

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

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

**PART I - COST REPORT STATUS**

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report 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.	Date: 11/28/2016 Time: 19:34
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 THOREK MEMORIAL HOSPITAL (14-0115) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII						
		TITLE V	PART A	PART B	HIT	TITLE XIX		
		1	2	3	4	5		
1	HOSPITAL		74,288	126,981	-637	732,964	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		74,288	126,981	-637	732,964	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
4	Subprovider - IPF								
5	Subprovider - IRF								
6	Subprovider - (OTHER)								
7	Swing Beds - SNF								
8	Swing Beds - NF								
9	Hospital-Based SNF								
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA								
13	Separately Certified ASC								
14	Hospital-Based Hospice								
15	Hospital-Based Health Clinic - RHC								
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis								
19	Other								

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2015	To: 06 / 30 / 2016	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

		1	2	3
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N	
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
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.	4,918			2,405	921
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.					

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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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

**Transplant Center Information**

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare 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			
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.25			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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

**COMPLETED BY ALL HOSPITALS**

		Y/N	Date		
<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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

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

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

Capital Related Cost			
22	Have assets been relieved for Medicare purposes? If yes, see instructions.		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			5,339	5,486	19,500	1
2	HMO and other (see instructions)						931	2,405		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			5,339	5,486	19,500	7
8	Intensive Care Unit	31	10	3,650			412	353	1,290	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			5,751	5,839	20,790	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								1,007	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,117	2,234	4,526	1
2	HMO and other (see instructions)					157			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			1,117	2,234	4,526	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**HOSPITAL WAGE INDEX INFORMATION**

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

**Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclassification 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	200	21,295,005		21,295,005	696,084.85	30.59	1
2							2
3							3
4		127,176		127,176	975.88	130.32	4
4.01							4.01
5		1,621,772		1,621,772	13,436.00	120.70	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		2,495,806		2,495,806	57,860.00	43.14	10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11		717,458		717,458	10,249.40	70.00	11
12							12
13		188,703		188,703	1,165.65	161.89	13
14							14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		2,441,794		2,441,794			17
18							18
19		357,428		357,428			19
20							20
21							21
22		18,213		18,213			22
22.01							22.01
23		232,257		232,257			23
24							24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		122,703		122,703	3,723.00	32.96	26
27		4,413,511		4,413,511	117,566.00	37.54	27
28							28
29							29
30		478,930		478,930	17,280.00	27.72	30
31							31
32							32
33							33
34		517,715	-150,696	367,019	29,289.00	12.53	34
35		259,318		259,318	5,672.00	45.72	35
36			150,696	150,696	12,873.00	11.71	36
37							37
38		404,715		404,715	10,705.00	37.81	38
39		79,580		79,580	6,306.00	12.62	39
40		745,743		745,743	21,028.00	35.46	40
41		496,617		496,617	22,194.00	22.38	41
42		313,567		313,567	7,231.00	43.36	42
43							43

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)	19,932,551		19,932,551	688,320.85	28.96	1
2	Excluded area salaries (see instructions)	2,495,806		2,495,806	57,860.00	43.14	2
3	Subtotal salaries (line 1 minus line 2)	17,436,745		17,436,745	630,460.85	27.66	3
4	Subtotal other wages & related costs (see instructions)	906,161		906,161	11,415.05	79.38	4
5	Subtotal wage-related costs (see instructions)	2,460,007		2,460,007		14.11%	5
6	Total (sum of lines 3 through 5)	20,802,913		20,802,913	641,875.90	32.41	6
7	Total overhead cost (see instructions)	7,832,399		7,832,399	253,867.00	30.85	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	15,423	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)	1,255,820	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	48,035	10
11	Life Insurance (If employee is owner or beneficiary)	12,893	11
12	Accident Insurance (If employee is owner or beneficiary)	1,612	12
13	Disability Insurance (If employee is owner or beneficiary)	86,631	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	153,324	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	1,447,283	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	23,098	19
20	State or Federal Unemployment Taxes		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	5,674	23
24	Total Wage Related cost (Sum of lines 1-23)	3,049,793	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	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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## HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

### Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.332460	1
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### Medicaid (see instructions for each line)

2	Net revenue from Medicaid		7,492,762	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		13,887,635	6
7	Medicaid cost (line 1 times line 6)		4,617,083	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)		1,572,775	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		3,968,153	14
15	State or local indigent care program cost (line 1 times line 14)		1,319,252	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	352,941	725,404	1,078,345	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	117,339	241,168	358,507	21
22	Partial payment by patients approved for charity care	138	14,013	14,151	22
23	Cost of charity care (line 21 minus line 22)	117,201	227,155	344,356	23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire hospital complex (see instructions)			3,860,240	26
27	Medicare bad debts for the entire hospital complex (see instructions)			1,011,673	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			2,848,567	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			947,035	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			1,291,391	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,291,391	31

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

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		4,958,871	4,958,871	-1,626,235	3,332,636	-695,649	2,636,987	1
2	00200	Cap Rel Costs-Mvble Equip				2,551,533	2,551,533		2,551,533	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	122,703	3,089,756	3,212,459		3,212,459		3,212,459	4
5	00500	Administrative & General	4,413,511	11,174,934	15,588,445	-214,354	15,374,091	-463,830	14,910,261	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	478,930	1,507,780	1,986,710		1,986,710		1,986,710	7
8	00800	Laundry & Linen Service				161,933	161,933		161,933	8
9	00900	Housekeeping		643,065	643,065		643,065		643,065	9
10	01000	Dietary	517,715	851,933	1,369,648	-356,714	1,012,934		1,012,934	10
11	01100	Cafeteria				356,714	356,714	-104,544	252,170	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	404,715	62,292	467,007		467,007	-2,235	464,772	13
14	01400	Central Services & Supply	79,580	68,912	148,492	-41,315	107,177		107,177	14
15	01500	Pharmacy	745,743	4,153,476	4,899,219	-4,020,201	879,018	-3,500	875,518	15
16	01600	Medical Records & Library	496,617	403,730	900,347		900,347	-7,403	892,944	16
17	01700	Social Service	313,567	21,651	335,218		335,218	-42,262	292,956	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	3,564,596	840,123	4,404,719	-171,035	4,233,684	-17,244	4,216,440	30
31	03100	Intensive Care Unit	729,214	113,531	842,745	-39,949	802,796	-5,316	797,480	31
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	930,718	2,503,202	3,433,920	-1,045,395	2,388,525	-88,326	2,300,199	50
53	05300	Anesthesiology		575,777	575,777	-36,356	539,421	-522,200	17,221	53
54	05400	Radiology-Diagnostic	726,122	709,800	1,435,922	-69,169	1,366,753		1,366,753	54
54.01	03630	ULTRASOUND	153,923	15,123	169,046	-4,320	164,726		164,726	54.01
60	06000	Laboratory	1,096,479	1,806,019	2,902,498	-7,619	2,894,879	-17,899	2,876,980	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	598,346	147,099	745,445	-37,224	708,221	-29,136	679,085	65
66	06600	Physical Therapy		155,161	155,161	-23	155,138		155,138	66
69	06900	Electrocardiology	69,030	34,576	103,606	-5,853	97,753		97,753	69
69.01	03140	CARDIAC CATH LAB	6,210	42,885	49,095	-34,293	14,802		14,802	69.01
70.01	07001	SLEEP LAB								70.01
71	07100	Medical Supplies Charged to Patients				1,322,608	1,322,608		1,322,608	71
72	07200	Impl. Dev. Charged to Patients				454,136	454,136		454,136	72
73	07300	Drugs Charged to Patients				3,976,946	3,976,946		3,976,946	73
74	07400	Renal Dialysis	26	161,846	161,872		161,872		161,872	74
75	07500	ASC (Non-Distinct Part)	463,863	36,490	500,353	-21,911	478,442		478,442	75
75.01	03480	ONCOLOGY	248,893	41,933	290,826	-33,658	257,168		257,168	75.01
75.02	03340	GI LAB		113,191	113,191	-85,827	27,364		27,364	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	1,125,497	93,007	1,218,504	-8,503	1,210,001	-721,649	488,352	90
90.01	09001	WOUND CARE CENTER	52,257	24,742	76,999	-17,763	59,236		59,236	90.01
91	09100	Emergency	1,460,944	1,004,583	2,465,527	-73,276	2,392,251	-1,724,808	667,443	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		872,877	872,877	-872,877				113
118		SUBTOTALS (sum of lines 1-117)	18,799,199	36,228,365	55,027,564		55,027,564	-4,446,001	50,581,563	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190.01	19001	SENIOR HEALTH								190.01
192	19200	Physicians' Private Offices	2,010,846	1,621,131	3,631,977		3,631,977		3,631,977	192
192.01	19201	RETAIL PHARMACY	196,692	529,091	725,783		725,783		725,783	192.01
192.02	19202	CHA SITES	229,149	20,993	250,142		250,142		250,142	192.02
192.03	19203	OTHER NON REIMBURSABLE		22,671	22,671		22,671		22,671	192.03
194	07950	SENIOR HEALTH	59,119	5,593	64,712		64,712		64,712	194
200		TOTAL (sum of lines 118-199)	21,295,005	38,427,844	59,722,849		59,722,849	-4,446,001	55,276,848	200

