radiology-Diagnostic		528	12,731		292,348		54
54.01	ULTRASOUND			2,025		11,876		54.01
60	Laboratory			16,465		187,928		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			2,535		110,300		65
66	Physical Therapy			177		86,442		66
69	Electrocardiology		5	1,884		3,055		69
69.01	CARDIAC CATH LAB		52	428		51,808		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	176,874		4,536		191,926		71
72	Impl. Dev. Charged to Patients	60,732		2,192		66,535		72
73	Drugs Charged to Patients		35,396	22,539		87,180		73
74	Renal Dialysis			380		4,127		74
75	ASC (Non-Distinct Part)		21	1,363		277,055		75
75.01	ONCOLOGY		50	2,655	495	106,706		75.01
75.02	GI LAB		2	1,100		60,715		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		185	2,020		241,183		90
90.01	WOUND CARE CENTER		4	334		29,345		90.01
91	Emergency		57	2,942	495	180,460		91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	237,606	37,082	100,901	4,953	3,655,336		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		1,290			119,002		192
192.01	RETAIL PHARMACY		8,565			63,187		192.01
192.02	CHA SITES		12			1,408,655		192.02
192.03	OTHER NON REIMBURSABLE					418		192.03
194	SENIOR HEALTH					1,671		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	237,606	46,949	100,901	4,953	5,248,269		202

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	<b>GENERAL SERVICE COST CENTERS</b>						
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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	1,262,412					30
31	Intensive Care Unit	123,745					31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	268,084					50
53	Anesthesiology	12,106					53
54	Radiology-Diagnostic	292,348					54
54.01	ULTRASOUND	11,876					54.01
60	Laboratory	187,928					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	110,300					65
66	Physical Therapy	86,442					66
69	Electrocardiology	3,055					69
69.01	CARDIAC CATH LAB	51,808					69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	191,926					71
72	Impl. Dev. Charged to Patients	66,535					72
73	Drugs Charged to Patients	87,180					73
74	Renal Dialysis	4,127					74
75	ASC (Non-Distinct Part)	277,055					75
75.01	ONCOLOGY	106,706					75.01
75.02	GI LAB	60,715					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	241,183					90
90.01	WOUND CARE CENTER	29,345					90.01
91	Emergency	180,460					91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	3,655,336					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	119,002					192
192.01	RETAIL PHARMACY	63,187					192.01
192.02	CHA SITES	1,408,655					192.02
192.03	OTHER NON REIMBURSABLE	418					192.03
194	SENIOR HEALTH	1,671					194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	5,248,269					202

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	278,485						1
2	Cap Rel Costs-Mvble Equip		278,485					2
4	Employee Benefits Department	467	467	20,730,541				4
5	Administrative & General	15,305	15,305	3,925,969	-13,414,309	41,635,998		5
6	Maintenance & Repairs							6
7	Operation of Plant	109,645	109,645	444,932		4,233,252	153,068	7
8	Laundry & Linen Service					195,199		8
9	Housekeeping	728	728	2,775		689,050	728	9
10	Dietary	6,796	6,796	371,926		1,233,148	6,796	10
11	Cafeteria	2,150	2,150	117,645		254,555	2,150	11
12	Maintenance of Personnel							12
13	Nursing Administration	357	357	512,247		627,413	357	13
14	Central Services & Supply	7,176	7,176	78,730		286,915	7,176	14
15	Pharmacy	1,100	1,100	576,429		1,130,392	1,100	15
16	Medical Records & Library	2,745	2,745	546,680		1,102,008	2,745	16
17	Social Service			461,330		442,621		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	28,533	28,533	4,318,617		5,900,945	28,533	30
31	Intensive Care Unit	3,186	3,186	738,393		1,041,137	3,186	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,452	7,452	981,111		2,276,777	7,452	50
53	Anesthesiology	323	323			24,328	323	53
54	Radiology-Diagnostic	8,068	8,068	800,668		1,654,323	8,068	54
54.01	ULTRASOUND	225	225	171,548		200,110	225	54.01
60	Laboratory	4,351	4,351	1,019,590		3,302,374	4,351	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,003	3,003	578,568		850,652	3,003	65
66	Physical Therapy	2,594	2,594			202,812	2,594	66
69	Electrocardiology			108,069		111,854		69
69.01	CARDIAC CATH LAB	1,550	1,550	70,380		80,402	1,550	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients					1,509,219		71
72	Impl. Dev. Charged to Patients					518,211		72
73	Drugs Charged to Patients					4,197,061		73
74	Renal Dialysis	70	70			209,126	70	74
75	ASC (Non-Distinct Part)	8,192	8,192	472,705		708,279	8,192	75
75.01	ONCOLOGY	3,000	3,000	277,481		459,966	3,000	75.01
75.02	GI LAB	1,798	1,798			114,493	1,798	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	6,949	6,949	1,218,456		905,289	6,949	90
90.01	WOUND CARE CENTER	850	850	75,707		98,694	850	90.01
91	Emergency	5,020	5,020	1,421,179		954,559	5,020	91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	231,633	231,633	19,291,135	-13,414,309	35,515,164	106,216	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	2,714	2,714	1,033,798		3,442,585	2,714	192
192.01	RETAIL PHARMACY	1,360	1,360	84,726		1,338,528	1,360	192.01
192.02	CHA SITES	42,778	42,778	153,471		1,101,585	42,778	192.02
192.03	OTHER NON REIMBURSABLE					59,948		192.03
194	SENIOR HEALTH			167,411		178,188		194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,546,282	2,701,987	3,150,987		13,414,309	5,597,125	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.143336	9.702451	0.151997		0.322181	36.566265	203
204	Cost to be allocated (Per Wkst. B, Part II)			8,801		290,104	2,096,036	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000425		0.006968	13.693496	205

