

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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: 11/30/2017 Time: 11:10
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 07/01/2016 and ending 06/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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		-27,582	197,206			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		-27,582	197,206			200

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

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

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

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 850 WEST IRVING PARK ROAD	P.O. Box:								1
2	City: CHICAGO	State: IL	ZIP Code: 60613	County: COOK						2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	THOREK MEMORIAL HOSPITAL	14-0115	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017							20
21	Type of control (see instructions)	2								21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,028				7,715	674	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
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?	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

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
<b>Inpatient Psychiatric Facility PPS</b>				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
<b>Inpatient Rehabilitation Facility PPS</b>				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
<b>Long Term Care Hospital PPS</b>							
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
<b>TEFRA Providers</b>							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

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

**WORKSHEET S-2  
PART I**

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

**Rural Providers**

		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.				109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

**Miscellaneous Cost Reporting Information**

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1,665,088	3,690,041		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)	9.99			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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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**

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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 relined 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			4,545	2,632	18,809	1
2	HMO and other (see instructions)						1,071	7,715		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			4,545	2,632	18,809	7
8	Intensive Care Unit	31	10	3,650			509	70	602	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			5,054	2,702	19,411	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)					993	897	4,111	1
2	HMO and other (see instructions)					183	1,468		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)		297.00			993	897	4,111	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)		297.00						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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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## HOSPITAL WAGE INDEX INFORMATION

## WORKSHEET S-3 PARTS II-III

### Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclass- ification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)		
	1	2	3	4	5	6		
<b>SALARIES</b>								
1	Total salaries (see instructions)	200	20,660,907	20,660,907	614,897.00	33.60	1	
2	Non-physician anesthetist Part A						2	
3	Non-physician anesthetest Part B						3	
4	Physician-Part A - Administrative		127,281	127,281	937.00	135.84	4	
4.01	Physician-Part A - Teaching						4.01	
5	Physician-Part B		1,661,958	1,661,958	13,608.00	122.13	5	
6	Non-physician-Part B						6	
7	Interns & residents (in an approved program)	21					7	
7.01	Contracted interns & residents (in an approved program)						7.01	
8	Home office and/or related organization personnel						8	
9	SNF	44					9	
10	Excluded area salaries (see instructions)		2,090,098	2,090,098	48,205.00	43.36	10	
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11	Contract labor (see instructions)		627,867	627,867	9,500.00	66.09	11	
12	Contract management and administrative services		55,115	55,115	612.00	90.06	12	
13	Contract labor: Physician-Part A - Administrative		128,816	128,816	900.00	143.13	13	
14	Home office salaries & wage-related costs						14	
14.01	Home office salaries						14.01	
14.02	Related organization salaries						14.02	
15	Home office: Physician Part A - Administrative						15	
16	Home office & Contract Physicians Part A - Teaching						16	
<b>WAGE-RELATED COSTS</b>								
17	Wage-related costs (core)(see instructions)		2,243,167	2,243,167			17	
18	Wage-related costs (other)(see instructions)						18	
19	Excluded areas		279,380	279,380			19	
20	Non-physician anesthetist Part A						20	
21	Non-physician anesthetist Part B						21	
22	Physician Part A - Administrative		17,013	17,013			22	
22.01	Physician Part A - Teaching						22.01	
23	Physician Part B		222,151	222,151			23	
24	Wage-related costs (RHC/FQHC)						24	
25	Interns & residents (in an approved program)						25	
25.50	Home office wage-related						25.50	
25.51	Related organization wage-related						25.51	
25.52	Home office: Physician Part A - Administrative - wage-related						25.52	
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						25.53	
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26	Employee Benefits Department		92,001	92,001	2,463.00	37.35	26	
27	Administrative & General		4,212,049	4,212,049	105,257.00	40.02	27	
28	Administrative & General under contract (see instructions)						28	
29	Maintenance & Repairs						29	
30	Operation of Plant		502,055	502,055	16,591.75	30.26	30	
31	Laundry & Linen Service						31	
32	Housekeeping						32	
33	Housekeeping under contract (see instructions)		439,973	439,973	27,024.00	16.28	33	
34	Dietary		537,745	-152,593	385,152	30,428.00	12.66	34
35	Dietary under contract (see instructions)		249,829		249,829	4,160.00	60.06	35
36	Cafeteria			152,593	152,593	12,055.00	12.66	36
37	Maintenance of Personnel						37	
38	Nursing Administration		380,417	380,417	6,550.81	58.07	38	
39	Central Services and Supply		78,677	78,677	6,190.25	12.71	39	
40	Pharmacy		742,279	742,279	18,644.43	39.81	40	
41	Medical Records & Medical Records Library		421,630	421,630	17,799.50	23.69	41	
42	Social Service		290,755	290,755	5,140.00	56.57	42	
43	Other General Service						43	

### Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		19,688,751	19,688,751	632,473.00	31.13	1
2	Excluded area salaries (see instructions)		2,090,098	2,090,098	48,205.00	43.36	2
3	Subtotal salaries (line 1 minus line 2)		17,598,653	17,598,653	584,268.00	30.12	3
4	Subtotal other wages & related costs (see instructions)		811,798	811,798	11,012.00	73.72	4
5	Subtotal wage-related costs (see instructions)		2,260,180	2,260,180		12.84%	5
6	Total (sum of lines 3 through 5)		20,670,631	20,670,631	595,280.00	34.72	6
7	Total overhead cost (see instructions)		7,947,410	7,947,410	252,303.74	31.50	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	19,928	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	1,076,303	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	44,014	10
11	Life Insurance (If employee is owner or beneficiary)	11,672	11
12	Accident Insurance (If employee is owner or beneficiary)	1,459	12
13	Disability Insurance (If employee is owner or beneficiary)	78,445	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	119,825	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	1,398,459	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	1,420	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	10,186	23
24	Total Wage Related cost (Sum of lines 1-23)	2,761,711	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**

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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

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

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

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

# KPMG LLP Compu-Max 2552-10

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## HOSPITAL 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)		0.279610	1
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### Medicaid (see instructions for each line)

2	Net revenue from Medicaid		12,157,585	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		30,566,354	6
7	Medicaid cost (line 1 times line 6)		8,546,658	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)		1,577,642	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		4,267,905	14
15	State or local indigent care program cost (line 1 times line 14)		1,193,349	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16