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	OTHER
1	DEPRECIATION GL CC 8850-8581	1				
		2				
500	Total reclassifications	A	Cap Rel Costs-Mvble Equip	2		2,551,533
	Code Letter - A					500
1	INSURANCE	B	Cap Rel Costs-Bldg & Fixt	1		52,421
500	Total reclassifications					52,421
	Code Letter - B					500
1	DRUGS CHARGED	C	Drugs Charged to Patients	73		3,976,946
500	Total reclassifications					3,976,946
	Code Letter - C					500
1	SUPPLIES CHARGED	D	Medical Supplies Charged to P	71		1,322,608
2			Impl. Dev. Charged to Patient	72		454,136
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
19						19
500	Total reclassifications					1,776,744
	Code Letter - D					500
1	CAFETERIA COSTS	E	Cafeteria	11	150,696	206,018
500	Total reclassifications				150,696	206,018
	Code Letter - E					500
1	INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		872,877
500	Total reclassifications					872,877
	Code Letter - F					500
1	LAUNDRY EXP	I	Laundry & Linen Service	8		161,933
500	Total reclassifications					161,933
	Code Letter - I					500
	GRAND TOTAL (Increases)				150,696	9,598,472

(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		2,551,533	9	1
500	Total reclassifications					2,551,533		500
	Code letter - A							
1	INSURANCE	B	Administrative & General	5		52,421	12	1
500	Total reclassifications					52,421		500
	Code letter - B							
1	DRUGS CHARGED	C	Pharmacy	15		3,976,946		1
500	Total reclassifications					3,976,946		500
	Code letter - C							
1	SUPPLIES CHARGED	D	Central Services & Supply	14		41,315		1
2			Pharmacy	15		43,255		2
3			Adults & Pediatrics	30		171,035		3
4			Intensive Care Unit	31		39,949		4
5			Operating Room	50		1,045,395		5
6			Anesthesiology	53		36,356		6
7			Radiology-Diagnostic	54		69,169		7
8			ULTRASOUND	54.01		4,320		8
9			Laboratory	60		7,619		9
10			Respiratory Therapy	65		37,224		10
11			Electrocardiology	69		5,853		11
12			CARDIAC CATH LAB	69.01		34,293		12
13			ASC (Non-Distinct Part)	75		21,911		13
14			ONCOLOGY	75.01		33,658		14
15			GI LAB	75.02		85,827		15
16			Clinic	90		8,503		16
17			WOUND CARE CENTER	90.01		17,763		17
18			Physical Therapy	66		23		18
19			Emergency	91		73,276		19
500	Total reclassifications					1,776,744		500
	Code letter - D							
1	CAFETERIA COSTS	E	Dietary	10	150,696	206,018		1
500	Total reclassifications				150,696	206,018		500
	Code letter - E							
1	INTEREST	F	Interest Expense	113		872,877	11	1
500	Total reclassifications					872,877		500
	Code letter - F							
1	LAUNDRY EXP	I	Administrative & General	5		161,933		1
500	Total reclassifications					161,933		500
	Code letter - I							
	<b>GRAND TOTAL (Decreases)</b>				150,696	9,598,472		

(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	1,521,808	107,140		107,140		1,628,948		2
3	Buildings and Fixtures	36,365,431	183,237		183,237		36,548,668		3
4	Building Improvements	24,054,931	133,003		133,003		24,187,934		4
5	Fixed Equipment	10,024,134	243,696		243,696		10,267,830		5
6	Movable Equipment	24,939,900	973,364		973,364		25,913,264		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	110,240,420	1,640,440		1,640,440		111,880,860		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	110,240,420	1,640,440		1,640,440		111,880,860		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	4,958,871						4,958,871	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	4,958,871						4,958,871	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	71,004,432		71,004,432	0.732626					1
2	Cap Rel Costs-Mvble Equip	25,913,264		25,913,264	0.267374					2
3	Total (sum of lines 1-2)	96,917,696		96,917,696	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	2,407,338		177,228	52,421			2,636,987	1	
2	Cap Rel Costs-Mvble Equip	2,551,533						2,551,533	2	
3	Total (sum of lines 1-2)	4,958,871		177,228	52,421			5,188,520	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	-695,649	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	-192	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	-17,661	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	-3,198,493				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	-104,140	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	-3,976	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-404	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							34
35							35
36							36
37							37
38							38
39							39
40							40
41	HOSPITALITY EXP	A	-125,624	Administrative & General	5		41
41.01	HOSPITALITY EXP	A	-2,235	Nursing Administration	13		41.01
41.03	HOSPITALITY EXP	A	-645	Laboratory	60		41.03
41.05	HOSPITALITY EXP	A	-1,623	Clinic	90		41.05
42	HOSPITALITY EXP	A	-71	Adults & Pediatrics	30		42
42.01	LDUES -LOBBYING PORTION	A	-30,144	Administrative & General	5		42.01
42.02	MARKETING EXP	A	-201,443	Administrative & General	5		42.02
42.03	MEDICARE PREMIUM FOR RETIRED EM	A	-3,776	Administrative & General	5		42.03
43	DONATION	A	-5,000	Administrative & General	5		43
44	ADVERTISING EXP	A	-53,270	Administrative & General	5		44
44.02	ADVERTISING EXP	A	-1,655	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)		-4,446,001				50

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

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

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

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

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

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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:

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	4	Employee Benefits De AGGREGATE								1
2	5	Administrative & Gen AGGREGATE	53,130		53,130	177,200	310	26,410	1,321	2
3	15	Pharmacy AGGREGATE	3,500	3,500		177,200				3
4	16	Medical Records & Li AGGREGATE	3,427	3,427		177,200				4
5										5
6	17	Social Service AGGREGATE	119,105		119,105	177,200	902	76,843	3,842	6
7										7
8	30	Adults & Pediatrics AGGREGATE	38,520	2,121	36,399	177,200	270	23,002	1,150	8
9	31	Intensive Care Unit AGGREGATE	12,302		12,302	177,200	82	6,986	349	9
10	50	Operating Room AGGREGATE	89,093	87,822	1,271	177,200	9	767	38	10
11										11
12	53	Anesthesiology AGGREGATE	522,200	522,200		177,200				12
13										13
14										14
15										15
16	60	Laboratory AGGREGATE	40,000		40,000	177,200	267	22,746	1,137	16
17										17
18	65	Respiratory Therapy AGGREGATE	53,671		53,671	177,200	288	24,535	1,227	18
19										19
20	75	ASC (Non-Distinct Pa AGGREGATE								20
22	90	Clinic AGGREGATE	720,026	720,026						22
24	91	Emergency AGGREGATE	1,724,808	1,724,808						24
200		TOTAL	3,379,782	3,063,904	315,878		2,128	181,289	9,064	200