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINISTRATION DIRECT NRSNG HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	<b>GENERAL SERVICE COST CENTERS</b>							
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	355,339						8
9	Housekeeping		165,913					9
10	Dietary		6,796	86,250				10
11	Cafeteria		2,150		25,800			11
12	Maintenance of Personnel							12
13	Nursing Administration		357		545	14,069		13
14	Central Services & Supply		7,176		300		2,027,430	14
15	Pharmacy		1,100		1,017			15
16	Medical Records & Library		2,745		1,144			16
17	Social Service				412	412		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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	254,217	42,106	84,790	8,298	8,298		30
31	Intensive Care Unit	10,044	3,186	1,460	1,129	1,129		31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	48,956	7,452		1,305	1,305		50
53	Anesthesiology		323					53
54	Radiology-Diagnostic	27,601	8,068		1,146			54
54.01	ULTRASOUND		225		366			54.01
60	Laboratory		4,351		2,036			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,003		1,202			65
66	Physical Therapy		2,594					66
69	Electrocardiology				122			69
69.01	CARDIAC CATH LAB		1,550		13			69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients						1,509,219	71
72	Impl. Dev. Charged to Patients						518,211	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		70					74
75	ASC (Non-Distinct Part)	13,740	8,192		619	619		75
75.01	ONCOLOGY		3,000		505	505		75.01
75.02	GI LAB		1,798					75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		6,949		1,732			90
90.01	WOUND CARE CENTER		850		119	119		90.01
91	Emergency	781	5,020		1,354	1,354		91
92	Observation Beds (Non-Distinct Part)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	355,339	119,061	86,250	23,364	13,741	2,027,430	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		2,714		1,612			192
192.01	RETAIL PHARMACY		1,360		276			192.01
192.02	CHA SITES		42,778		420	328		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH				128			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	258,088	937,669	1,917,357	427,336	853,653	687,279	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.726315	5.651570	22.230226	16.563411	60.676167	0.338990	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,360	28,490	231,055	72,152	17,792	237,606	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.003827	0.171717	2.678899	2.796589	1.264624	0.117196	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE				
	COSTED REQUIS.	GROSS REVENUE	TIME SPENT				
	15	16	17				

<b>GENERAL SERVICE COST CENTERS</b>							
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	5,566,873					15
16	Medical Records & Library		131,701,233				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
<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	32,761	24,470,287	60			30
31	Intensive Care Unit	10,426	3,062,917	20			31
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	33,021	2,968,722				50
53	Anesthesiology	16,556	1,607,013				53
54	Radiology-Diagnostic	62,608	16,619,958				54
54.01	ULTRASOUND		2,643,794				54.01
60	Laboratory		21,494,618				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		3,309,174				65
66	Physical Therapy		231,527				66
69	Electrocardiology	538	2,460,122				69
69.01	CARDIAC CATH LAB	6,195	558,664				69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients		5,921,431				71
72	Impl. Dev. Charged to Patients		2,862,263				72
73	Drugs Charged to Patients	4,197,061	29,399,433				73
74	Renal Dialysis		496,600				74
75	ASC (Non-Distinct Part)	2,538	1,778,845				75
75.01	ONCOLOGY	5,896	3,465,428	10			75.01
75.02	GI LAB	269	1,436,351				75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	21,939	2,637,191				90
90.01	WOUND CARE CENTER	439	435,594				90.01
91	Emergency	6,762	3,841,301	10			91
92	Observation Beds (Non-Distinct Part)						92
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	4,397,009	131,701,233	100			118
<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	153,006					192
192.01	RETAIL PHARMACY	1,015,484					192.01
192.02	CHA SITES	1,374					192.02
192.03	OTHER NON REIMBURSABLE						192.03
194	SENIOR HEALTH						194
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	1,557,868	1,591,891	617,048			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.279846	0.012087	6,170.480000			203
204	Cost to be allocated (Per Wkst. B, Part II)	46,949	100,901	4,953			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.008434	0.000766	49.530000			205