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

17	Private grants, donations, or endowment income restricted to 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

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

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,126,856	13,776,352	14,903,208	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	315,080	13,776,352	14,091,432	21
22	Payments received from patients for amounts previously written off as charity care	1,794	10,769,023	10,770,817	22
23	Cost of charity care (line 21 minus line 22)	313,286	3,007,329	3,320,615	23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit				25
26	Total bad debt expense for the entire hospital complex (see instructions)			4,563,370	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			845,126	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,300,194	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)			3,263,176	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,367,485	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			4,688,100	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,688,100	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		4,558,663	4,558,663	-1,061,885	3,496,778	-696,698	2,800,080	1
2	00200	Cap Rel Costs-Mvble Equip				2,008,228	2,008,228		2,008,228	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	92,001	2,833,594	2,925,595		2,925,595		2,925,595	4
5	00500	Administrative & General	4,212,049	10,486,586	14,698,635	-204,685	14,493,950	-4,899,431	9,594,519	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	502,055	1,726,370	2,228,425		2,228,425	-648	2,227,777	7
8	00800	Laundry & Linen Service				152,202	152,202		152,202	8
9	00900	Housekeeping		589,168	589,168		589,168		589,168	9
10	01000	Dietary	537,745	751,245	1,288,990	-365,769	923,221		923,221	10
11	01100	Cafeteria				365,769	365,769	-95,625	270,144	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	380,417	52,003	432,420		432,420		432,420	13
14	01400	Central Services & Supply	78,677	164,127	242,804	-122,956	119,848		119,848	14
15	01500	Pharmacy	742,279	4,124,974	4,867,253	-4,024,944	842,309		842,309	15
16	01600	Medical Records & Library	421,630	320,584	742,214		742,214	-103,341	638,873	16
17	01700	Social Service	290,755	4,318	295,073	-3,521	291,552	-44,385	247,167	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	3,804,612	684,755	4,489,367	-149,701	4,339,666	-17,167	4,322,499	30
31	03100	Intensive Care Unit	628,238	86,024	714,262	-18,318	695,944	-9,962	685,982	31
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	885,786	2,699,653	3,585,439	-835,861	2,749,578	-105,868	2,643,710	50
53	05300	Anesthesiology		560,339	560,339	-28,430	531,909	-525,700	6,209	53
54	05400	Radiology-Diagnostic	753,240	824,799	1,578,039	-61,325	1,516,714	-53,913	1,462,801	54
54.01	03630	ULTRASOUND	159,773	28,602	188,375	-18,397	169,978		169,978	54.01
60	06000	Laboratory	1,094,457	1,956,472	3,050,929	-14,803	3,036,126	-17,722	3,018,404	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	485,799	129,075	614,874	-36,675	578,199	-24,638	553,561	65
66	06600	Physical Therapy		121,127	121,127		121,127		121,127	66
69	06900	Electrocardiology	69,578	25,976	95,554	-2,777	92,777		92,777	69
69.01	03140	CARDIAC CATH LAB	3,001	128,366	131,367	-111,335	20,032		20,032	69.01
70.01	07001	SLEEP LAB								70.01
71	07100	Medical Supplies Charged to Patients				1,201,091	1,201,091		1,201,091	71
72	07200	Impl. Dev. Charged to Patients				412,411	412,411		412,411	72
73	07300	Drugs Charged to Patients				4,020,218	4,020,218		4,020,218	73
74	07400	Renal Dialysis		163,572	163,572		163,572		163,572	74
75	07500	ASC (Non-Distinct Part)	355,108	45,800	400,908	-20,096	380,812		380,812	75
75.01	03480	ONCOLOGY	262,740	42,108	304,848	-30,674	274,174		274,174	75.01
75.02	03340	GI LAB		70,713	70,713	-62,172	8,541		8,541	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	1,336,225	189,264	1,525,489	-9,775	1,515,714	-842,792	672,922	90
90.01	09001	WOUND CARE CENTER	52,589	16,907	69,496	-14,551	54,945		54,945	90.01
91	09100	Emergency	1,422,055	987,024	2,409,079	-67,409	2,341,670	-1,624,860	716,810	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		893,860	893,860	-893,860				113
118		SUBTOTALS (sum of lines 1-117)	18,570,809	35,266,068	53,836,877		53,836,877	-9,062,750	44,774,127	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190.01	19001	SENIOR HEALTH								190.01
192	19200	Physicians' Private Offices	1,847,982	1,555,349	3,403,331		3,403,331		3,403,331	192
192.01	19201	RETAIL PHARMACY	164,110	1,301,162	1,465,272		1,465,272		1,465,272	192.01
192.02	19202	CHA SITES	71,831	21,864	93,695		93,695		93,695	192.02
192.03	19203	OTHER NON REIMBURSABLE		137,283	137,283		137,283		137,283	192.03
194	07950	SENIOR HEALTH	6,175	750	6,925		6,925		6,925	194
200		TOTAL (sum of lines 118-199)	20,660,907	38,282,476	58,943,383		58,943,383	-9,062,750	49,880,633	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		2,008,228
	Code Letter - A					500
1	INSURANCE	B	Cap Rel Costs-Bldg & Fixt	1		52,483
500	Total reclassifications					52,483
	Code Letter - B					500
1	DRUGS CHARGED	C	Drugs Charged to Patients	73		4,020,218
500	Total reclassifications					4,020,218
	Code Letter - C					500
1	SUPPLIES CHARGED	D	Medical Supplies Charged to P	71		1,201,091
2			Impl. Dev. Charged to Patient	72		412,411
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					1,613,502
	Code Letter - D					500
1	CAFETERIA COSTS	E	Cafeteria	11	152,593	213,176
500	Total reclassifications				152,593	213,176
	Code Letter - E					500
1	INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		893,860
500	Total reclassifications					893,860
	Code Letter - F					500
1	LAUNDRY EXP	I	Laundry & Linen Service	8		152,202
500	Total reclassifications					152,202
	Code Letter - I					500
	GRAND TOTAL (Increases)				152,593	8,953,669

(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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**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		2,008,228	9	1
500	Total reclassifications					2,008,228		500
	Code letter - A							
1	INSURANCE	B	Administrative & General	5		52,483	12	1
500	Total reclassifications					52,483		500
	Code letter - B							
1	DRUGS CHARGED	C	Pharmacy	15		4,020,218		1
500	Total reclassifications					4,020,218		500
	Code letter - C							
1	SUPPLIES CHARGED	D	Central Services & Supply	14		122,956		1
2			Pharmacy	15		4,726		2
3			Adults & Pediatrics	30		149,701		3
4			Intensive Care Unit	31		18,318		4
5			Operating Room	50		835,861		5
6			Anesthesiology	53		28,430		6
7			Radiology-Diagnostic	54		61,325		7
8			ULTRASOUND	54.01		18,397		8
9			Laboratory	60		14,803		9
10			Respiratory Therapy	65		36,675		10
11			Social Service	17		3,521		11
12			CARDIAC CATH LAB	69.01		111,335		12
13			ASC (Non-Distinct Part)	75		20,096		13
14			ONCOLOGY	75.01		30,674		14
15			GI LAB	75.02		62,172		15
16			Clinic	90		9,775		16
17			WOUND CARE CENTER	90.01		14,551		17
18			Electrocardiology	69		2,777		18
19			Emergency	91		67,409		19
500	Total reclassifications					1,613,502		500
	Code letter - D							
1	CAFETERIA COSTS	E	Dietary	10	152,593	213,176		1
500	Total reclassifications				152,593	213,176		500
	Code letter - E							
1	INTEREST	F	Interest Expense	113		893,860	11	1
500	Total reclassifications					893,860		500
	Code letter - F							
1	LAUNDRY EXP	I	Administrative & General	5		152,202		1
500	Total reclassifications					152,202		500
	Code letter - I							
	<b>GRAND TOTAL (Decreases)</b>				152,593	8,953,669		

(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	14,137,215					14,137,215		1
2	Land Improvements	1,628,948					1,628,948		2
3	Buildings and Fixtures	35,482,670		144,538	144,538		35,627,208		3
4	Building Improvements	24,450,932	97,983		97,983		24,548,915		4
5	Fixed Equipment	10,267,830	2,986,226		2,986,226		13,254,056		5
6	Movable Equipment	26,306,022	433,727		433,727		26,739,749		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	112,273,617	3,517,936	144,538	3,662,474		115,936,091		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	112,273,617	3,517,936	144,538	3,662,474		115,936,091		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	4,558,663						4,558,663	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	4,558,663						4,558,663	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	59,887,047		59,887,047	0.691322					1
2	Cap Rel Costs-Mvble Equip	26,739,749		26,739,749	0.308678					2
3	Total (sum of lines 1-2)	86,626,796		86,626,796	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	2,550,435		197,162	52,483			2,800,080	1	
2	Cap Rel Costs-Mvble Equip	2,008,228						2,008,228	2	
3	Total (sum of lines 1-2)	4,558,663		197,162	52,483			4,808,308	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	2	3	
1	Investment income-buildings & fixtures (chapter 2)	B	-696,698	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-8,330	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	-3,374,655				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	-95,625	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	-3,138	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
40							40
41	HOSPITALITY EXP	A	-141,628	Administrative & General	5		41
41.01	HOSPITALITY EXP	A	-648	Operation of Plant	7		41.01
41.03	HOSPITALITY EXP	A	-468	Laboratory	60		41.03
41.05	HOSPITALITY EXP	A	-1,563	Clinic	90		41.05
42							42
42.01	LDUES -LOBBYING PORTION	A	-17,213	Administrative & General	5		42.01
42.02	MARKETING EXP	A	-156,492	Administrative & General	5		42.02
42.03	MEDICARE PREMIUM FOR RETIRED EM	A	-4,300	Administrative & General	5		42.03
43							43
44	ADVERTISING EXP	A	-43,490	Administrative & General	5		44
44.02	ADVERTISING EXP	A	-1,708	Adults & Pediatrics	30		44.02
45	MEDICAID ASSESSMENT TAX	A	-4,516,794	Administrative & General	5		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)		-9,062,750				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.