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	4	Employee Benefits De AGGREGATE								1
2	5	Administrative & Gen AGGREGATE					26,410	26,720	26,720	2
3	15	Pharmacy AGGREGATE							3,500	3
4	16	Medical Records & Li AGGREGATE							3,427	4
5										5
6	17	Social Service AGGREGATE					76,843	42,262	42,262	6
7										7
8	30	Adults & Pediatrics AGGREGATE					23,002	13,397	15,518	8
9	31	Intensive Care Unit AGGREGATE					6,986	5,316	5,316	9
10	50	Operating Room AGGREGATE					767	504	88,326	10
11										11
12	53	Anesthesiology AGGREGATE							522,200	12
13										13
14										14
15										15
16	60	Laboratory AGGREGATE					22,746	17,254	17,254	16
17										17
18	65	Respiratory Therapy AGGREGATE					24,535	29,136	29,136	18
19										19
20	75	ASC (Non-Distinct Pa AGGREGATE								20
22	90	Clinic AGGREGATE							720,026	22
24	91	Emergency AGGREGATE							1,724,808	24
200		TOTAL					181,289	134,589	3,198,493	200

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	2,636,987	2,636,987					1
2	Cap Rel Costs-Mvble Equip	2,551,533		2,551,533				2
4	Employee Benefits Department	3,212,459	4,119	3,985	3,220,563			4
5	Administrative & General	14,910,261	149,065	144,235	609,915	15,813,476	15,813,476	5
6	Maintenance & Repairs							6
7	Operation of Plant	1,986,710	556,148	538,124	69,122	3,150,104	1,262,288	7
8	Laundry & Linen Service	161,933				161,933	64,889	8
9	Housekeeping	643,065	8,329	8,059	431	659,884	264,424	9
10	Dietary	1,012,934	71,106	68,802	57,780	1,210,622	485,112	10
11	Cafeteria	252,170	31,245	30,233	18,277	331,925	133,007	11
12	Maintenance of Personnel							12
13	Nursing Administration	464,772			79,580	544,352	218,129	13
14	Central Services & Supply	107,177	86,860	84,046	12,231	290,314	116,333	14
15	Pharmacy	875,518	11,441	11,070	89,551	987,580	395,736	15
16	Medical Records & Library	892,944	34,186	33,078	84,929	1,045,137	418,800	16
17	Social Service	292,956			71,669	364,625	146,110	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	4,216,440	481,507	465,904	670,903	5,834,754	2,338,047	30
31	Intensive Care Unit	797,480	36,451	35,270	114,712	983,913	394,267	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	2,300,199	85,259	82,496	152,420	2,620,374	1,050,018	50
53	Anesthesiology	17,221	3,695	3,576		24,492	9,814	53
54	Radiology-Diagnostic	1,366,753	99,629	96,400	124,387	1,687,169	676,071	54
54.01	ULTRASOUND	164,726	2,574	2,491	26,651	196,442	78,717	54.01
60	Laboratory	2,876,980	62,731	60,698	158,397	3,158,806	1,265,775	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	679,085	34,357	33,244	89,883	836,569	335,224	65
66	Physical Therapy	155,138	29,678	28,716		213,532	85,565	66
69	Electrocardiology	97,753	2,231	2,159	16,789	118,932	47,658	69
69.01	CARDIAC CATH LAB	14,802	17,734	17,159	10,934	60,629	24,295	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	1,322,608				1,322,608	529,986	71
72	Impl. Dev. Charged to Patients	454,136				454,136	181,978	72
73	Drugs Charged to Patients	3,976,946				3,976,946	1,593,614	73
74	Renal Dialysis	161,872	801	775		163,448	65,496	74
75	ASC (Non-Distinct Part)	478,442	93,725	90,688	73,437	736,292	295,042	75
75.01	ONCOLOGY	257,168	51,874	50,193	43,108	402,343	161,224	75.01
75.02	GI LAB	27,364	20,571	19,904		67,839	27,184	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	488,352	66,999	64,828	189,292	809,471	324,366	90
90.01	WOUND CARE CENTER	59,236	9,725	9,410	11,761	90,132	36,117	90.01
91	Emergency	667,443	39,472	38,192	220,786	965,893	387,046	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)	50,581,563	2,091,512	2,023,735	2,996,945	49,284,672	13,412,332	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	3,631,977	14,576	14,104	160,605	3,821,262	1,531,229	192
192.01	RETAIL PHARMACY	725,783	4,119	3,985	13,163	747,050	299,353	192.01
192.02	CHA SITES	250,142	526,780	509,709	23,842	1,310,473	525,124	192.02
192.03	OTHER NON REIMBURSABLE	22,671				22,671	9,085	192.03
194	SENIOR HEALTH	64,712			26,008	90,720	36,353	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	55,276,848	2,636,987	2,551,533	3,220,563	55,276,848	15,813,476	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<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	4,412,392						7
8	Laundry & Linen Service		226,822					8
9	Housekeeping	19,065		943,373				9
10	Dietary	162,761		34,875	1,893,370			10
11	Cafeteria	71,521		15,325		551,778		11
12	Maintenance of Personnel							12
13	Nursing Administration			2,003		11,468	775,952	13
14	Central Services & Supply	198,823		42,602		6,747		14
15	Pharmacy	26,188		5,611		22,513		15
16	Medical Records & Library	78,251		16,767		23,760		16
17	Social Service					7,749	24,654	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	1,102,168	161,086	236,164	1,873,662	165,229	444,017	30
31	Intensive Care Unit	83,436	4,307	17,878	19,708	25,564	68,697	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	195,157	30,348	41,817		29,572	79,468	50
53	Anesthesiology	8,459		1,813				53
54	Radiology-Diagnostic	228,049	20,595	48,865		25,630		54
54.01	ULTRASOUND	5,892		1,263		10,577		54.01
60	Laboratory	143,591		30,768		42,465		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	78,644		16,851		25,809		65
66	Physical Therapy	67,933		14,556				66
69	Electrocardiology	5,107		1,094		2,338		69
69.01	CARDIAC CATH LAB	40,592		8,698		200		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	1,833		393				74
75	ASC (Non-Distinct Part)	214,536	10,349	45,969		15,120	40,632	75
75.01	ONCOLOGY	118,739		25,442		10,600	28,484	75.01
75.02	GI LAB	47,087		10,089				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	153,360		32,861		30,997		90
90.01	WOUND CARE CENTER	22,260		4,770		2,049	5,505	90.01
91	Emergency	90,350	137	19,360		31,442	84,495	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)	3,163,802	226,822	675,834	1,893,370	489,829	775,952	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	33,364		7,149		44,558		192
192.01	RETAIL PHARMACY	9,428		2,020		7,059		192.01
192.02	CHA SITES	1,205,798		258,370		8,796		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					1,536		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,412,392	226,822	943,373	1,893,370	551,778	775,952	202