**KPMG LLP Compu-Max 2552-10**

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

**KPMG LLP Compu-Max 2552-10**

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C  
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics	12,469,054		12,469,054	20,067	12,489,121	30
31	Intensive Care Unit	1,801,381		1,801,381	6,080	1,807,461	31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	3,506,396		3,506,396	1,736	3,508,132	50
53	Anesthesiology	69,859		69,859		69,859	53
54	Radiology-Diagnostic	2,785,363		2,785,363		2,785,363	54
54.01	ULTRASOUND	312,099		312,099		312,099	54.01
60	Laboratory	4,843,554		4,843,554	18,724	4,862,278	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,311,403		1,311,403	15,729	1,327,132	65
66	Physical Therapy	380,465		380,465		380,465	66
69	Electrocardiology	179,798		179,798		179,798	69
69.01	CARDIAC CATH LAB	180,446		180,446		180,446	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	2,578,644		2,578,644		2,578,644	71
72	Impl. Dev. Charged to Patients	895,433		895,433		895,433	72
73	Drugs Charged to Patients	7,079,175		7,079,175		7,079,175	73
74	Renal Dialysis	285,460		285,460		285,460	74
75	ASC (Non-Distinct Part)	1,362,325		1,362,325		1,362,325	75
75.01	ONCOLOGY	879,060		879,060		879,060	75.01
75.02	GI LAB	244,724		244,724		244,724	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	1,557,032		1,557,032		1,557,032	90
90.01	WOUND CARE CENTER	180,955		180,955		180,955	90.01
91	Emergency	1,689,211		1,689,211		1,689,211	91
92	Observation Beds (Non-Distinct Part)	478,220		478,220		478,220	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	45,070,057		45,070,057	62,336	45,132,393	200
201	Less Observation Beds	478,220		478,220		478,220	201
202	Total (line 200 minus line 201)	44,591,837		44,591,837		44,654,173	202

**KPMG LLP Compu-Max 2552-10**

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	24,470,287		24,470,287				30
31	Intensive Care Unit	3,062,917		3,062,917				31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	1,031,959	1,936,763	2,968,722	1.181113	1.181113	1.181698	50
53	Anesthesiology	470,332	1,136,681	1,607,013	0.043471	0.043471	0.043471	53
54	Radiology-Diagnostic	4,544,475	12,075,483	16,619,958	0.167591	0.167591	0.167591	54
54.01	ULTRASOUND	640,930	2,002,863	2,643,793	0.118050	0.118050	0.118050	54.01
60	Laboratory	7,972,035	13,522,584	21,494,619	0.225338	0.225338	0.226209	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,774,800	534,374	3,309,174	0.396293	0.396293	0.401046	65
66	Physical Therapy	221,858	9,669	231,527	1.643286	1.643286	1.643286	66
69	Electrocardiology	1,056,049	1,404,073	2,460,122	0.073085	0.073085	0.073085	69
69.01	CARDIAC CATH LAB	282,866	275,798	558,664	0.322996	0.322996	0.322996	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	2,598,049	3,323,382	5,921,431	0.435476	0.435476	0.435476	71
72	Impl. Dev. Charged to Patients	1,930,318	931,946	2,862,264	0.312841	0.312841	0.312841	72
73	Drugs Charged to Patients	11,649,538	17,749,895	29,399,433	0.240793	0.240793	0.240793	73
74	Renal Dialysis	482,275	14,325	496,600	0.574829	0.574829	0.574829	74
75	ASC (Non-Distinct Part)	307,076	1,471,769	1,778,845	0.765848	0.765848	0.765848	75
75.01	ONCOLOGY	534,088	2,931,340	3,465,428	0.253666	0.253666	0.253666	75.01
75.02	GI LAB	250,765	1,185,586	1,436,351	0.170379	0.170379	0.170379	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	4,776	2,632,415	2,637,191	0.590413	0.590413	0.590413	90
90.01	WOUND CARE CENTER	6,195	429,399	435,594	0.415421	0.415421	0.415421	90.01
91	Emergency	1,145,260	2,696,041	3,841,301	0.439750	0.439750	0.439750	91
92	Observation Beds (Non-Distinct Part)		1,106,402	1,106,402	0.432230	0.432230	0.432230	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	65,436,848	67,370,788	132,807,636				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	65,436,848	67,370,788	132,807,636				202

