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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11/26/2014 TIME: 15:48 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY THOREK MEMORIAL HOSPITAL (14-0115) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		676,194	154,239	-145,648	480,438	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		676,194	154,239	-145,648	480,438	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 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	Prov-ider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	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 / 2013	To: 06 / 30 / 2014	20
21	Type of control (see instructions)	2		21

	Inpatient PPS Information	1	2	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	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
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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	7,246	1,347			636		24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	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 in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67
Inpatient Psychiatric Faciltiy PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			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	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.					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
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		2,024,813			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.			N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.			Y		121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

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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 Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.75			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

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A	12/31/2014	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
			Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
				Y/N	
BAD DEBTS					
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	11/18/2014	Y	11/18/2014	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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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 COSTS			
22	HAVE ASSETS BEEN RELIFED 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 CAPITALIZED 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

		Y/N	DATE	
HOME OFFICE COSTS		1	2	
36	WERE 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 REORT PREPARER INFORMATION				
41	FIRST NAME: RAJ	LAST NAME: SHAH	TITLE: SR. REIMBURSEMENT CONSULTA	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT GROUP LLC			42
43	PHONE NUMBER: 630-530-7100 EXT 107	E-MAIL ADDRESS: RAJ.SHAH@SRGROUP.LLC		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	146	53,290			8,006	8,074	20,154	1
2	HMO AND OTHER (see instructions)						31	636		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			8,006	8,074	20,154	7
8	INTENSIVE CARE UNIT	31	10	3,650			427	519	1,201	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			8,433	8,593	21,355	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								963	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,617	1,703	4,476	1
2	HMO AND OTHER (see instructions)					10			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)		344.00			1,617	1,703	4,476	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)		344.00						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF-ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (see instructions)	200	20,871,068		20,871,068	715,536.00	29.17	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE		9,118		9,118	67.00	136.09	4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		1,864,263		1,864,263	27,732.00	67.22	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		1,439,406		1,439,406	26,816.00	53.68	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (see instructions)		426,109		426,109	10,011.00	42.56	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		147,372		147,372	884.00	166.71	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (core)(see instructions)		2,431,357		2,431,357			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		199,320		199,320			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE		1,263		1,263			22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		258,151		258,151			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		140,527		140,527	4,133.00	34.00	26
27	ADMINISTRATIVE & GENERAL		3,925,969		3,925,969	126,256.00	31.10	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		18,618		18,618	74.00	251.59	28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		444,932		444,932	17,347.00	25.65	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		2,775		2,775			32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)		553,775		553,775	29,330.00	18.88	33
34	DIETARY		489,571	-117,645	371,926	31,256.00	11.90	34
35	DIETARY UNDER CONTRACT (see instructions)		172,115		172,115	4,160.00	41.37	35
36	CAFETERIA			117,645	117,645	10,378.00	11.34	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		512,247		512,247	11,565.00	44.29	38
39	CENTRAL SERVICES AND SUPPLY		78,730		78,730	6,081.00	12.95	39
40	PHARMACY		576,429		576,429	19,345.00	29.80	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		546,680		546,680	24,834.00	22.01	41
42	SOCIAL SERVICE		461,330		461,330	8,985.00	51.34	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	19,751,313		19,751,313	721,368.00	27.38	1
2	EXCLUDED AREA SALARIES (see instructions)	1,439,406		1,439,406	26,816.00	53.68	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	18,311,907		18,311,907	694,552.00	26.37	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	573,481		573,481	10,895.00	52.64	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	2,432,620		2,432,620		13.28%	5
6	TOTAL (sum of lines 3 through 5)	21,318,008		21,318,008	705,447.00	30.22	6
7	TOTAL OVERHEAD COST (see instructions)	7,923,698		7,923,698	293,744.00	26.97	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	17,607	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,006,565	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	46,052	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	13,412	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)	1,676	12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	86,911	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	172,944	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	1,477,486	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	40,945	20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	26,492	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	2,890,090	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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

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

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

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

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	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