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

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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	654,819						14
15	Pharmacy		1,437,628					15
16	Medical Records & Library			1,582,715				16
17	Social Service				543,138			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		4,003	273,531	325,882	12,758,543		30
31	Intensive Care Unit		2,152	29,721	108,628	1,738,271		31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		2,158	55,326		4,104,238		50
53	Anesthesiology		4,623	18,048		67,249		53
54	Radiology-Diagnostic		19,436	176,444		2,882,259		54
54.01	ULTRASOUND			29,650		322,541		54.01
60	Laboratory			264,264		4,905,669		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			77,479		1,370,576		65
66	Physical Therapy			2,459		384,045		66
69	Electrocardiology		326	29,397		204,852		69
69.01	CARDIAC CATH LAB		668	3,665		138,747		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	487,447		68,873		2,408,914		71
72	Impl. Dev. Charged to Patients	167,372		34,278		837,764		72
73	Drugs Charged to Patients		1,190,750	352,049		7,113,359		73
74	Renal Dialysis			4,386		235,556		74
75	ASC (Non-Distinct Part)		1,116	23,072		1,382,128		75
75.01	ONCOLOGY		544	42,462	54,314	844,152		75.01
75.02	GI LAB		17	16,518		168,734		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		5,034	27,553		1,383,642		90
90.01	WOUND CARE CENTER		113	7,224		168,170		90.01
91	Emergency		2,710	46,316	54,314	1,682,063		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)	654,819	1,233,650	1,582,715	543,138	45,101,472		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		59,244			5,496,806		192
192.01	RETAIL PHARMACY		144,038			1,208,948		192.01
192.02	CHA SITES		696			3,309,257		192.02
192.03	OTHER NON REIMBURSABLE					31,756		192.03
194	SENIOR HEALTH					128,609		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	654,819	1,437,628	1,582,715	543,138	55,276,848		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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	12,758,543					30
31	Intensive Care Unit	1,738,271					31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	4,104,238					50
53	Anesthesiology	67,249					53
54	Radiology-Diagnostic	2,882,259					54
54.01	ULTRASOUND	322,541					54.01
60	Laboratory	4,905,669					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,370,576					65
66	Physical Therapy	384,045					66
69	Electrocardiology	204,852					69
69.01	CARDIAC CATH LAB	138,747					69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	2,408,914					71
72	Impl. Dev. Charged to Patients	837,764					72
73	Drugs Charged to Patients	7,113,359					73
74	Renal Dialysis	235,556					74
75	ASC (Non-Distinct Part)	1,382,128					75
75.01	ONCOLOGY	844,152					75.01
75.02	GI LAB	168,734					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	1,383,642					90
90.01	WOUND CARE CENTER	168,170					90.01
91	Emergency	1,682,063					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)	45,101,472					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	5,496,806					192
192.01	RETAIL PHARMACY	1,208,948					192.01
192.02	CHA SITES	3,309,257					192.02
192.03	OTHER NON REIMBURSABLE	31,756					192.03
194	SENIOR HEALTH	128,609					194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	55,276,848					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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	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		4,119	3,985	8,104	8,104		4
5	Administrative & General		149,065	144,235	293,300	1,535	294,835	5
6	Maintenance & Repairs							6
7	Operation of Plant		556,148	538,124	1,094,272	174	23,534	7
8	Laundry & Linen Service						1,210	8
9	Housekeeping		8,329	8,059	16,388	1	4,930	9
10	Dietary		71,106	68,802	139,908	145	9,045	10
11	Cafeteria		31,245	30,233	61,478	46	2,480	11
12	Maintenance of Personnel							12
13	Nursing Administration					200	4,067	13
14	Central Services & Supply		86,860	84,046	170,906	31	2,169	14
15	Pharmacy		11,441	11,070	22,511	225	7,378	15
16	Medical Records & Library		34,186	33,078	67,264	214	7,808	16
17	Social Service					180	2,724	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		481,507	465,904	947,411	1,688	43,594	30
31	Intensive Care Unit		36,451	35,270	71,721	289	7,351	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		85,259	82,496	167,755	384	19,577	50
53	Anesthesiology		3,695	3,576	7,271		183	53
54	Radiology-Diagnostic		99,629	96,400	196,029	313	12,605	54
54.01	ULTRASOUND		2,574	2,491	5,065	67	1,468	54.01
60	Laboratory		62,731	60,698	123,429	399	23,599	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		34,357	33,244	67,601	226	6,250	65
66	Physical Therapy		29,678	28,716	58,394		1,595	66
69	Electrocardiology		2,231	2,159	4,390	42	889	69
69.01	CARDIAC CATH LAB		17,734	17,159	34,893	28	453	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients						9,881	71
72	Impl. Dev. Charged to Patients						3,393	72
73	Drugs Charged to Patients						29,712	73
74	Renal Dialysis		801	775	1,576		1,221	74
75	ASC (Non-Distinct Part)		93,725	90,688	184,413	185	5,501	75
75.01	ONCOLOGY		51,874	50,193	102,067	108	3,006	75.01
75.02	GI LAB		20,571	19,904	40,475		507	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		66,999	64,828	131,827	476	6,048	90
90.01	WOUND CARE CENTER		9,725	9,410	19,135	30	673	90.01
91	Emergency		39,472	38,192	77,664	556	7,216	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)		2,091,512	2,023,735	4,115,247	7,542	250,067	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		14,576	14,104	28,680	404	28,549	192
192.01	RETAIL PHARMACY		4,119	3,985	8,104	33	5,581	192.01
192.02	CHA SITES		526,780	509,709	1,036,489	60	9,791	192.02
192.03	OTHER NON REIMBURSABLE						169	192.03
194	SENIOR HEALTH					65	678	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,636,987	2,551,533	5,188,520	8,104	294,835	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	1,117,980						7
8	Laundry & Linen Service		1,210					8
9	Housekeeping	4,831		26,150				9
10	Dietary	41,239		967	191,304			10
11	Cafeteria	18,121		425		82,550		11
12	Maintenance of Personnel							12
13	Nursing Administration			56		1,716	6,039	13
14	Central Services & Supply	50,376		1,181		1,009		14
15	Pharmacy	6,635		156		3,368		15
16	Medical Records & Library	19,827		465		3,555		16
17	Social Service					1,159	192	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	279,259	859	6,546	189,313	24,721	3,455	30
31	Intensive Care Unit	21,141	23	496	1,991	3,825	535	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	49,447	162	1,159		4,424	618	50
53	Anesthesiology	2,143		50				53
54	Radiology-Diagnostic	57,781	110	1,355		3,834		54
54.01	ULTRASOUND	1,493		35		1,582		54.01
60	Laboratory	36,382		853		6,353		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	19,926		467		3,861		65
66	Physical Therapy	17,212		403				66
69	Electrocardiology	1,294		30		350		69
69.01	CARDIAC CATH LAB	10,285		241		30		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	464		11				74
75	ASC (Non-Distinct Part)	54,358	55	1,274		2,262	316	75
75.01	ONCOLOGY	30,085		705		1,586	222	75.01
75.02	GI LAB	11,931		280				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	38,857		911		4,637		90
90.01	WOUND CARE CENTER	5,640		132		306	43	90.01
91	Emergency	22,892	1	537		4,704	658	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)	801,619	1,210	18,735	191,304	73,282	6,039	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	8,454		198		6,666		192
192.01	RETAIL PHARMACY	2,389		56		1,056		192.01
192.02	CHA SITES	305,518		7,161		1,316		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					230		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,117,980	1,210	26,150	191,304	82,550	6,039	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	225,672						14
15	Pharmacy		40,273					15
16	Medical Records & Library			99,133				16
17	Social Service				4,255			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		112	17,133	2,552	1,516,643		30
31	Intensive Care Unit		60	1,862	851	110,145		31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		60	3,466		247,052		50
53	Anesthesiology		130	1,131		10,908		53
54	Radiology-Diagnostic		544	11,052		283,623		54
54.01	ULTRASOUND			1,857		11,567		54.01
60	Laboratory			16,553		207,568		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			4,853		103,184		65
66	Physical Therapy			154		77,758		66
69	Electrocardiology		9	1,841		8,845		69
69.01	CARDIAC CATH LAB		19	230		46,179		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	167,990		4,314		182,185		71
72	Impl. Dev. Charged to Patients	57,682		2,147		63,222		72
73	Drugs Charged to Patients		33,358	22,045		85,115		73
74	Renal Dialysis			275		3,547		74
75	ASC (Non-Distinct Part)		31	1,445		249,840		75
75.01	ONCOLOGY		15	2,660	426	140,880		75.01
75.02	GI LAB			1,035		54,228		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		141	1,726		184,623		90
90.01	WOUND CARE CENTER		3	453		26,415		90.01
91	Emergency		76	2,901	426	117,631		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)	225,672	34,558	99,133	4,255	3,731,158		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		1,660			74,611		192
192.01	RETAIL PHARMACY		4,035			21,254		192.01
192.02	CHA SITES		20			1,360,355		192.02
192.03	OTHER NON REIMBURSABLE					169		192.03
194	SENIOR HEALTH					973		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	225,672	40,273	99,133	4,255	5,188,520		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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	1,516,643					30
31	Intensive Care Unit	110,145					31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	247,052					50
53	Anesthesiology	10,908					53
54	Radiology-Diagnostic	283,623					54
54.01	ULTRASOUND	11,567					54.01
60	Laboratory	207,568					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	103,184					65
66	Physical Therapy	77,758					66
69	Electrocardiology	8,845					69
69.01	CARDIAC CATH LAB	46,179					69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	182,185					71
72	Impl. Dev. Charged to Patients	63,222					72
73	Drugs Charged to Patients	85,115					73
74	Renal Dialysis	3,547					74
75	ASC (Non-Distinct Part)	249,840					75
75.01	ONCOLOGY	140,880					75.01
75.02	GI LAB	54,228					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	184,623					90
90.01	WOUND CARE CENTER	26,415					90.01
91	Emergency	117,631					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)	3,731,158					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	74,611					192
192.01	RETAIL PHARMACY	21,254					192.01
192.02	CHA SITES	1,360,355					192.02
192.03	OTHER NON REIMBURSABLE	169					192.03
194	SENIOR HEALTH	973					194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	5,188,520					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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	230,485						1
2	Cap Rel Costs-Mvble Equip		230,485					2
4	Employee Benefits Department	360	360	20,730,541				4
5	Administrative & General	13,029	13,029	3,925,969	-15,813,476	39,463,372		5
6	Maintenance & Repairs							6
7	Operation of Plant	48,610	48,610	444,932		3,150,104	168,486	7
8	Laundry & Linen Service					161,933		8
9	Housekeeping	728	728	2,775		659,884	728	9
10	Dietary	6,215	6,215	371,926		1,210,622	6,215	10
11	Cafeteria	2,731	2,731	117,645		331,925	2,731	11
12	Maintenance of Personnel							12
13	Nursing Administration			512,247		544,352		13
14	Central Services & Supply	7,592	7,592	78,730		290,314	7,592	14
15	Pharmacy	1,000	1,000	576,429		987,580	1,000	15
16	Medical Records & Library	2,988	2,988	546,680		1,045,137	2,988	16
17	Social Service			461,330		364,625		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	42,086	42,086	4,318,617		5,834,754	42,086	30
31	Intensive Care Unit	3,186	3,186	738,393		983,913	3,186	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,452	7,452	981,111		2,620,374	7,452	50
53	Anesthesiology	323	323			24,492	323	53
54	Radiology-Diagnostic	8,708	8,708	800,668		1,687,169	8,708	54
54.01	ULTRASOUND	225	225	171,548		196,442	225	54.01
60	Laboratory	5,483	5,483	1,019,590		3,158,806	5,483	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,003	3,003	578,568		836,569	3,003	65
66	Physical Therapy	2,594	2,594			213,532	2,594	66
69	Electrocardiology	195	195	108,069		118,932	195	69
69.01	CARDIAC CATH LAB	1,550	1,550	70,380		60,629	1,550	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients					1,322,608		71
72	Impl. Dev. Charged to Patients					454,136		72
73	Drugs Charged to Patients					3,976,946		73
74	Renal Dialysis	70	70			163,448	70	74
75	ASC (Non-Distinct Part)	8,192	8,192	472,705		736,292	8,192	75
75.01	ONCOLOGY	4,534	4,534	277,481		402,343	4,534	75.01
75.02	GI LAB	1,798	1,798			67,839	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	5,856	5,856	1,218,456		809,471	5,856	90
90.01	WOUND CARE CENTER	850	850	75,707		90,132	850	90.01