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D  
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,262,412		1,262,412	21,624	58.38	5,870	342,691	30
31	Intensive Care Unit	123,745		123,745	1,584	78.12	623	48,669	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)	1,386,157		1,386,157	23,208		6,493	391,360	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0115

WORKSHEET D  
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	268,084	2,968,722	0.090303	573,886	51,824	50
53	Anesthesiology	12,106	1,607,013	0.007533	171,215	1,290	53
54	Radiology-Diagnostic	292,348	16,619,958	0.017590	1,636,834	28,792	54
54.01	ULTRASOUND	11,876	2,643,793	0.004492	196,474	883	54.01
60	Laboratory	187,928	21,494,619	0.008743	3,057,959	26,736	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	110,300	3,309,174	0.033332	1,039,246	34,640	65
66	Physical Therapy	86,442	231,527	0.373356	66,880	24,970	66
69	Electrocardiology	3,055	2,460,122	0.001242	409,983	509	69
69.01	CARDIAC CATH LAB	51,808	558,664	0.092736	83,106	7,707	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	191,926	5,921,431	0.032412	955,530	30,971	71
72	Impl. Dev. Charged to Patients	66,535	2,862,264	0.023246	674,236	15,673	72
73	Drugs Charged to Patients	87,180	29,399,433	0.002965	4,309,786	12,779	73
74	Renal Dialysis	4,127	496,600	0.008311	198,640	1,651	74
75	ASC (Non-Distinct Part)	277,055	1,778,845	0.155750			75
75.01	ONCOLOGY	106,706	3,465,428	0.030792			75.01
75.02	GI LAB	60,715	1,436,351	0.042270	109,134	4,613	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	241,183	2,637,191	0.091455	877	80	90
90.01	WOUND CARE CENTER	29,345	435,594	0.067368			90.01
91	Emergency	180,460	3,841,301	0.046979	251,038	11,794	91
92	Observation Beds (Non-Distinct	48,339	1,106,402	0.043690			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	2,317,518	105,274,432		13,734,824	254,912	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	21,624		5,870		30
31	Intensive Care Unit	1,584		623		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)	23,208		6,493		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0115**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
75.01	ONCOLOGY							75.01
75.02	GI LAB							75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.01	WOUND CARE CENTER							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0115**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	2,968,722			573,886		564,313		50
53	Anesthesiology	1,607,013			171,215		184,927		53
54	Radiology-Diagnostic	16,619,958			1,636,834		2,875,808		54
54.01	ULTRASOUND	2,643,793			196,474		218,192		54.01
60	Laboratory	21,494,619			3,057,959		990,768		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	3,309,174			1,039,246		78,830		65
66	Physical Therapy	231,527			66,880				66
69	Electrocardiology	2,460,122			409,983		422,478		69
69.01	CARDIAC CATH LAB	558,664			83,106		85,828		69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	5,921,431			955,530		480,482		71
72	Impl. Dev. Charged to Patients	2,862,264			674,236		238,685		72
73	Drugs Charged to Patients	29,399,433			4,309,786		6,035,215		73
74	Renal Dialysis	496,600			198,640				74
75	ASC (Non-Distinct Part)	1,778,845							75
75.01	ONCOLOGY	3,465,428					387,210		75.01
75.02	GI LAB	1,436,351			109,134		165,192		75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	2,637,191			877		752,194		90
90.01	WOUND CARE CENTER	435,594							90.01
91	Emergency	3,841,301			251,038		226,870		91
92	Observation Beds (Non-Distinct)	1,106,402					236,392		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	105,274,432			13,734,824		13,943,384		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0115

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	1.181113	564,313			666,517			50
53	Anesthesiology	0.043471	184,927			8,039			53
54	Radiology-Diagnostic	0.167591	2,875,808			481,960			54
54.01	ULTRASOUND	0.118050	218,192			25,758			54.01
60	Laboratory	0.225338	990,768			223,258			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.396293	78,830			31,240			65
66	Physical Therapy	1.643286							66
69	Electrocardiology	0.073085	422,478			30,877			69
69.01	CARDIAC CATH LAB	0.322996	85,828			27,722			69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	0.435476	480,482			209,238			71
72	Impl. Dev. Charged to Patients	0.312841	238,685			74,670			72
73	Drugs Charged to Patients	0.240793	6,035,215		9,753	1,453,238		2,348	73
74	Renal Dialysis	0.574829							74
75	ASC (Non-Distinct Part)	0.765848							75
75.01	ONCOLOGY	0.253666	387,210			98,222			75.01
75.02	GI LAB	0.170379	165,192			28,145			75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	0.590413	752,194			444,105			90
90.01	WOUND CARE CENTER	0.415421							90.01
91	Emergency	0.439750	226,870			99,766			91
92	Observation Beds (Non-Distinct	0.432230	236,392			102,176			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		13,943,384		9,753	4,004,931		2,348	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		13,943,384		9,753	4,004,931		2,348	202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