**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		LINE#	Wkst. A-7 Ref.
				COST CENTER			
		1	2	3		4	5

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

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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**STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS**

**WORKSHEET A-8-1**

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

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

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

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

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

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

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

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

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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	4	Employee Benefits De AGGREGATE								1
2	5	Administrative & Gen AGGREGATE	27,882	512	27,370	177,200	196	16,698	835	2
3	15	Pharmacy AGGREGATE								3
4	16	Medical Records & Li AGGREGATE	100,203	100,203		177,200				4
5										5
6	17	Social Service AGGREGATE	119,013		119,013	177,200	876	74,628	3,731	6
7										7
8	30	Adults & Pediatrics AGGREGATE	38,205	2,205	36,000	177,200	267	22,746	1,137	8
9	31	Intensive Care Unit AGGREGATE	22,996		22,996	177,200	153	13,034	652	9
10	50	Operating Room AGGREGATE	105,868	105,868		177,200				10
11										11
12	53	Anesthesiology AGGREGATE	525,700	525,700		177,200				12
13	54	Radiology-Diagnostic AGGREGATE	53,913	53,913						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	31,368	20,650	10,718	177,200	79	6,730	337	18
19										19
20	75	ASC (Non-Distinct Pa AGGREGATE								20
22	90	Clinic AGGREGATE	841,229	841,229						22
24	91	Emergency AGGREGATE	1,624,860	1,624,860						24
200		TOTAL	3,531,237	3,275,140	256,097		1,838	156,582	7,829	200

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

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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	4	Employee Benefits De	AGGREGATE							1
2	5	Administrative & Gen	AGGREGATE				16,698	10,672	11,184	2
3	15	Pharmacy	AGGREGATE							3
4	16	Medical Records & Li	AGGREGATE						100,203	4
5										5
6	17	Social Service	AGGREGATE				74,628	44,385	44,385	6
7										7
8	30	Adults & Pediatrics	AGGREGATE				22,746	13,254	15,459	8
9	31	Intensive Care Unit	AGGREGATE				13,034	9,962	9,962	9
10	50	Operating Room	AGGREGATE						105,868	10
11										11
12	53	Anesthesiology	AGGREGATE						525,700	12
13	54	Radiology-Diagnostic	AGGREGATE						53,913	13
14										14
15										15
16	60	Laboratory	AGGREGATE				22,746	17,254	17,254	16
17										17
18	65	Respiratory Therapy	AGGREGATE				6,730	3,988	24,638	18
19										19
20	75	ASC (Non-Distinct Pa	AGGREGATE							20
22	90	Clinic	AGGREGATE						841,229	22
24	91	Emergency	AGGREGATE						1,624,860	24
200		TOTAL					156,582	99,515	3,374,655	200

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

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
<b>GENERAL SERVICE COST CENTERS</b>								
1	Cap Rel Costs-Bldg & Fixt	2,800,080	2,800,080					1
2	Cap Rel Costs-Mvble Equip	2,008,228		2,008,228				2
4	Employee Benefits Department	2,925,595	4,374	3,137	2,933,106			4
5	Administrative & General	9,594,519	158,285	113,522	600,637	10,466,963	10,466,963	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,227,777	590,546	423,542	71,593	3,313,458	879,945	7
8	Laundry & Linen Service	152,202				152,202	40,420	8
9	Housekeeping	589,168	8,844	6,343		604,355	160,497	9
10	Dietary	923,221	75,504	54,152	54,922	1,107,799	294,195	10
11	Cafeteria	270,144	33,178	23,795	21,760	348,877	92,650	11
12	Maintenance of Personnel							12
13	Nursing Administration	432,420			54,247	486,667	129,243	13
14	Central Services & Supply	119,848	92,232	66,149	11,219	289,448	76,868	14
15	Pharmacy	842,309	12,149	8,713	105,848	969,019	257,339	15
16	Medical Records & Library	638,873	36,300	26,035	60,124	761,332	202,185	16
17	Social Service	247,167			41,461	288,628	76,650	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	4,322,499	511,288	366,698	542,534	5,743,019	1,525,151	30
31	Intensive Care Unit	685,982	38,706	27,760	89,586	842,034	223,616	31
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	2,643,710	90,532	64,930	126,312	2,925,484	776,912	50
53	Anesthesiology	6,209	3,924	2,814		12,947	3,438	53
54	Radiology-Diagnostic	1,462,801	105,790	75,873	107,411	1,751,875	465,240	54
54.01	ULTRASOUND	169,978	2,733	1,960	22,783	197,454	52,437	54.01
60	Laboratory	3,018,404	66,611	47,774	156,068	3,288,857	873,412	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	553,561	36,482	26,165	69,274	685,482	182,041	65
66	Physical Therapy	121,127	31,514	22,602		175,243	46,539	66
69	Electrocardiology	92,777	2,369	1,699	9,922	106,767	28,354	69
69.01	CARDIAC CATH LAB	20,032	18,830	13,505	428	52,795	14,021	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	1,201,091				1,201,091	318,970	71
72	Impl. Dev. Charged to Patients	412,411				412,411	109,523	72
73	Drugs Charged to Patients	4,020,218				4,020,218	1,067,637	73
74	Renal Dialysis	163,572	850	610		165,032	43,827	74
75	ASC (Non-Distinct Part)	380,812	99,522	71,377	50,638	602,349	159,964	75
75.01	ONCOLOGY	274,174	55,082	39,505	37,466	406,227	107,880	75.01
75.02	GI LAB	8,541	21,843	15,666		46,050	12,229	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	672,922	71,142	51,024	190,544	985,632	261,751	90
90.01	WOUND CARE CENTER	54,945	10,326	7,406	7,499	80,176	21,292	90.01
91	Emergency	716,810	41,913	30,060	202,784	991,567	263,327	91
92	Observation Beds (Non-Distinct Part)							92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
<b>SPECIAL PURPOSE COST CENTERS</b>								
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	44,774,127	2,220,869	1,592,816	2,635,060	43,481,458	8,767,553	118
<b>NONREIMBURSABLE COST CENTERS</b>								
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	3,403,331	15,477	11,100	263,520	3,693,428	980,853	192
192.01	RETAIL PHARMACY	1,465,272	4,374	3,137	23,402	1,496,185	397,337	192.01
192.02	CHA SITES	93,695	559,360	401,175	10,243	1,064,473	282,689	192.02
192.03	OTHER NON REIMBURSABLE	137,283				137,283	36,458	192.03
194	SENIOR HEALTH	6,925			881	7,806	2,073	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	49,880,633	2,800,080	2,008,228	2,933,106	49,880,633	10,466,963	202