91	Emergency	3,450	3,450	1,421,179		965,893	3,450	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)	182,808	182,808	19,291,135	-15,813,476	33,471,196	120,809	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	1,274	1,274	1,033,798		3,821,262	1,274	192
192.01	RETAIL PHARMACY	360	360	84,726		747,050	360	192.01
192.02	CHA SITES	46,043	46,043	153,471		1,310,473	46,043	192.02
192.03	OTHER NON REIMBURSABLE					22,671		192.03
194	SENIOR HEALTH			167,411		90,720		194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,636,987	2,551,533	3,220,563		15,813,476	4,412,392	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.441035	11.070278	0.155354		0.400713	26.188479	203
204	Cost to be allocated (Per Wkst. B, Part II)			8,104		294,835	1,117,980	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000391		0.007471	6.635447	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 NRSING 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	315,278						8
9	Housekeeping		168,115					9
10	Dietary		6,215	73,304				10
11	Cafeteria		2,731		24,779			11
12	Maintenance of Personnel							12
13	Nursing Administration		357		515	12,967		13
14	Central Services & Supply		7,592		303		2,027,430	14
15	Pharmacy		1,000		1,011			15
16	Medical Records & Library		2,988		1,067			16
17	Social Service				348	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	223,907	42,086	72,541	7,420	7,420		30
31	Intensive Care Unit	5,986	3,186	763	1,148	1,148		31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	42,183	7,452		1,328	1,328		50
53	Anesthesiology		323					53
54	Radiology-Diagnostic	28,626	8,708		1,151			54
54.01	ULTRASOUND		225		475			54.01
60	Laboratory		5,483		1,907			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,003		1,159			65
66	Physical Therapy		2,594					66
69	Electrocardiology		195		105			69
69.01	CARDIAC CATH LAB		1,550		9			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)	14,385	8,192		679	679		75
75.01	ONCOLOGY		4,534		476	476		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		5,856		1,392			90
90.01	WOUND CARE CENTER		850		92	92		90.01
91	Emergency	191	3,450		1,412	1,412		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)	315,278	120,438	73,304	21,997	12,967	2,027,430	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		1,274		2,001			192
192.01	RETAIL PHARMACY		360		317			192.01
192.02	CHA SITES		46,043		395			192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH				69			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	226,822	943,373	1,893,370	551,778	775,952	654,819	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.719435	5.611474	25.829013	22.267969	59.840518	0.322980	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,210	26,150	191,304	82,550	6,039	225,672	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.003838	0.155548	2.609735	3.331450	0.465721	0.111309	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	4,801,478					15
16	Medical Records & Library		134,147,419				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	13,369	23,184,516	60			30
31	Intensive Care Unit	7,187	2,519,184	20			31
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,208	4,689,467				50
53	Anesthesiology	15,439	1,529,788				53
54	Radiology-Diagnostic	64,912	14,955,445				54
54.01	ULTRASOUND		2,513,167				54.01
60	Laboratory		22,399,042				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		6,567,091				65
66	Physical Therapy		208,427				66
69	Electrocardiology	1,088	2,491,675				69
69.01	CARDIAC CATH LAB	2,231	310,606				69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients		5,837,655				71
72	Impl. Dev. Charged to Patients		2,905,406				72
73	Drugs Charged to Patients	3,976,946	29,836,019				73
74	Renal Dialysis		371,745				74
75	ASC (Non-Distinct Part)	3,728	1,955,599				75
75.01	ONCOLOGY	1,818	3,599,110	10			75.01
75.02	GI LAB	56	1,400,056				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	16,812	2,335,368				90
90.01	WOUND CARE CENTER	376	612,333				90.01
91	Emergency	9,050	3,925,720	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)	4,120,220	134,147,419	100			118
<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	197,866					192
192.01	RETAIL PHARMACY	481,066					192.01
192.02	CHA SITES	2,326					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)	1,437,628	1,582,715	543,138			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.299414	0.011798	5,431.380000			203
204	Cost to be allocated (Per Wkst. B, Part II)	40,273	99,133	4,255			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.008388	0.000739	42.550000			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	12,758,543		12,758,543	13,397	12,771,940	30
31	Intensive Care Unit	1,738,271		1,738,271	5,316	1,743,587	31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	4,104,238		4,104,238	504	4,104,742	50
53	Anesthesiology	67,249		67,249		67,249	53
54	Radiology-Diagnostic	2,882,259		2,882,259		2,882,259	54
54.01	ULTRASOUND	322,541		322,541		322,541	54.01
60	Laboratory	4,905,669		4,905,669	17,254	4,922,923	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,370,576		1,370,576	29,136	1,399,712	65
66	Physical Therapy	384,045		384,045		384,045	66
69	Electrocardiology	204,852		204,852		204,852	69
69.01	CARDIAC CATH LAB	138,747		138,747		138,747	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	2,408,914		2,408,914		2,408,914	71
72	Impl. Dev. Charged to Patients	837,764		837,764		837,764	72
73	Drugs Charged to Patients	7,113,359		7,113,359		7,113,359	73
74	Renal Dialysis	235,556		235,556		235,556	74
75	ASC (Non-Distinct Part)	1,382,128		1,382,128		1,382,128	75
75.01	ONCOLOGY	844,152		844,152		844,152	75.01
75.02	GI LAB	168,734		168,734		168,734	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	1,383,642		1,383,642		1,383,642	90
90.01	WOUND CARE CENTER	168,170		168,170		168,170	90.01
91	Emergency	1,682,063		1,682,063		1,682,063	91
92	Observation Beds (Non-Distinct Part)	627,170		627,170		627,170	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)	45,728,642		45,728,642	65,607	45,794,249	200
201	Less Observation Beds	627,170		627,170		627,170	201
202	Total (line 200 minus line 201)	45,101,472		45,101,472		45,167,079	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	23,184,516		23,184,516				30
31	Intensive Care Unit	2,519,184		2,519,184				31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	1,983,582	2,705,884	4,689,466	0.875204	0.875204	0.875311	50
53	Anesthesiology	433,074	1,096,714	1,529,788	0.043960	0.043960	0.043960	53
54	Radiology-Diagnostic	3,575,757	11,379,688	14,955,445	0.192723	0.192723	0.192723	54
54.01	ULTRASOUND	496,356	2,016,811	2,513,167	0.128340	0.128340	0.128340	54.01
60	Laboratory	7,355,892	15,043,150	22,399,042	0.219012	0.219012	0.219783	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,777,956	789,135	6,567,091	0.208704	0.208704	0.213140	65
66	Physical Therapy	202,590	5,837	208,427	1.842588	1.842588	1.842588	66
69	Electrocardiology	861,938	1,629,737	2,491,675	0.082215	0.082215	0.082215	69
69.01	CARDIAC CATH LAB	95,959	214,647	310,606	0.446698	0.446698	0.446698	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	2,289,538	3,548,117	5,837,655	0.412651	0.412651	0.412651	71
72	Impl. Dev. Charged to Patients	2,119,496	785,910	2,905,406	0.288347	0.288347	0.288347	72
73	Drugs Charged to Patients	10,154,417	19,681,602	29,836,019	0.238415	0.238415	0.238415	73
74	Renal Dialysis	348,825	22,920	371,745	0.633649	0.633649	0.633649	74
75	ASC (Non-Distinct Part)	311,073	1,644,526	1,955,599	0.706754	0.706754	0.706754	75
75.01	ONCOLOGY	592,579	3,006,531	3,599,110	0.234545	0.234545	0.234545	75.01
75.02	GI LAB	198,175	1,201,881	1,400,056	0.120519	0.120519	0.120519	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	3,901	2,331,466	2,335,367	0.592473	0.592473	0.592473	90
90.01	WOUND CARE CENTER	29,048	583,285	612,333	0.274638	0.274638	0.274638	90.01
91	Emergency	935,517	2,990,203	3,925,720	0.428472	0.428472	0.428472	91
92	Observation Beds (Non-Distinct Part)		1,512,242	1,512,242	0.414729	0.414729	0.414729	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)	63,469,373	72,190,286	135,659,659				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	63,469,373	72,190,286	135,659,659				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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)	1,516,643		1,516,643	20,507	73.96	5,339	394,872	30
31	Intensive Care Unit	110,145		110,145	1,290	85.38	412	35,177	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)	1,626,788		1,626,788	21,797		5,751	430,049	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	247,052	4,689,466	0.052682	573,886	30,233	50
53	Anesthesiology	10,908	1,529,788	0.007130	171,215	1,221	53
54	Radiology-Diagnostic	283,623	14,955,445	0.018965	1,636,834	31,043	54
54.01	ULTRASOUND	11,567	2,513,167	0.004603	196,474	904	54.01
60	Laboratory	207,568	22,399,042	0.009267	3,057,959	28,338	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	103,184	6,567,091	0.015712	1,039,246	16,329	65
66	Physical Therapy	77,758	208,427	0.373071	66,880	24,951	66
69	Electrocardiology	8,845	2,491,675	0.003550	409,983	1,455	69
69.01	CARDIAC CATH LAB	46,179	310,606	0.148674	83,106	12,356	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	182,185	5,837,655	0.031209	955,530	29,821	71
72	Impl. Dev. Charged to Patients	63,222	2,905,406	0.021760	674,236	14,671	72
73	Drugs Charged to Patients	85,115	29,836,019	0.002853	4,309,786	12,296	73
74	Renal Dialysis	3,547	371,745	0.009541	198,640	1,895	74
75	ASC (Non-Distinct Part)	249,840	1,955,599	0.127756			75
75.01	ONCOLOGY	140,880	3,599,110	0.039143			75.01
75.02	GI LAB	54,228	1,400,056	0.038733	109,134	4,227	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	184,623	2,335,367	0.079055	877	69	90
90.01	WOUND CARE CENTER	26,415	612,333	0.043138			90.01
91	Emergency	117,631	3,925,720	0.029964	251,038	7,522	91
92	Observation Beds (Non-Distinct	74,475	1,512,242	0.049248			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	2,178,845	109,955,959		13,734,824	217,331	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)	20,507		5,339		30
31	Intensive Care Unit	1,290		412		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)	21,797		5,751		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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	4,689,466			573,886		564,313		50
53	Anesthesiology	1,529,788			171,215		184,927		53
54	Radiology-Diagnostic	14,955,445			1,636,834		2,875,808		54
54.01	ULTRASOUND	2,513,167			196,474		218,192		54.01
60	Laboratory	22,399,042			3,057,959		990,768		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	6,567,091			1,039,246		78,830		65
66	Physical Therapy	208,427			66,880				66
69	Electrocardiology	2,491,675			409,983		422,478		69
69.01	CARDIAC CATH LAB	310,606			83,106		85,828		69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	5,837,655			955,530		480,482		71
72	Impl. Dev. Charged to Patients	2,905,406			674,236		238,685		72
73	Drugs Charged to Patients	29,836,019			4,309,786		6,035,215		73
74	Renal Dialysis	371,745			198,640				74
75	ASC (Non-Distinct Part)	1,955,599							75
75.01	ONCOLOGY	3,599,110					387,210		75.01
75.02	GI LAB	1,400,056			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	2,335,367			877		752,194		90
90.01	WOUND CARE CENTER	612,333							90.01
91	Emergency	3,925,720			251,038		226,870		91
92	Observation Beds (Non-Distinct)	1,512,242					236,392		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	109,955,959			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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	0.875204	564,313			493,889			50
53	Anesthesiology	0.043960	184,927			8,129			53
54	Radiology-Diagnostic	0.192723	2,875,808			554,234			54
54.01	ULTRASOUND	0.128340	218,192			28,003			54.01
60	Laboratory	0.219012	990,768			216,990			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.208704	78,830			16,452			65
66	Physical Therapy	1.842588							66
69	Electrocardiology	0.082215	422,478			34,734			69
69.01	CARDIAC CATH LAB	0.446698	85,828			38,339			69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	0.412651	480,482			198,271			71
72	Impl. Dev. Charged to Patients	0.288347	238,685			68,824			72
73	Drugs Charged to Patients	0.238415	6,035,215		14,320	1,438,886		3,414	73
74	Renal Dialysis	0.633649							74
75	ASC (Non-Distinct Part)	0.706754							75
75.01	ONCOLOGY	0.234545	387,210			90,818			75.01
75.02	GI LAB	0.120519	165,192			19,909			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	0.592473	752,194			445,655			90
90.01	WOUND CARE CENTER	0.274638							90.01
91	Emergency	0.428472	226,870			97,207			91
92	Observation Beds (Non-Distinct	0.414729	236,392			98,039			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		13,943,384		14,320	3,848,379		3,414	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		13,943,384		14,320	3,848,379		3,414	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