Check  Title V  
 Applicable  Title XVIII, Part A  
 Boxes:  Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,262,412		1,262,412	21,624	58.38	8,973	523,844	30
31	Intensive Care Unit	123,745		123,745	1,584	78.12	577	45,075	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)	1,386,157		1,386,157	23,208		9,550	568,919	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0115

WORKSHEET D  
PART II

Check [ ] Title V [XX] Hospital [ ] SUB (Other)  
 Applicable [ ] Title XVIII, Part A [ ] IPF  
 Boxes: [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	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	268,084	2,968,722	0.090303	366,110	33,061	50
53	Anesthesiology	12,106	1,607,013	0.007533	106,425	802	53
54	Radiology-Diagnostic	292,348	16,619,958	0.017590	825,542	14,521	54
54.01	ULTRASOUND	11,876	2,643,793	0.004492			54.01
60	Laboratory	187,928	21,494,619	0.008743	1,869,764	16,347	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	110,300	3,309,174	0.033332	475,181	15,839	65
66	Physical Therapy	86,442	231,527	0.373356	19,414	7,248	66
69	Electrocardiology	3,055	2,460,122	0.001242	240,501	299	69
69.01	CARDIAC CATH LAB	51,808	558,664	0.092736	49,498	4,590	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	191,926	5,921,431	0.032412	764,997	24,795	71
72	Impl. Dev. Charged to Patients	66,535	2,862,264	0.023246			72
73	Drugs Charged to Patients	87,180	29,399,433	0.002965	1,455,388	4,315	73
74	Renal Dialysis	4,127	496,600	0.008311	35,430	294	74
75	ASC (Non-Distinct Part)	277,055	1,778,845	0.155750			75
75.01	ONCOLOGY	106,706	3,465,428	0.030792			75.01
75.02	GI LAB	60,715	1,436,351	0.042270	40,973	1,732	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	241,183	2,637,191	0.091455	3,899	357	90
90.01	WOUND CARE CENTER	29,345	435,594	0.067368			90.01
91	Emergency	180,460	3,841,301	0.046979	64,631	3,036	91
92	Observation Beds (Non-Distinct	48,339	1,106,402	0.043690			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	2,317,518	105,274,432		6,317,753	127,236	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

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

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6	7	8	9			
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	21,624		8,973		30
31	Intensive Care Unit	1,584		577		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)	23,208		9,550		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0115**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	ULTRASOUND							54.01
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
69.01	CARDIAC CATH LAB							69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
75.01	ONCOLOGY							75.01
75.02	GI LAB							75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic							90
90.01	WOUND CARE CENTER							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0115**

**WORKSHEET D  
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	2,968,722			366,110				50
53	Anesthesiology	1,607,013			106,425				53
54	Radiology-Diagnostic	16,619,958			825,542				54
54.01	ULTRASOUND	2,643,793							54.01
60	Laboratory	21,494,619			1,869,764				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	3,309,174			475,181				65
66	Physical Therapy	231,527			19,414				66
69	Electrocardiology	2,460,122			240,501				69
69.01	CARDIAC CATH LAB	558,664			49,498				69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	5,921,431			764,997				71
72	Impl. Dev. Charged to Patients	2,862,264							72
73	Drugs Charged to Patients	29,399,433			1,455,388				73
74	Renal Dialysis	496,600			35,430				74
75	ASC (Non-Distinct Part)	1,778,845							75
75.01	ONCOLOGY	3,465,428							75.01
75.02	GI LAB	1,436,351			40,973				75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	2,637,191			3,899				90
90.01	WOUND CARE CENTER	435,594							90.01
91	Emergency	3,841,301			64,631				91
92	Observation Beds (Non-Distinct	1,106,402							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	105,274,432			6,317,753				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0115

WORKSHEET D  
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	1.181113						50
53	Anesthesiology	0.043471						53
54	Radiology-Diagnostic	0.167591						54
54.01	ULTRASOUND	0.118050						54.01
60	Laboratory	0.225338						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.396293						65
66	Physical Therapy	1.643286						66
69	Electrocardiology	0.073085						69
69.01	CARDIAC CATH LAB	0.322996						69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Pat	0.435476						71
72	Impl. Dev. Charged to Patients	0.312841						72
73	Drugs Charged to Patients	0.240793						73
74	Renal Dialysis	0.574829						74
75	ASC (Non-Distinct Part)	0.765848						75
75.01	ONCOLOGY	0.253666						75.01
75.02	GI LAB	0.170379						75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	0.590413						90
90.01	WOUND CARE CENTER	0.415421						90.01
91	Emergency	0.439750						91
92	Observation Beds (Non-Distinct)	0.432230						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0115