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7	8	9	10	11	13	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	4,193,403						7
8	Laundry & Linen Service		192,622					8
9	Housekeeping	18,119		782,971				9
10	Dietary	154,683		28,945	1,585,622			10
11	Cafeteria	67,971		12,719		522,217		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,663		7,635	625,208	13
14	Central Services & Supply	188,955		35,359		7,223		14
15	Pharmacy	24,889		4,657		21,719		15
16	Medical Records & Library	74,368		13,916		20,749		16
17	Social Service					5,987		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	1,047,467	136,798	196,009	1,579,770	171,738	397,273	30
31	Intensive Care Unit	79,296	3,657	14,838	5,852	17,234	39,868	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	185,471	25,772	34,707		30,009	69,418	50
53	Anesthesiology	8,039		1,504				53
54	Radiology-Diagnostic	216,731	17,489	40,556		24,288		54
54.01	ULTRASOUND	5,600		1,048		4,945		54.01
60	Laboratory	136,465		25,536		46,904		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	74,741		13,986		19,901		65
66	Physical Therapy	64,561		12,081				66
69	Electrocardiology	4,853		908		2,545		69
69.01	CARDIAC CATH LAB	38,578		7,219		97		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	1,742		326				74
75	ASC (Non-Distinct Part)	203,889	8,789	38,153		11,853	27,419	75
75.01	ONCOLOGY	112,846		21,116		11,368	26,298	75.01
75.02	GI LAB	44,750		8,374				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	145,748		27,273		34,178		90
90.01	WOUND CARE CENTER	21,155		3,959		2,133	4,934	90.01
91	Emergency	85,866	117	16,068		25,936	59,998	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)	3,006,783	192,622	560,920	1,585,622	466,442	625,208	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	31,708		5,933		43,122		192
192.01	RETAIL PHARMACY	8,960		1,677		7,199		192.01
192.02	CHA SITES	1,145,952		214,441		4,993		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					461		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,193,403	192,622	782,971	1,585,622	522,217	625,208	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	597,853					14
15	Pharmacy		1,277,623				15
16	Medical Records & Library			1,072,550			16
17	Social Service				371,265		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		1,807	198,703	222,758	11,220,493	30
31	Intensive Care Unit		265	9,580	74,253	1,310,493	31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room		1,882	44,997		4,094,652	50
53	Anesthesiology		2,026	12,421		40,375	53
54	Radiology-Diagnostic		12,344	114,925		2,643,448	54
54.01	ULTRASOUND			18,837		280,321	54.01
60	Laboratory			176,199		4,547,373	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy			58,200		1,034,351	65
66	Physical Therapy			1,508		299,932	66
69	Electrocardiology		87	19,810		163,324	69
69.01	CARDIAC CATH LAB		76	4,462		117,248	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	445,042		43,101		2,008,204	71
72	Impl. Dev. Charged to Patients	152,811		20,094		694,839	72
73	Drugs Charged to Patients		935,626	245,011		6,268,492	73
74	Renal Dialysis			3,242		214,169	74
75	ASC (Non-Distinct Part)		189	14,447		1,067,052	75
75.01	ONCOLOGY		394	26,109	37,127	749,365	75.01
75.02	GI LAB		26	11,406		122,835	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		1,711	10,591		1,466,884	90
90.01	WOUND CARE CENTER		20	1,277		134,946	90.01
91	Emergency		767	37,630	37,127	1,518,403	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)	597,853	957,220	1,072,550	371,265	39,997,199	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices		19,133			4,774,177	192
192.01	RETAIL PHARMACY		301,258			2,212,616	192.01
192.02	CHA SITES		12			2,712,560	192.02
192.03	OTHER NON REIMBURSABLE					173,741	192.03
194	SENIOR HEALTH					10,340	194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	597,853	1,277,623	1,072,550	371,265	49,880,633	202

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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	11,220,493					30
31	Intensive Care Unit	1,310,493					31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	4,094,652					50
53	Anesthesiology	40,375					53
54	Radiology-Diagnostic	2,643,448					54
54.01	ULTRASOUND	280,321					54.01
60	Laboratory	4,547,373					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,034,351					65
66	Physical Therapy	299,932					66
69	Electrocardiology	163,324					69
69.01	CARDIAC CATH LAB	117,248					69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	2,008,204					71
72	Impl. Dev. Charged to Patients	694,839					72
73	Drugs Charged to Patients	6,268,492					73
74	Renal Dialysis	214,169					74
75	ASC (Non-Distinct Part)	1,067,052					75
75.01	ONCOLOGY	749,365					75.01
75.02	GI LAB	122,835					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	1,466,884					90
90.01	WOUND CARE CENTER	134,946					90.01
91	Emergency	1,518,403					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)	39,997,199					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	4,774,177					192
192.01	RETAIL PHARMACY	2,212,616					192.01
192.02	CHA SITES	2,712,560					192.02
192.03	OTHER NON REIMBURSABLE	173,741					192.03
194	SENIOR HEALTH	10,340					194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	49,880,633					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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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		4,374	3,137	7,511	7,511		4
5	Administrative & General		158,285	113,522	271,807	1,541	273,348	5
6	Maintenance & Repairs							6
7	Operation of Plant		590,546	423,542	1,014,088	183	22,979	7
8	Laundry & Linen Service						1,056	8
9	Housekeeping		8,844	6,343	15,187		4,191	9
10	Dietary		75,504	54,152	129,656	141	7,683	10
11	Cafeteria		33,178	23,795	56,973	56	2,419	11
12	Maintenance of Personnel							12
13	Nursing Administration					139	3,375	13
14	Central Services & Supply		92,232	66,149	158,381	29	2,007	14
15	Pharmacy		12,149	8,713	20,862	271	6,720	15
16	Medical Records & Library		36,300	26,035	62,335	154	5,280	16
17	Social Service					106	2,002	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		511,288	366,698	877,986	1,389	39,844	30
31	Intensive Care Unit		38,706	27,760	66,466	229	5,840	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		90,532	64,930	155,462	323	20,288	50
53	Anesthesiology		3,924	2,814	6,738		90	53
54	Radiology-Diagnostic		105,790	75,873	181,663	275	12,149	54
54.01	ULTRASOUND		2,733	1,960	4,693	58	1,369	54.01
60	Laboratory		66,611	47,774	114,385	399	22,808	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		36,482	26,165	62,647	177	4,754	65
66	Physical Therapy		31,514	22,602	54,116		1,215	66
69	Electrocardiology		2,369	1,699	4,068	25	740	69
69.01	CARDIAC CATH LAB		18,830	13,505	32,335	1	366	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients						8,330	71
72	Impl. Dev. Charged to Patients						2,860	72
73	Drugs Charged to Patients						27,880	73
74	Renal Dialysis		850	610	1,460		1,144	74
75	ASC (Non-Distinct Part)		99,522	71,377	170,899	130	4,177	75
75.01	ONCOLOGY		55,082	39,505	94,587	96	2,817	75.01
75.02	GI LAB		21,843	15,666	37,509		319	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		71,142	51,024	122,166	488	6,835	90
90.01	WOUND CARE CENTER		10,326	7,406	17,732	19	556	90.01
91	Emergency		41,913	30,060	71,973	519	6,877	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)		2,220,869	1,592,816	3,813,685	6,748	228,970	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		15,477	11,100	26,577	675	25,614	192
192.01	RETAIL PHARMACY		4,374	3,137	7,511	60	10,376	192.01
192.02	CHA SITES		559,360	401,175	960,535	26	7,382	192.02
192.03	OTHER NON REIMBURSABLE						952	192.03
194	SENIOR HEALTH					2	54	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,800,080	2,008,228	4,808,308	7,511	273,348	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	1,037,250						7
8	Laundry & Linen Service		1,056					8
9	Housekeeping	4,482		23,860				9
10	Dietary	38,261		882	176,623			10
11	Cafeteria	16,813		388		76,649		11
12	Maintenance of Personnel							12
13	Nursing Administration			51		1,121	4,686	13
14	Central Services & Supply	46,739		1,078		1,060		14
15	Pharmacy	6,156		142		3,188		15
16	Medical Records & Library	18,395		424		3,045		16
17	Social Service					879		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	259,094	750	5,973	175,971	25,205	2,977	30
31	Intensive Care Unit	19,614	20	452	652	2,530	299	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	45,877	141	1,058		4,405	520	50
53	Anesthesiology	1,988		46				53
54	Radiology-Diagnostic	53,609	96	1,236		3,565		54
54.01	ULTRASOUND	1,385		32		726		54.01
60	Laboratory	33,755		778		6,884		60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	18,487		426		2,921		65
66	Physical Therapy	15,969		368				66
69	Electrocardiology	1,200		28		374		69
69.01	CARDIAC CATH LAB	9,542		220		14		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	431		10				74
75	ASC (Non-Distinct Part)	50,432	48	1,163		1,740	206	75
75.01	ONCOLOGY	27,913		643		1,669	197	75.01
75.02	GI LAB	11,069		255				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	36,051		831		5,016		90
90.01	WOUND CARE CENTER	5,233		121		313	37	90.01
91	Emergency	21,239	1	490		3,807	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>							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	743,734	1,056	17,095	176,623	68,462	4,686	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	7,843		181		6,329		192
192.01	RETAIL PHARMACY	2,216		51		1,057		192.01
192.02	CHA SITES	283,457		6,533		733		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					68		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,037,250	1,056	23,860	176,623	76,649	4,686	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	209,294						14
15	Pharmacy		37,339					15
16	Medical Records & Library			89,633				16
17	Social Service				2,987			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		53	16,601	1,792	1,407,635		30
31	Intensive Care Unit		8	800	597	97,507		31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		55	3,759		231,888		50
53	Anesthesiology		59	1,038		9,959		53
54	Radiology-Diagnostic		361	9,602		262,556		54
54.01	ULTRASOUND			1,574		9,837		54.01
60	Laboratory			14,721		193,730		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			4,863		94,275		65
66	Physical Therapy			126		71,794		66
69	Electrocardiology		3	1,655		8,093		69
69.01	CARDIAC CATH LAB		2	373		42,853		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	155,799		3,601		167,730		71
72	Impl. Dev. Charged to Patients	53,495		1,679		58,034		72
73	Drugs Charged to Patients		27,342	20,493		75,715		73
74	Renal Dialysis			271		3,316		74
75	ASC (Non-Distinct Part)		6	1,207		230,008		75
75.01	ONCOLOGY		12	2,181	299	130,414		75.01
75.02	GI LAB		1	953		50,106		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		50	885		172,322		90
90.01	WOUND CARE CENTER		1	107		24,119		90.01
91	Emergency		22	3,144	299	108,821		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)	209,294	27,975	89,633	2,987	3,450,712		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		559			67,778		192
192.01	RETAIL PHARMACY		8,805			30,076		192.01
192.02	CHA SITES					1,258,666		192.02
192.03	OTHER NON REIMBURSABLE					952		192.03
194	SENIOR HEALTH					124		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	209,294	37,339	89,633	2,987	4,808,308		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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	1,407,635					30
31	Intensive Care Unit	97,507					31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	231,888					50
53	Anesthesiology	9,959					53
54	Radiology-Diagnostic	262,556					54
54.01	ULTRASOUND	9,837					54.01
60	Laboratory	193,730					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	94,275					65
66	Physical Therapy	71,794					66
69	Electrocardiology	8,093					69
69.01	CARDIAC CATH LAB	42,853					69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	167,730					71
72	Impl. Dev. Charged to Patients	58,034					72
73	Drugs Charged to Patients	75,715					73
74	Renal Dialysis	3,316					74
75	ASC (Non-Distinct Part)	230,008					75
75.01	ONCOLOGY	130,414					75.01
75.02	GI LAB	50,106					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	172,322					90
90.01	WOUND CARE CENTER	24,119					90.01
91	Emergency	108,821					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)	3,450,712					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	67,778					192
192.01	RETAIL PHARMACY	30,076					192.01
192.02	CHA SITES	1,258,666					192.02
192.03	OTHER NON REIMBURSABLE	952					192.03
194	SENIOR HEALTH	124					194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	4,808,308					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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	20,568,906				4
5	Administrative & General	13,029	13,029	4,212,049	-10,466,963	39,413,670		5
6	Maintenance & Repairs							6
7	Operation of Plant	48,610	48,610	502,055		3,313,458	168,486	7
8	Laundry & Linen Service					152,202		8
9	Housekeeping	728	728			604,355	728	9
10	Dietary	6,215	6,215	385,152		1,107,799	6,215	10
11	Cafeteria	2,731	2,731	152,593		348,877	2,731	11
12	Maintenance of Personnel							12
13	Nursing Administration			380,417		486,667		13
14	Central Services & Supply	7,592	7,592	78,677		289,448	7,592	14
15	Pharmacy	1,000	1,000	742,279		969,019	1,000	15
16	Medical Records & Library	2,988	2,988	421,630		761,332	2,988	16
17	Social Service			290,755		288,628		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	3,804,612		5,743,019	42,086	30
31	Intensive Care Unit	3,186	3,186	628,238		842,034	3,186	31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,452	7,452	885,786		2,925,484	7,452	50
53	Anesthesiology	323	323			12,947	323	53
54	Radiology-Diagnostic	8,708	8,708	753,240		1,751,875	8,708	54
54.01	ULTRASOUND	225	225	159,773		197,454	225	54.01
60	Laboratory	5,483	5,483	1,094,457		3,288,857	5,483	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,003	3,003	485,799		685,482	3,003	65
66	Physical Therapy	2,594	2,594			175,243	2,594	66
69	Electrocardiology	195	195	69,578		106,767	195	69
69.01	CARDIAC CATH LAB	1,550	1,550	3,001		52,795	1,550	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients					1,201,091		71
72	Impl. Dev. Charged to Patients					412,411		72
73	Drugs Charged to Patients					4,020,218		73
74	Renal Dialysis	70	70			165,032	70	74
75	ASC (Non-Distinct Part)	8,192	8,192	355,108		602,349	8,192	75
75.01	ONCOLOGY	4,534	4,534	262,740		406,227	4,534	75.01
75.02	GI LAB	1,798	1,798			46,050	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	1,336,225		985,632	5,856	90
90.01	WOUND CARE CENTER	850	850	52,589		80,176	850	90.01
91	Emergency	3,450	3,450	1,422,055		991,567	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	18,478,808	-10,466,963	33,014,495	120,809	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	1,274	1,274	1,847,982		3,693,428	1,274	192
192.01	RETAIL PHARMACY	360	360	164,110		1,496,185	360	192.01
192.02	CHA SITES	46,043	46,043	71,831		1,064,473	46,043	192.02
192.03	OTHER NON REIMBURSABLE					137,283		192.03
194	SENIOR HEALTH			6,175		7,806		194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,800,080	2,008,228	2,933,106		10,466,963	4,193,403	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.148643	8.713053	0.142599		0.265567	24.888733	203
204	Cost to be allocated (Per Wkst. B, Part II)			7,511		273,348	1,037,250	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000365		0.006935	6.156298	205