Check  Title V  
 Applicable  Title XVIII, Part A  
 Boxes:  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)	1,516,643		1,516,643	20,507	73.96	5,486	405,745	30
31	Intensive Care Unit	110,145		110,145	1,290	85.38	353	30,139	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)	1,626,788		1,626,788	21,797		5,839	435,884	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	247,052	4,689,466	0.052682	420,615	22,159	50
53	Anesthesiology	10,908	1,529,788	0.007130	52,851	377	53
54	Radiology-Diagnostic	283,623	14,955,445	0.018965	396,340	7,517	54
54.01	ULTRASOUND	11,567	2,513,167	0.004603	62,235	286	54.01
60	Laboratory	207,568	22,399,042	0.009267	1,133,112	10,501	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	103,184	6,567,091	0.015712	807,646	12,690	65
66	Physical Therapy	77,758	208,427	0.373071	17,381	6,484	66
69	Electrocardiology	8,845	2,491,675	0.003550	126,272	448	69
69.01	CARDIAC CATH LAB	46,179	310,606	0.148674	8,801	1,308	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	182,185	5,837,655	0.031209	38,310	1,196	71
72	Impl. Dev. Charged to Patients	63,222	2,905,406	0.021760			72
73	Drugs Charged to Patients	85,115	29,836,019	0.002853	863,460	2,463	73
74	Renal Dialysis	3,547	371,745	0.009541	22,920	219	74
75	ASC (Non-Distinct Part)	249,840	1,955,599	0.127756	31,142	3,979	75
75.01	ONCOLOGY	140,880	3,599,110	0.039143	29,696	1,162	75.01
75.02	GI LAB	54,228	1,400,056	0.038733	22,581	875	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	184,623	2,335,367	0.079055	202	16	90
90.01	WOUND CARE CENTER	26,415	612,333	0.043138	5,763	249	90.01
91	Emergency	117,631	3,925,720	0.029964	172,787	5,177	91
92	Observation Beds (Non-Distinct)	74,475	1,512,242	0.049248			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	2,178,845	109,955,959		4,212,114	77,106	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