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,624	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,624	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)	20,796	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,870	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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,489,121	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,489,121	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)	12,489,121	37

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0115**

**WORKSHEET D-1  
PART II**

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

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

38	Adjusted general inpatient routine service cost per diem (see instructions)					577.56	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,390,277	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)					3,390,277	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
	<b>Intensive Care Type Inpatient Hospital Units</b>						
43	Intensive Care Unit	1,807,461	1,584	1,141.07	623	710,887	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,166,844	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					8,268,008	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					391,360	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					254,912	51
52	Total Program excludable cost (sum of lines 50 and 51)					646,272	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					7,621,736	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

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

**PROGRAM INPATIENT ROUTINE SWING BED COST**

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

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0115

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					828	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					577.56	88
89	Observation bed cost (line 87 x line 88) (see instructions)					478,220	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,262,412	12,489,121	0.101081	478,220	48,339	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0115

WORKSHEET D-1  
PART I

Check [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS  
 Applicable [ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA  
 Boxes: [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)	21,624	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,624	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)	20,796	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,973	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		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,469,054	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,469,054	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)	12,469,054	37

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0115

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						576.63	38
39	Program general inpatient routine service cost (line 9 x line 38)						5,174,101	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)						5,174,101	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
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit						1,801,381	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)						1,992,159	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						7,822,447	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						568,919	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						127,236	51
52	Total Program excludable cost (sum of lines 50 and 51)						696,155	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53

**TARGET AMOUNT AND LIMIT COMPUTATION**

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

**PROGRAM INPATIENT ROUTINE SWING BED COST**

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

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0115

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					828	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0115

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		7,138,237		30
31	Intensive Care Unit		970,044		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	1.181698	573,886	678,160	50
53	Anesthesiology	0.043471	171,215	7,443	53
54	Radiology-Diagnostic	0.167591	1,636,834	274,319	54
54.01	ULTRASOUND	0.118050	196,474	23,194	54.01
60	Laboratory	0.226209	3,057,959	691,738	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.401046	1,039,246	416,785	65
66	Physical Therapy	1.643286	66,880	109,903	66
69	Electrocardiology	0.073085	409,983	29,964	69
69.01	CARDIAC CATH LAB	0.322996	83,106	26,843	69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients	0.435476	955,530	416,110	71
72	Impl. Dev. Charged to Patients	0.312841	674,236	210,929	72
73	Drugs Charged to Patients	0.240793	4,309,786	1,037,766	73
74	Renal Dialysis	0.574829	198,640	114,184	74
75	ASC (Non-Distinct Part)	0.765848			75
75.01	ONCOLOGY	0.253666			75.01
75.02	GI LAB	0.170379	109,134	18,594	75.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	0.590413	877	518	90
90.01	WOUND CARE CENTER	0.415421			90.01
91	Emergency	0.439750	251,038	110,394	91
92	Observation Beds (Non-Distinct Part)	0.432230			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		13,734,824	4,166,844	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		13,734,824		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0115