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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	72,347				10
11	Cafeteria		2,731		21,544			11
12	Maintenance of Personnel							12
13	Nursing Administration		357		315	11,150		13
14	Central Services & Supply		7,592		298		1,613,502	14
15	Pharmacy		1,000		896			15
16	Medical Records & Library		2,988		856			16
17	Social Service				247			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	72,080	7,085	7,085		30
31	Intensive Care Unit	5,986	3,186	267	711	711		31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	42,183	7,452		1,238	1,238		50
53	Anesthesiology		323					53
54	Radiology-Diagnostic	28,626	8,708		1,002			54
54.01	ULTRASOUND		225		204			54.01
60	Laboratory		5,483		1,935			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,003		821			65
66	Physical Therapy		2,594					66
69	Electrocardiology		195		105			69
69.01	CARDIAC CATH LAB		1,550		4			69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients						1,201,091	71
72	Impl. Dev. Charged to Patients						412,411	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		70					74
75	ASC (Non-Distinct Part)	14,385	8,192		489	489		75
75.01	ONCOLOGY		4,534		469	469		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		1,410			90
90.01	WOUND CARE CENTER		850		88	88		90.01
91	Emergency	191	3,450		1,070	1,070		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	72,347	19,243	11,150	1,613,502	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		1,274		1,779			192
192.01	RETAIL PHARMACY		360		297			192.01
192.02	CHA SITES		46,043		206			192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH				19			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	192,622	782,971	1,585,622	522,217	625,208	597,853	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.610959	4.657354	21.916900	24.239556	56.072466	0.370531	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,056	23,860	176,623	76,649	4,686	209,294	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.003349	0.141927	2.441331	3.557789	0.420269	0.129714	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

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

<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	5,489,707					15
16	Medical Records & Library		131,974,342				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	7,766	24,449,789	60			30
31	Intensive Care Unit	1,138	1,178,791	20			31
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	8,086	5,536,668				50
53	Anesthesiology	8,706	1,528,315				53
54	Radiology-Diagnostic	53,041	14,141,170				54
54.01	ULTRASOUND		2,317,786				54.01
60	Laboratory		21,680,646				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		7,161,367				65
66	Physical Therapy		185,544				66
69	Electrocardiology	372	2,437,504				69
69.01	CARDIAC CATH LAB	325	549,061				69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients		5,303,375				71
72	Impl. Dev. Charged to Patients		2,472,492				72
73	Drugs Charged to Patients	4,020,218	30,148,692				73
74	Renal Dialysis		398,880				74
75	ASC (Non-Distinct Part)	813	1,777,633				75
75.01	ONCOLOGY	1,691	3,212,614	10			75.01
75.02	GI LAB	111	1,403,528				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	7,352	1,303,178				90
90.01	WOUND CARE CENTER	86	157,071				90.01
91	Emergency	3,295	4,630,238	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)	4,113,000	131,974,342	100			118
<b>NONREIMBURSABLE COST CENTERS</b>							
190.01	SENIOR HEALTH						190.01
192	Physicians' Private Offices	82,210					192
192.01	RETAIL PHARMACY	1,294,447					192.01
192.02	CHA SITES	50					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)	1,277,623	1,072,550	371,265			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.232731	0.008127	3,712.650000			203
204	Cost to be allocated (Per Wkst. B, Part II)	37,339	89,633	2,987			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.006802	0.000679	29.870000			205