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

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	<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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check            [ ] Title V                            [ ] PPS  
Applicable    [ ] Title XVIII, Part A        [ ] TEFRA  
Boxes:        [XX] Title XIX                    [XX] 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)	20,507		5,486		30
31	Intensive Care Unit	1,290		353		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)	21,797		5,839		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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	4,689,466			420,615				50
53	Anesthesiology	1,529,788			52,851				53
54	Radiology-Diagnostic	14,955,445			396,340				54
54.01	ULTRASOUND	2,513,167			62,235				54.01
60	Laboratory	22,399,042			1,133,112				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	6,567,091			807,646				65
66	Physical Therapy	208,427			17,381				66
69	Electrocardiology	2,491,675			126,272				69
69.01	CARDIAC CATH LAB	310,606			8,801				69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	5,837,655			38,310				71
72	Impl. Dev. Charged to Patients	2,905,406							72
73	Drugs Charged to Patients	29,836,019			863,460				73
74	Renal Dialysis	371,745			22,920				74
75	ASC (Non-Distinct Part)	1,955,599			31,142				75
75.01	ONCOLOGY	3,599,110			29,696				75.01
75.02	GI LAB	1,400,056			22,581				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	2,335,367			202				90
90.01	WOUND CARE CENTER	612,333			5,763				90.01
91	Emergency	3,925,720			172,787				91
92	Observation Beds (Non-Distinct)	1,512,242							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	109,955,959			4,212,114				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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	0.875204						50
53	Anesthesiology	0.043960						53
54	Radiology-Diagnostic	0.192723						54
54.01	ULTRASOUND	0.128340						54.01
60	Laboratory	0.219012						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.208704						65
66	Physical Therapy	1.842588						66
69	Electrocardiology	0.082215						69
69.01	CARDIAC CATH LAB	0.446698						69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Pat	0.412651						71
72	Impl. Dev. Charged to Patients	0.288347						72
73	Drugs Charged to Patients	0.238415						73
74	Renal Dialysis	0.633649						74
75	ASC (Non-Distinct Part)	0.706754						75
75.01	ONCOLOGY	0.234545						75.01
75.02	GI LAB	0.120519						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	0.592473						90
90.01	WOUND CARE CENTER	0.274638						90.01
91	Emergency	0.428472						91
92	Observation Beds (Non-Distinct)	0.414729						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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)	20,507	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,507	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)	19,500	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)	5,339	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)	12,771,940	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)	12,771,940	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)	12,771,940	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)						622.81	38
39	Program general inpatient routine service cost (line 9 x line 38)						3,325,183	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)						3,325,183	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						1,743,587	43
44	Coronary Care Unit						1,290	44
45	Burn Intensive Care Unit						1,351.62	45
46	Surgical Intensive Care Unit						412	46
47	Other Special Care (specify)							47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						3,801,517	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						7,683,567	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						430,049	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						217,331	51
52	Total Program excludable cost (sum of lines 50 and 51)						647,380	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						7,036,187	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)					1,007	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					622.81	88
89	Observation bed cost (line 87 x line 88) (see instructions)					627,170	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,516,643	12,771,940	0.118748	627,170	74,475	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)	20,507	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,507	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)	19,500	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)	5,486	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)	12,758,543	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)	12,758,543	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)	12,758,543	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)						622.16	38					
39	Program general inpatient routine service cost (line 9 x line 38)						3,413,170	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)						3,413,170	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						1,738,271	1,290	1,347.50	353	475,668	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)						1,261,507	48					
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						5,150,345	49					

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						435,884	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						77,106	51
52	Total Program excludable cost (sum of lines 50 and 51)						512,990	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)					1,007	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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		7,138,237		30
31	Intensive Care Unit		970,044		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.875311	573,886	502,329	50
53	Anesthesiology	0.043960	171,215	7,527	53
54	Radiology-Diagnostic	0.192723	1,636,834	315,456	54
54.01	ULTRASOUND	0.128340	196,474	25,215	54.01
60	Laboratory	0.219783	3,057,959	672,087	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.213140	1,039,246	221,505	65
66	Physical Therapy	1.842588	66,880	123,232	66
69	Electrocardiology	0.082215	409,983	33,707	69
69.01	CARDIAC CATH LAB	0.446698	83,106	37,123	69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients	0.412651	955,530	394,300	71
72	Impl. Dev. Charged to Patients	0.288347	674,236	194,414	72
73	Drugs Charged to Patients	0.238415	4,309,786	1,027,518	73
74	Renal Dialysis	0.633649	198,640	125,868	74
75	ASC (Non-Distinct Part)	0.706754			75
75.01	ONCOLOGY	0.234545			75.01
75.02	GI LAB	0.120519	109,134	13,153	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	0.592473	877	520	90
90.01	WOUND CARE CENTER	0.274638			90.01
91	Emergency	0.428472	251,038	107,563	91
92	Observation Beds (Non-Distinct Part)	0.414729			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		13,734,824	3,801,517	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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		4,341,348		30
31	Intensive Care Unit		290,380		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.875204	420,615	368,124	50
53	Anesthesiology	0.043960	52,851	2,323	53
54	Radiology-Diagnostic	0.192723	396,340	76,384	54
54.01	ULTRASOUND	0.128340	62,235	7,987	54.01
60	Laboratory	0.219012	1,133,112	248,165	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.208704	807,646	168,559	65
66	Physical Therapy	1.842588	17,381	32,026	66
69	Electrocardiology	0.082215	126,272	10,381	69
69.01	CARDIAC CATH LAB	0.446698	8,801	3,931	69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients	0.412651	38,310	15,809	71
72	Impl. Dev. Charged to Patients	0.288347			72
73	Drugs Charged to Patients	0.238415	863,460	205,862	73
74	Renal Dialysis	0.633649	22,920	14,523	74
75	ASC (Non-Distinct Part)	0.706754	31,142	22,010	75
75.01	ONCOLOGY	0.234545	29,696	6,965	75.01
75.02	GI LAB	0.120519	22,581	2,721	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	0.592473	202	120	90
90.01	WOUND CARE CENTER	0.274638	5,763	1,583	90.01
91	Emergency	0.428472	172,787	74,034	91
92	Observation Beds (Non-Distinct Part)	0.414729			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		4,212,114	1,261,507	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,212,114		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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)	1,922,206			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,594,943			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)	39,529			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	1,117,437			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	152.82			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 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)	0.2129			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.3965			31
32	Sum of lines 30 and 31	0.6094			32
33	Allowable disproportionate share percentage (see instructions)	0.3950			33
34	Disproportionate share adjustment (see instructions)	742,319			34
		<b>Prior to</b>		<b>On or after</b>	
	<b>Uncompensated Care Adjustment</b>	<b>October 1 (1.00)</b>	<b>(1.01)</b>	<b>October 1 (2.00)</b>	
35	Total uncompensated care amount (see instructions)	7,647,644,885		6,406,145,534	35
35.01	Factor 3 (see instructions)	0.000298729		0.000314481	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,284,573		2,014,611	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	575,838		1,508,206	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,084,044			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**