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		6,273,689		30
31	Intensive Care Unit		372,506		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	1.181113	366,110	432,417	50
53	Anesthesiology	0.043471	106,425	4,626	53
54	Radiology-Diagnostic	0.167591	825,542	138,353	54
54.01	ULTRASOUND	0.118050			54.01
60	Laboratory	0.225338	1,869,764	421,329	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.396293	475,181	188,311	65
66	Physical Therapy	1.643286	19,414	31,903	66
69	Electrocardiology	0.073085	240,501	17,577	69
69.01	CARDIAC CATH LAB	0.322996	49,498	15,988	69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients	0.435476	764,997	333,138	71
72	Impl. Dev. Charged to Patients	0.312841			72
73	Drugs Charged to Patients	0.240793	1,455,388	350,447	73
74	Renal Dialysis	0.574829	35,430	20,366	74
75	ASC (Non-Distinct Part)	0.765848			75
75.01	ONCOLOGY	0.253666			75.01
75.02	GI LAB	0.170379	40,973	6,981	75.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	0.590413	3,899	2,302	90
90.01	WOUND CARE CENTER	0.415421			90.01
91	Emergency	0.439750	64,631	28,421	91
92	Observation Beds (Non-Distinct Part)	0.432230			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		6,317,753	1,992,159	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		6,317,753		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,063,718			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,844,254			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	33,578			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	465,334			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	153.73			4
	<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	<b>Disproportionate Share Adjustment</b>				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.2093			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4863			31
32	Sum of lines 30 and 31	0.6956			32
33	Allowable disproportionate share percentage (see instructions)	0.4661			33
34	Disproportionate share adjustment (see instructions)	921,477			34
		<b>Prior to</b>	<b>On or after</b>		
		<b>October 1</b>	<b>October 1</b>		
	<b>Uncompensated Care Adjustment</b>				
35	Total uncompensated care amount (see instructions)	9,046,380,143	7,647,644,885		35
35.01	Factor 3 (see instructions)	0.000406948	0.000298729		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,681,406	2,284,573		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	927,917	1,708,735		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,636,652			36
	<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
47	Subtotal (see instructions)	11,499,679			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	11,499,679			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	730,319			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	12,229,998			59
60	Primary payer payments	4,674			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	12,225,324			61
62	Deductibles billed to program beneficiaries	806,560			62
63	Coinsurance billed to program beneficiaries	219,019			63
64	Allowable bad debts (see instructions)	643,090			64
65	Adjusted reimbursable bad debts (see instructions)	418,009			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	561,394			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	11,617,754			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-15,233			70.93
70.94	HRR adjustment amount (see instructions)	-36,360			70.94
71	Amount due provider (see instructions)	11,566,161			71
71.01	Sequestration adjustment (see instructions)	231,323			71.01
72	Interim payments	11,787,231			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-452,393			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	97,192			75

**TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)**

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

**HSP Bonus Payment Amount**

**Prior to 10/1      On or After 10/1**

100	HSP bonus amount (see instructions)				100
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**HVBP Adjustment for HSP Bonus Payment**

**Prior to 10/1      On or After 10/1**

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

**HRR Adjustment for HSP Bonus Payment**

**Prior to 10/1      On or After 10/1**

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 14-0115**

**WORKSHEET E  
PART B**

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

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,348			1
2	Medical and other services reimbursed under OPPTS (see instructions)	4,004,931			2
3	PPS payments	3,897,858			3
4	Outlier payment (see instructions)	3,570			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.820			5
6	Line 2 times line 5	3,284,043			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,348			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	9,753			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)	9,753			14
	<b>CUSTOMARY CHARGES</b>				
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)	1.000000			17
18	Total customary charges (see instructions)	9,753			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	7,405			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	2,348			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	3,901,428			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	862,586			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)	3,041,190			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)	3,041,190			30
31	Primary payer payments	2,659			31
32	Subtotal (line 30 minus line 31)	3,038,531			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	341,235			34
35	Adjusted reimbursable bad debts (see instructions)	221,803			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	285,166			36
37	Subtotal (see instructions)	3,260,334			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)	3,260,334			40
40.01	Sequestration adjustment (see instructions)	65,207			40.01
41	Interim payments	3,165,229			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	29,898			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 (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0115

WORKSHEET E-1  
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	Total interim payments paid to provider		12,722,315		3,314,543	1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
						3.01	
						3.02	
		Program				3.03	
		to				3.04	
		Provider				3.05	
						3.06	
						3.07	
						3.08	
						3.09	
						3.10	
						3.50	
			02/26/2015			3.51	
		Provider	06/18/2015	935,084	06/18/2015	149,314	3.52
		to				3.53	
		Program				3.54	
						3.55	
						3.56	
						3.57	
						3.58	
						3.59	
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-935,084		-149,314	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)		11,787,231		3,165,229	4	
<b>TO BE COMPLETED BY CONTRACTOR</b>							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
						5.01	
						5.02	
		Program				5.03	
		to				5.04	
		Provider				5.05	
						5.06	
						5.07	
						5.08	
						5.09	
						5.10	
						5.50	
						5.51	
		Provider				5.52	
		to				5.53	
		Program				5.54	
						5.55	
						5.56	
						5.57	
						5.58	
						5.59	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99	
6	Determined net settlement amount (balance due) based on the cost report (1)				29,898	6.01	
				-452,393		6.02	
7	Total Medicare program liability (see instructions)		11,334,838		3,195,127	7	
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8	

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

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**

**WORKSHEET E-1  
PART II**

Check applicable box:             Hospital             CAH

**TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS**

**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	4,785	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	6,493	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	529	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	22,380	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	132,807,636	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,117,581	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	434,716	8
9	Sequestration adjustment amount (see instructions)	8,694	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	426,022	10

**INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH**

30	Initial/interim HIT payment(s)	528,557	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-102,535	32

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



**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**BALANCE SHEET**

**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
<b>Assets</b> (Omit Cents)		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	Cash on hand and in banks	3,837,610				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	16,001,158				4
5	Other receivables	3,105,261				5
6	Allowances for uncollectible notes and accounts receivable	-11,994,367				6
7	Inventory	1,109,049				7
8	Prepaid expenses	1,208,825				8
9	Other current assets	483,676				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	13,751,212				11
<b>FIXED ASSETS</b>						
12	Land	13,334,215				12
13	Land improvements	1,521,808				13
14	Accumulated depreciation	-1,331,385				14
15	Buildings	60,375,477				15
16	Accumulated depreciation	-34,617,348				16
17	Leasehold improvements	44,885				17
18	Accumulated depreciation	-5,929				18
19	Fixed equipment	10,024,134				19
20	Accumulated depreciation	-3,424,456				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	24,939,900				23
24	Accumulated depreciation	-17,839,314				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)	53,021,987				30
<b>OTHER ASSETS</b>						
31	Investments	237,487,420				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,941,044				34
35	Total other assets (sum of lines 31-34)	241,428,464				35
36	Total assets (sum of lines 11, 30 and 35)	308,201,663				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	1,331,836				37
38	Salaries, wages and fees payable	1,653,947				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	9,996,626				44
45	Total current liabilities (sum of lines 37 thru 44)	12,982,409				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	15,707,735				49
50	Total long term liabilities (sum of lines 46 thru 49)	15,707,735				50
51	Total liabilities (sum of lines 45 and 50)	28,690,144				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	279,511,519				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)	279,511,519				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	308,201,663				60

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**STATEMENT OF CHANGES IN FUND BALANCES**

**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		268,609,224			1
2	Net income (loss) (from Worksheet G-3, line 29)		10,881,474			2
3	Total (sum of line 1 and line 2)		279,490,698			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)		279,490,698			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)		279,490,698			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

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2  
PARTS I & II**

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	24,485,065		24,485,065	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)	24,485,065		24,485,065	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	3,046,400		3,046,400	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)	3,046,400		3,046,400	16
17	Total inpatient routine care services (sum of lines 10 and 16)	27,531,465		27,531,465	17
18	Ancillary services	37,807,798		37,807,798	18
19	Outpatient services		74,234,642	74,234,642	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	65,339,263	74,234,642	139,573,905	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		59,386,125	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		59,386,125	43

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**STATEMENT OF REVENUES AND EXPENSES****WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	139,573,905	1
2	Less contractual allowances and discounts on patients' accounts	87,157,036	2
3	Net patient revenues (line 1 minus line 2)	52,416,869	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	59,386,125	4
5	Net income from service to patients (line 3 minus line 4)	-6,969,256	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.		6
7	Income from investments	5,934,152	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	153	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	98,537	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	5,135	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	951,702	22
23	Governmental appropriations		23
24	Other (UNREALIZED GAIN ON INVESTMENT)	-12,816,666	24
24.01	Other (MEANINGFUL USE REVENUE INCL ACCRUAL)		24.01
24.02	Other (UNREALIZED GAIN ON INVESTMENT)	12,176,921	24.02
24.03	Other (MISC OPERATING REVENUE)	1,602,244	24.03
24.04	Other (PROVIDER TAX REV)	9,898,552	24.04
25	Total other income (sum of lines 6-24)	17,850,730	25
26	Total (line 5 plus line 25)	10,881,474	26
29	Net income (or loss) for the period (line 26 minus line 28)	10,881,474	29

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 14-0115**

**WORKSHEET L**

Check  Title V  Hospital  PPS  
 Applicable  Title XVIII, Part A  SUB (Other)  Cost Method  
 Boxes:  Title XIX

**PART I - FULLY PROSPECTIVE METHOD**

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	632,164	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	2,509	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	61.32	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2093	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4863	8
9	Sum of lines 7 and 8	0.6956	9
10	Allowable disproportionate share percentage (see instructions)	0.1513	10
11	Disproportionate share adjustment (see instructions)	95,646	11
12	Total prospective capital payments (see instructions)	730,319	12

**PART II - PAYMENT UNDER REASONABLE COST**

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

**KPMG LLP Compu-Max 2552-10**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 16:55 Version: 2015.10 (11/24/2015)
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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
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
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room						50
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	ULTRASOUND						54.01
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
69.01	CARDIAC CATH LAB						69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
75.01	ONCOLOGY						75.01
75.02	GI LAB						75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic						90
90.01	WOUND CARE CENTER						90.01
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices						192
192.01	RETAIL PHARMACY						192.01
192.02	CHA SITES						192.02
192.03	OTHER NON REIMBURSABLE						192.03
194	SENIOR HEALTH						194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202