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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	11,220,493		11,220,493	13,254	11,233,747	30
31	Intensive Care Unit	1,310,493		1,310,493	9,962	1,320,455	31
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	4,094,652		4,094,652		4,094,652	50
53	Anesthesiology	40,375		40,375		40,375	53
54	Radiology-Diagnostic	2,643,448		2,643,448		2,643,448	54
54.01	ULTRASOUND	280,321		280,321		280,321	54.01
60	Laboratory	4,547,373		4,547,373	17,254	4,564,627	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,034,351		1,034,351	3,988	1,038,339	65
66	Physical Therapy	299,932		299,932		299,932	66
69	Electrocardiology	163,324		163,324		163,324	69
69.01	CARDIAC CATH LAB	117,248		117,248		117,248	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	2,008,204		2,008,204		2,008,204	71
72	Impl. Dev. Charged to Patients	694,839		694,839		694,839	72
73	Drugs Charged to Patients	6,268,492		6,268,492		6,268,492	73
74	Renal Dialysis	214,169		214,169		214,169	74
75	ASC (Non-Distinct Part)	1,067,052		1,067,052		1,067,052	75
75.01	ONCOLOGY	749,365		749,365		749,365	75.01
75.02	GI LAB	122,835		122,835		122,835	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	1,466,884		1,466,884		1,466,884	90
90.01	WOUND CARE CENTER	134,946		134,946		134,946	90.01
91	Emergency	1,518,403		1,518,403		1,518,403	91
92	Observation Beds (Non-Distinct Part)	570,868		570,868		570,868	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)	40,568,067		40,568,067	44,458	40,612,525	200
201	Less Observation Beds	570,868		570,868		570,868	201
202	Total (line 200 minus line 201)	39,997,199		39,997,199		40,041,657	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				
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	24,449,789		24,449,789				30
31	Intensive Care Unit	1,178,791		1,178,791				31
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	3,492,950	2,043,718	5,536,668	0.739552	0.739552	0.739552	50
53	Anesthesiology	438,798	1,089,517	1,528,315	0.026418	0.026418	0.026418	53
54	Radiology-Diagnostic	3,537,625	10,603,545	14,141,170	0.186933	0.186933	0.186933	54
54.01	ULTRASOUND	568,585	1,749,201	2,317,786	0.120943	0.120943	0.120943	54.01
60	Laboratory	7,662,976	14,017,670	21,680,646	0.209743	0.209743	0.210539	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,438,503	722,864	7,161,367	0.144435	0.144435	0.144992	65
66	Physical Therapy	176,202	9,342	185,544	1.616501	1.616501	1.616501	66
69	Electrocardiology	891,880	1,545,624	2,437,504	0.067005	0.067005	0.067005	69
69.01	CARDIAC CATH LAB	177,606	371,455	549,061	0.213543	0.213543	0.213543	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	2,016,966	3,286,409	5,303,375	0.378665	0.378665	0.378665	71
72	Impl. Dev. Charged to Patients	1,570,693	901,800	2,472,493	0.281028	0.281028	0.281028	72
73	Drugs Charged to Patients	20,021,811	20,126,881	40,148,692	0.156132	0.156132	0.156132	73
74	Renal Dialysis	360,056	38,824	398,880	0.536926	0.536926	0.536926	74
75	ASC (Non-Distinct Part)	253,494	1,524,139	1,777,633	0.600266	0.600266	0.600266	75
75.01	ONCOLOGY	261,562	2,951,052	3,212,614	0.233257	0.233257	0.233257	75.01
75.02	GI LAB	194,650	1,208,878	1,403,528	0.087519	0.087519	0.087519	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	5,475	1,297,703	1,303,178	1.125621	1.125621	1.125621	90
90.01	WOUND CARE CENTER	12,821	144,250	157,071	0.859140	0.859140	0.859140	90.01
91	Emergency	1,408,014	3,222,224	4,630,238	0.327932	0.327932	0.327932	91
92	Observation Beds (Non-Distinct Part)		1,072,199	1,072,199	0.532427	0.532427	0.532427	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)	75,119,247	67,927,295	143,046,542				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	75,119,247	67,927,295	143,046,542				202

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

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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)	1,407,635		1,407,635	19,816	71.04	4,545	322,877	30
31	Intensive Care Unit	97,507		97,507	602	161.97	509	82,443	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)	1,505,142		1,505,142	20,418		5,054	405,320	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	231,888	5,536,668	0.041882	455,851	19,092	50
53	Anesthesiology	9,959	1,528,315	0.006516	102,281	666	53
54	Radiology-Diagnostic	262,556	14,141,170	0.018567	1,340,966	24,898	54
54.01	ULTRASOUND	9,837	2,317,786	0.004244	180,299	765	54.01
60	Laboratory	193,730	21,680,646	0.008936	2,744,887	24,528	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	94,275	7,161,367	0.013164	2,255,250	29,688	65
66	Physical Therapy	71,794	185,544	0.386938	62,697	24,260	66
69	Electrocardiology	8,093	2,437,504	0.003320	390,921	1,298	69
69.01	CARDIAC CATH LAB	42,853	549,061	0.078048	30,185	2,356	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	167,730	5,303,375	0.031627	591,724	18,714	71
72	Impl. Dev. Charged to Patients	58,034	2,472,493	0.023472	515,781	12,106	72
73	Drugs Charged to Patients	75,715	40,148,692	0.001886	3,424,281	6,458	73
74	Renal Dialysis	3,316	398,880	0.008313	97,291	809	74
75	ASC (Non-Distinct Part)	230,008	1,777,633	0.129390			75
75.01	ONCOLOGY	130,414	3,212,614	0.040594			75.01
75.02	GI LAB	50,106	1,403,528	0.035700	67,081	2,395	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	172,322	1,303,178	0.132232	4,736	626	90
90.01	WOUND CARE CENTER	24,119	157,071	0.153555			90.01
91	Emergency	108,821	4,630,238	0.023502	324,430	7,625	91
92	Observation Beds (Non-Distinct	71,532	1,072,199	0.066715			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	2,017,102	117,417,962		12,588,661	176,284	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)	19,816		4,545		30
31	Intensive Care Unit	602		509		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)	20,418		5,054		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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	5,536,668			455,851		564,186		50
53	Anesthesiology	1,528,315			102,281		142,459		53
54	Radiology-Diagnostic	14,141,170			1,340,966		2,760,415		54
54.01	ULTRASOUND	2,317,786			180,299		249,268		54.01
60	Laboratory	21,680,646			2,744,887		1,264,383		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	7,161,367			2,255,250		126,441		65
66	Physical Therapy	185,544			62,697				66
69	Electrocardiology	2,437,504			390,921		473,604		69
69.01	CARDIAC CATH LAB	549,061			30,185		157,693		69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	5,303,375			591,724		478,925		71
72	Impl. Dev. Charged to Patients	2,472,493			515,781		277,322		72
73	Drugs Charged to Patients	40,148,692			3,424,281		9,147,773		73
74	Renal Dialysis	398,880			97,291				74
75	ASC (Non-Distinct Part)	1,777,633							75
75.01	ONCOLOGY	3,212,614					170,192		75.01
75.02	GI LAB	1,403,528			67,081		157,824		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	1,303,178			4,736		706,515		90
90.01	WOUND CARE CENTER	157,071							90.01
91	Emergency	4,630,238			324,430		255,529		91
92	Observation Beds (Non-Distinct)	1,072,199					272,529		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	117,417,962			12,588,661		17,205,058		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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	0.739552	564,186			417,245			50
53	Anesthesiology	0.026418	142,459			3,763			53
54	Radiology-Diagnostic	0.186933	2,760,415			516,013			54
54.01	ULTRASOUND	0.120943	249,268			30,147			54.01
60	Laboratory	0.209743	1,264,383			265,195			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.144435	126,441			18,263			65
66	Physical Therapy	1.616501							66
69	Electrocardiology	0.067005	473,604			31,734			69
69.01	CARDIAC CATH LAB	0.213543	157,693			33,674			69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	0.378665	478,925			181,352			71
72	Impl. Dev. Charged to Patients	0.281028	277,322			77,935			72
73	Drugs Charged to Patients	0.156132	9,147,773		17,163	1,428,260		2,680	73
74	Renal Dialysis	0.536926							74
75	ASC (Non-Distinct Part)	0.600266							75
75.01	ONCOLOGY	0.233257	170,192			39,698			75.01
75.02	GI LAB	0.087519	157,824			13,813			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	1.125621	706,515			795,268			90
90.01	WOUND CARE CENTER	0.859140							90.01
91	Emergency	0.327932	255,529			83,796			91
92	Observation Beds (Non-Distinct	0.532427	272,529			145,102			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		17,205,058		17,163	4,081,258		2,680	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		17,205,058		17,163	4,081,258		2,680	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)	1,407,635		1,407,635	19,816	71.04	2,632	186,977	30
31	Intensive Care Unit	97,507		97,507	602	161.97	70	11,338	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)	1,505,142		1,505,142	20,418		2,702	198,315	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-0115**