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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)	10,383,041			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)	10,383,041			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	685,578			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)	11,068,619			59
60	Primary payer payments	6,392			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	11,062,227			61
62	Deductibles billed to program beneficiaries	748,748			62
63	Coinsurance billed to program beneficiaries	129,815			63
64	Allowable bad debts (see instructions)	1,016,984			64
65	Adjusted reimbursable bad debts (see instructions)	661,040			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	485,100			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,844,704			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)	-11,486			70.93
70.94	HRR adjustment amount (see instructions)	-24,479			70.94
71	Amount due provider (see instructions)	10,808,739			71
71.01	Sequestration adjustment (see instructions)	216,175			71.01
72	Interim payments	10,518,276			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	74,288			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	81,280			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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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)	3,414			1
2	Medical and other services reimbursed under OPPTS (see instructions)	3,848,379			2
3	PPS payments	4,704,200			3
4	Outlier payment (see instructions)	3,239			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.820			5
6	Line 2 times line 5	3,155,671			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	3,414			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	14,320			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	14,320			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)	14,320			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	10,906			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	3,414			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)	4,707,439			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)	1,009,312			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)	3,701,541			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)	3,701,541			30
31	Primary payer payments	2,446			31
32	Subtotal (line 30 minus line 31)	3,699,095			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)	539,436			34
35	Adjusted reimbursable bad debts (see instructions)	350,633			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	268,345			36
37	Subtotal (see instructions)	4,049,728			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)	4,049,728			40
40.01	Sequestration adjustment (see instructions)	80,995			40.01
41	Interim payments	3,841,752			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	126,981			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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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		11,378,037		3,838,768	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
				06/21/2016	2,984	3.10
						3.50
						3.51
		Provider	06/21/2016	859,761		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)		-859,761		2,984	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)		10,518,276		3,841,752	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)		74,288		126,981	6.01
						6.02
7	Total Medicare program liability (see instructions)		10,592,564		3,968,733	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**

**WORKSHEET E-1  
PART II**

Check applicable box:             Hospital             CAH

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

**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	4,526	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	5,751	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	931	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	20,790	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	135,659,659	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,078,345	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)	216,708	8
9	Sequestration adjustment amount (see instructions)	4,334	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	212,374	10

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

30	Initial/interim HIT payment(s)	213,011	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-637	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0115

WORKSHEET E-3  
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	Inpatient hospital/SNF/NF services	5,150,345	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	5,150,345	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	5,150,345	7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8	Routine service charges	4,050,968	8
9	Ancillary service charges	4,212,114	9
10	Organ acquisition charges, net of revenue		10
11	Incentive from target amount computation		11
12	Total reasonable charges (sum of lines 8-11)	8,263,082	12
<b>CUSTOMARY CHARGES</b>			
13	Amount actually collected from patients liable for payment for services on a cahрге basis		13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(c)		14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	15
16	Total customary charges (see instructions)	8,263,082	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,112,737	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		18
19	Interns and residents (see instructions)		19
20	Cost of physicians' services in a teaching hospital (see instructions)		20
21	Cost of covered services (lesser of line 4 or line 16)	5,150,345	21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22	Other than outlier payments		22
23	Outlier payments		23
24	Program capital payments		24
25	Capital exception payments (see instructions)		25
26	Routine and ancillary service other pass through costs		26
27	Subtotal (sum of lines 22 through 26)		27
28	Customary charges (Titles V or XIX PPS covered services only)		28
29	Titles V or XIX (sum of lines 21 and 27)	5,150,345	29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30	Excess of reasonable cost (from line 18)		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	5,150,345	31
32	Deductibles		32
33	Coinsurance		33
34	Allowable bad debts (see instructions)		34
35	Utilization review		35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	5,150,345	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)	5,150,345	38
39	Direct graduate medical education payments (from Wkst. E-4)		39
40	Total amount payable to the provider (sum of lines 38 and 39)	5,150,345	40
41	Interim payments	4,417,381	41
42	Balance due provider/program (line 40 minus line 41)	732,964	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

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

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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	2,935,772				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	16,004,884				4
5	Other receivables	1,676,730				5
6	Allowances for uncollectible notes and accounts receivable	-9,140,913				6
7	Inventory	1,349,042				7
8	Prepaid expenses	758,829				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	13,584,344				11
<b>FIXED ASSETS</b>						
12	Land	13,334,215				12
13	Land improvements	2,431,949				13
14	Accumulated depreciation	-1,374,618				14
15	Buildings	59,888,717				15
16	Accumulated depreciation	-36,437,845				16
17	Leasehold improvements	44,885				17
18	Accumulated depreciation	-10,969				18
19	Fixed equipment	10,267,830				19
20	Accumulated depreciation	-3,902,167				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	26,306,022				23
24	Accumulated depreciation	-20,448,842				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)	50,099,177				30
<b>OTHER ASSETS</b>						
31	Investments	241,753,499				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,244,657				34
35	Total other assets (sum of lines 31-34)	246,998,156				35
36	Total assets (sum of lines 11, 30 and 35)	310,681,677				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	1,229,274				37
38	Salaries, wages and fees payable	1,693,707				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	9,407,270				44
45	Total current liabilities (sum of lines 37 thru 44)	12,330,251				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	16,294,347				49
50	Total long term liabilities (sum of lines 46 thru 49)	16,294,347				50
51	Total liabilities (sum of lines 45 and 50)	28,624,598				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	282,057,079				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)	282,057,079				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	310,681,677				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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**STATEMENT OF CHANGES IN FUND BALANCES**

**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		268,609,224			1
2	Net income (loss) (from Worksheet G-3, line 29)		-5,888,238			2
3	Total (sum of line 1 and line 2)		262,720,986			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)		262,720,986			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)		262,720,986			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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

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

**PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	23,184,516		23,184,516	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)	23,184,516		23,184,516	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	2,519,184		2,519,184	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)	2,519,184		2,519,184	16
17	Total inpatient routine care services (sum of lines 10 and 16)	25,703,700		25,703,700	17
18	Ancillary services	37,765,674		37,765,674	18
19	Outpatient services		72,190,285	72,190,285	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)	63,469,374	72,190,285	135,659,659	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		59,722,849	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)		59,722,849	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**STATEMENT OF REVENUES AND EXPENSES**

**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	135,659,659	1
2	Less contractual allowances and discounts on patients' accounts	92,982,248	2
3	Net patient revenues (line 1 minus line 2)	42,677,411	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	59,722,849	4
5	Net income from service to patients (line 3 minus line 4)	-17,045,438	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.		6
7	Income from investments	6,440,424	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	192	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	104,140	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	3,976	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	1,049,399	22
23	Governmental appropriations		23
24	Other (UNREALIZED GAIN ON INVESTMENT)	-5,349,754	24
24.01	Other (MEANINGFUL USE REVENUE INCL ACCRUAL)		24.01
24.02	Other (UNREALIZED GAIN ON INVESTMENT)	-759,723	24.02
24.03	Other (MISC OPERATING REVENUE)	533,159	24.03
24.04	Other (PROVIDER TAX REV)	9,135,387	24.04
25	Total other income (sum of lines 6-24)	11,157,200	25
26	Total (line 5 plus line 25)	-5,888,238	26
29	Net income (or loss) for the period (line 26 minus line 28)	-5,888,238	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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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	602,464	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	4,010	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)	56.80	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)	0.2129	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.3965	8
9	Sum of lines 7 and 8	0.6094	9
10	Allowable disproportionate share percentage (see instructions)	0.1313	10
11	Disproportionate share adjustment (see instructions)	79,104	11
12	Total prospective capital payments (see instructions)	685,578	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: 07/01/2015 To: 06/30/2016	Run Date: 11/28/2016 Run Time: 19:34 Version: 2016.05 (11/01/2016)
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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY 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