**WORKSHEET D  
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	231,888	5,536,668	0.041882	297,421	12,457	50
53	Anesthesiology	9,959	1,528,315	0.006516	49,094	320	53
54	Radiology-Diagnostic	262,556	14,141,170	0.018567	384,942	7,147	54
54.01	ULTRASOUND	9,837	2,317,786	0.004244	48,697	207	54.01
60	Laboratory	193,730	21,680,646	0.008936	833,249	7,446	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	94,275	7,161,367	0.013164	786,349	10,351	65
66	Physical Therapy	71,794	185,544	0.386938	15,533	6,010	66
69	Electrocardiology	8,093	2,437,504	0.003320	113,134	376	69
69.01	CARDIAC CATH LAB	42,853	549,061	0.078048	30,751	2,400	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	167,730	5,303,375	0.031627	18,126	573	71
72	Impl. Dev. Charged to Patients	58,034	2,472,493	0.023472			72
73	Drugs Charged to Patients	75,715	40,148,692	0.001886	1,121,382	2,115	73
74	Renal Dialysis	3,316	398,880	0.008313	30,090	250	74
75	ASC (Non-Distinct Part)	230,008	1,777,633	0.129390	23,947	3,099	75
75.01	ONCOLOGY	130,414	3,212,614	0.040594	16,470	669	75.01
75.02	GI LAB	50,106	1,403,528	0.035700	10,473	374	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	172,322	1,303,178	0.132232	339	45	90
90.01	WOUND CARE CENTER	24,119	157,071	0.153555	1,829	281	90.01
91	Emergency	108,821	4,630,238	0.023502	150,987	3,548	91
92	Observation Beds (Non-Distinct	71,532	1,072,199	0.066715			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	2,017,102	117,417,962		3,932,813	57,668	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	1 Nursing School	2 Allied Health Cost	3 All Other Medical Education Cost	4 Swing-Bed Adjust- ment Amount (see instruct- ions)	5 Total Costs (sum of cols. 1 through 3 minus col 4.)	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)	19,816		2,632		30
31	Intensive Care Unit	602		70		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)	20,418		2,702		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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	5,536,668			297,421				50
53	Anesthesiology	1,528,315			49,094				53
54	Radiology-Diagnostic	14,141,170			384,942				54
54.01	ULTRASOUND	2,317,786			48,697				54.01
60	Laboratory	21,680,646			833,249				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	7,161,367			786,349				65
66	Physical Therapy	185,544			15,533				66
69	Electrocardiology	2,437,504			113,134				69
69.01	CARDIAC CATH LAB	549,061			30,751				69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	5,303,375			18,126				71
72	Impl. Dev. Charged to Patients	2,472,493							72
73	Drugs Charged to Patients	40,148,692			1,121,382				73
74	Renal Dialysis	398,880			30,090				74
75	ASC (Non-Distinct Part)	1,777,633			23,947				75
75.01	ONCOLOGY	3,212,614			16,470				75.01
75.02	GI LAB	1,403,528			10,473				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	1,303,178			339				90
90.01	WOUND CARE CENTER	157,071			1,829				90.01
91	Emergency	4,630,238			150,987				91
92	Observation Beds (Non-Distinct)	1,072,199							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	117,417,962			3,932,813				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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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/ID

(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	0.739552						50
53	Anesthesiology	0.026418						53
54	Radiology-Diagnostic	0.186933						54
54.01	ULTRASOUND	0.120943						54.01
60	Laboratory	0.209743						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.144435						65
66	Physical Therapy	1.616501						66
69	Electrocardiology	0.067005						69
69.01	CARDIAC CATH LAB	0.213543						69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Pat	0.378665						71
72	Impl. Dev. Charged to Patients	0.281028						72
73	Drugs Charged to Patients	0.156132						73
74	Renal Dialysis	0.536926						74
75	ASC (Non-Distinct Part)	0.600266						75
75.01	ONCOLOGY	0.233257						75.01
75.02	GI LAB	0.087519						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	1.125621						90
90.01	WOUND CARE CENTER	0.859140						90.01
91	Emergency	0.327932						91
92	Observation Beds (Non-Distinct	0.532427						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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0115

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,816	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,816	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)	18,809	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)	4,545	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)	11,233,747	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)	11,233,747	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)	11,233,747	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0115

WORKSHEET D-1  
PART II

Check [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS  
 Applicable [XX] 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)						566.90	38
39	Program general inpatient routine service cost (line 9 x line 38)						2,576,561	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)						2,576,561	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	1,320,455	602	2,193.45	509	1,116,466	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)						2,724,679	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						6,417,706	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						405,320	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						176,284	51
52	Total Program excludable cost (sum of lines 50 and 51)						581,604	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						5,836,102	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)					566.90	88
89	Observation bed cost (line 87 x line 88) (see instructions)					570,868	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	1,407,635	11,233,747	0.125304	570,868	71,532	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)	19,816	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,816	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)	18,809	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)	2,632	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)	11,220,493	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)	11,220,493	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)	11,220,493	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0115**

**WORKSHEET D-1  
PART II**

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

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

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

38	Adjusted general inpatient routine service cost per diem (see instructions)					566.23	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,490,317	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,490,317	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	1,310,493	602	2,176.90	70	152,383	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					895,408	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,538,108	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					198,315	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					57,668	51
52	Total Program excludable cost (sum of lines 50 and 51)					255,983	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0115

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		6,132,288		30
31	Intensive Care Unit		360,480		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.739552	455,851	337,126	50
53	Anesthesiology	0.026418	102,281	2,702	53
54	Radiology-Diagnostic	0.186933	1,340,966	250,671	54
54.01	ULTRASOUND	0.120943	180,299	21,806	54.01
60	Laboratory	0.210539	2,744,887	577,906	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.144992	2,255,250	326,993	65
66	Physical Therapy	1.616501	62,697	101,350	66
69	Electrocardiology	0.067005	390,921	26,194	69
69.01	CARDIAC CATH LAB	0.213543	30,185	6,446	69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients	0.378665	591,724	224,065	71
72	Impl. Dev. Charged to Patients	0.281028	515,781	144,949	72
73	Drugs Charged to Patients	0.156132	3,424,281	534,640	73
74	Renal Dialysis	0.536926	97,291	52,238	74
75	ASC (Non-Distinct Part)	0.600266			75
75.01	ONCOLOGY	0.233257			75.01
75.02	GI LAB	0.087519	67,081	5,871	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	1.125621	4,736	5,331	90
90.01	WOUND CARE CENTER	0.859140			90.01
91	Emergency	0.327932	324,430	106,391	91
92	Observation Beds (Non-Distinct Part)	0.532427			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		12,588,661	2,724,679	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		12,588,661		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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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		2,936,129		30
31	Intensive Care Unit		92,223		31
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.739552	297,421	219,958	50
53	Anesthesiology	0.026418	49,094	1,297	53
54	Radiology-Diagnostic	0.186933	384,942	71,958	54
54.01	ULTRASOUND	0.120943	48,697	5,890	54.01
60	Laboratory	0.209743	833,249	174,768	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.144435	786,349	113,576	65
66	Physical Therapy	1.616501	15,533	25,109	66
69	Electrocardiology	0.067005	113,134	7,581	69
69.01	CARDIAC CATH LAB	0.213543	30,751	6,567	69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients	0.378665	18,126	6,864	71
72	Impl. Dev. Charged to Patients	0.281028			72
73	Drugs Charged to Patients	0.156132	1,121,382	175,084	73
74	Renal Dialysis	0.536926	30,090	16,156	74
75	ASC (Non-Distinct Part)	0.600266	23,947	14,375	75
75.01	ONCOLOGY	0.233257	16,470	3,842	75.01
75.02	GI LAB	0.087519	10,473	917	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	1.125621	339	382	90
90.01	WOUND CARE CENTER	0.859140	1,829	1,571	90.01
91	Emergency	0.327932	150,987	49,513	91
92	Observation Beds (Non-Distinct Part)	0.532427			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		3,932,813	895,408	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,932,813		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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

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

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,239,146			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,478,292			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)	25,769			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	1,302,060			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	153.24			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)	0.2032			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5367			31
32	Sum of lines 30 and 31	0.7399			32
33	Allowable disproportionate share percentage (see instructions)	0.5026			33
34	Disproportionate share adjustment (see instructions)	844,047			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)	6,406,145,534		5,977,483,147	35
35.01	Factor 3 (see instructions)	0.000314481		0.000341979	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,014,611		2,044,174	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	506,405		1,528,930	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,035,335			36
	<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)	9,622,589			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)	9,622,589			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	633,414			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)	10,256,003			59
60	Primary payer payments	2,503			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	10,253,500			61
62	Deductibles billed to program beneficiaries	689,164			62
63	Coinsurance billed to program beneficiaries	121,352			63
64	Allowable bad debts (see instructions)	685,736			64
65	Adjusted reimbursable bad debts (see instructions)	445,728			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	514,643			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,888,712			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)	-29,437			70.93
70.94	HRR adjustment amount (see instructions)	-35,058			70.94
71	Amount due provider (see instructions)	9,824,217			71
71.01	Sequestration adjustment (see instructions)	196,484			71.01
72	Interim payments	9,655,315			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-27,582			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	783,763			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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 14-0115**

**WORKSHEET E  
PART B**

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

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

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,680			1
2	Medical and other services reimbursed under OPPS (see instructions)	4,081,258			2
3	PPS payments	4,920,330			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.820			5
6	Line 2 times line 5	3,346,632			6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,680			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	17,163			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)	17,163			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)	17,163			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	14,483			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) (see instructions)	2,680			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)	4,920,330			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)	1,001,059			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)	3,921,951			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)	3,921,951			30
31	Primary payer payments	2,268			31
32	Subtotal (line 30 minus line 31)	3,919,683			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)	614,458			34
35	Adjusted reimbursable bad debts (see instructions)	399,398			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	341,945			36
37	Subtotal (see instructions)	4,319,081			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)	4,319,081			40
40.01	Sequestration adjustment (see instructions)	86,382			40.01
41	Interim payments	4,035,493			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	197,206			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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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		9,460,852		4,163,051	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10	06/22/2017	194,463		3.10
		.50				3.50
		.51				3.51
	Provider	.52		06/22/2017	127,558	3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		194,463	-127,558	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)			9,655,315	4,035,493	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)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			197,206	6.01
		.02		-27,582		6.02
7	Total Medicare program liability (see instructions)			9,627,733	4,232,699	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)	4,111	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	5,054	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,071	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	19,411	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	143,046,542	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	14,903,208	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)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

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

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

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

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	2,538,108	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	2,538,108	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,538,108	7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8	Routine service charges	2,843,906	8
9	Ancillary service charges	3,932,813	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)	6,776,719	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)	6,776,719	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,238,611	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)	2,538,108	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)	2,538,108	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)	2,538,108	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)	2,538,108	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)	2,538,108	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)	2,538,108	40
41	Interim payments	2,538,108	41
42	Balance due provider/program (line 40 minus line 41)		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**

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	1,652,671				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	16,839,222				4
5	Other receivables	1,303,243				5
6	Allowances for uncollectible notes and accounts receivable	-10,049,206				6
7	Inventory	1,285,683				7
8	Prepaid expenses	291,598				8
9	Other current assets	239,225				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	11,562,436				11
<b>FIXED ASSETS</b>						
12	Land	13,334,215				12
13	Land improvements	2,431,949				13
14	Accumulated depreciation	-1,420,568				14
15	Buildings	59,842,162				15
16	Accumulated depreciation	-38,148,152				16
17	Leasehold improvements	44,885				17
18	Accumulated depreciation	-16,009				18
19	Fixed equipment	13,254,056				19
20	Accumulated depreciation	-4,514,640				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	26,739,749				23
24	Accumulated depreciation	-22,417,067				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)	49,130,580				30
<b>OTHER ASSETS</b>						
31	Investments	276,603,253				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,067,266				34
35	Total other assets (sum of lines 31-34)	281,670,519				35
36	Total assets (sum of lines 11, 30 and 35)	342,363,535				36
<b>Liabilities and Fund Balances</b> (Omit Cents)						
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	Accounts payable	1,210,850				37
38	Salaries, wages and fees payable	1,994,251				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	6,405,801				44
45	Total current liabilities (sum of lines 37 thru 44)	9,610,902				45
<b>LONG TERM LIABILITIES</b>						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	14,901,071				49
50	Total long term liabilities (sum of lines 46 thru 49)	14,901,071				50
51	Total liabilities (sum of lines 45 and 50)	24,511,973				51
<b>CAPITAL ACCOUNTS</b>						
52	General fund balance	317,851,564				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)	317,851,564				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	342,363,537				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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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		282,057,079			1
2	Net income (loss) (from Worksheet G-3, line 29)		35,794,485			2
3	Total (sum of line 1 and line 2)		317,851,564			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)		317,851,564			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)		317,851,564			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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	24,202,289		24,202,289	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	24,202,289		24,202,289	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	1,165,358		1,165,358	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)	1,165,358		1,165,358	16
17	Total inpatient routine care services (sum of lines 10 and 16)	25,367,647		25,367,647	17
18	Ancillary services	39,442,784		39,442,784	18
19	Outpatient services		76,793,205	76,793,205	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)	64,810,431	76,793,205	141,603,636	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		58,943,383	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)		58,943,383	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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)	141,603,636	1
2	Less contractual allowances and discounts on patients' accounts	93,108,617	2
3	Net patient revenues (line 1 minus line 2)	48,495,019	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	58,943,383	4
5	Net income from service to patients (line 3 minus line 4)	-10,448,364	5

**OTHER INCOME**

6	Contributions, donations, bequests, etc.		6
7	Income from investments	6,023,698	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	54	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	95,625	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	3,138	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	1,055,186	22
23	Governmental appropriations		23
24	Other (UNREALIZED GAIN ON INVESTMENT)	19,881,730	24
24.01	Other (MEANINGFUL USE REVENUE INCL ACCRUAL)		24.01
24.02	Other (UNREALIZED GAIN ON INVESTMENT)	7,067,749	24.02
24.03	Other (MISC OPERATING REVENUE)	278,837	24.03
24.04	Other (PROVIDER TAX REV)	11,836,832	24.04
25	Total other income (sum of lines 6-24)	46,242,849	25
26	Total (line 5 plus line 25)	35,794,485	26
29	Net income (or loss) for the period (line 26 minus line 28)	35,794,485	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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	542,556	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	3,181	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)	53.18	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)	0.2032	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5367	8
9	Sum of lines 7 and 8	0.7399	9
10	Allowable disproportionate share percentage (see instructions)	0.1616	10
11	Disproportionate share adjustment (see instructions)	87,677	11
12	Total prospective capital payments (see instructions)	633,414	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: 07/01/2016 To: 06/30/2017	Run Date: 11/30/2017 Run Time: 11:10 Version: 2017.10 (11/27/2017)
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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