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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)	0.337018	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	16,721,474	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	33,213,725	6
7	MEDICAID COST (line 1 times line 6)	11,193,623	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)	611,991	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)	1,481,978	14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)	499,453	15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	2,775,814		2,775,814	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	935,499		935,499	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	935,499		935,499	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,815,616	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	954,455	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	861,161	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	290,227	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,225,726	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	1,225,726	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	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		4,357,701	4,357,701	-981,880	3,375,821	-917,953	2,457,868	1
2	00200	CAP REL COSTS-MVBLE EQUIP				2,339,525	2,339,525		2,339,525	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	140,527	2,964,744	3,105,271		3,105,271	-5,462	3,099,809	4
5	00500	ADMINISTRATIVE & GENERAL	3,925,969	9,595,751	13,521,720	-308,636	13,213,084	-592,451	12,620,633	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	444,932	1,632,285	2,077,217		2,077,217		2,077,217	7
8	00800	LAUNDRY & LINEN SERVICE				249,736	249,736		249,736	8
9	00900	HOUSEKEEPING	2,775	817,167	819,942		819,942		819,942	9
10	01000	DIETARY	489,571	782,158	1,271,729	-305,599	966,130		966,130	10
11	01100	CAFETERIA				305,599	305,599	-92,984	212,615	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	512,247	66,935	579,182		579,182	-2,482	576,700	13
14	01400	CENTRAL SERVICES & SUPPLY	78,730	258,838	337,568	-225,407	112,161		112,161	14
15	01500	PHARMACY	576,429	5,139,907	5,716,336	-4,688,518	1,027,818		1,027,818	15
16	01600	MEDICAL RECORDS & LIBRARY	546,680	635,460	1,182,140		1,182,140	-8,503	1,173,637	16
17	01700	SOCIAL SERVICE	461,330	39,089	500,419		500,419	-182,767	317,652	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	4,318,617	779,084	5,097,701	-245,954	4,851,747	-47,191	4,804,556	30
31	03100	INTENSIVE CARE UNIT	738,393	136,960	875,353	-53,463	821,890	-9,266	812,624	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	981,111	2,011,502	2,992,613	-1,095,064	1,897,549	-197,713	1,699,836	50
53	05300	ANESTHESIOLOGY		581,898	581,898	-34,283	547,615	-522,300	25,315	53
54	05400	RADIOLOGY-DIAGNOSTIC	800,668	670,897	1,471,565	-104,334	1,367,231	-1,140	1,366,091	54
54.01	03630	ULTRASOUND	171,548	8,198	179,746	-3,796	175,950		175,950	54.01
60	06000	LABORATORY	1,019,590	1,773,535	2,793,125	-7,907	2,785,218	-16,257	2,768,961	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	578,568	121,130	699,698	-39,951	659,747	-7,922	651,825	65
66	06600	PHYSICAL THERAPY		107,491	107,491	-195	107,296		107,296	66
69	06900	ELECTROCARDIOLOGY	108,069	40,461	148,530	-2,766	145,764		145,764	69
69.01	03140	CARDIAC CATH LAB	70,380	249,380	319,760	-201,077	118,683		118,683	69.01
70.01	07001	SLEEP LAB								70.01
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				1,758,650	1,758,650		1,758,650	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				603,857	603,857		603,857	72
73	07300	DRUGS CHARGED TO PATIENTS				4,634,975	4,634,975		4,634,975	73
74	07400	RENAL DIALYSIS		189,519	189,519		189,519		189,519	74
75	07500	ASC (NON-DISTINCT PART)	472,705	50,394	523,099	-17,749	505,350	-1,923	503,427	75
75.01	03480	ONCOLOGY	277,481	47,774	325,255	-35,253	290,002		290,002	75.01
75.02	03340	GI LAB		112,718	112,718	-91,974	20,744		20,744	75.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	CLINIC	1,218,456	233,095	1,451,551	-13,627	1,437,924	-698,587	739,337	90
90.01	09001	WOUND CARE CENTER	75,707	48,109	123,816	-28,612	95,204		95,204	90.01
91	09100	EMERGENCY	1,421,179	917,607	2,338,786	-107,552	2,231,234	-1,488,399	742,835	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		1,298,745	1,298,745	-1,298,745				113
118		SUBTOTALS (sum of lines 1-117)	19,431,662	35,668,532	55,100,194		55,100,194	-4,793,300	50,306,894	118
		NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH								190.01
192	19200	PHYSICIANS' PRIVATE OFFICES	1,033,798	1,242,363	2,276,161		2,276,161		2,276,161	192
192.01	19201	RETAIL PHARMACY	84,726	1,671,014	1,755,740		1,755,740		1,755,740	192.01
192.02	19202	CHA SITES	153,471	43,630	197,101		197,101		197,101	192.02
192.03	19203	OTHER NON REIMBURSABLE		42,975	42,975		42,975		42,975	192.03
194	07950	SENIOR HEALTH	167,411	9,234	176,645		176,645		176,645	194
200		TOTAL (sum of lines 118-199)	20,871,068	38,677,748	59,548,816		59,548,816	-4,793,300	54,755,516	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION GL CC 8850-8581	A	CAP REL COSTS-MVBLE EQUIP	2		2,339,525	1
500	TOTAL RECLASSIFICATIONS					2,339,525	500
	CODE LETTER - A						
1	INSURANCE	B	CAP REL COSTS-BLDG & FIXT	1		58,900	1
500	TOTAL RECLASSIFICATIONS					58,900	500
	CODE LETTER - B						
1	DRUGS CHARGED	C	DRUGS CHARGED TO PATIENTS	73		4,634,975	1
500	TOTAL RECLASSIFICATIONS					4,634,975	500
	CODE LETTER - C						
1	SUPPLIES CHARGED	D	MEDICAL SUPPLIES CHARGED TO P	71		1,758,650	1
2			IMPL. DEV. CHARGED TO PATIENT	72		603,857	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
500	TOTAL RECLASSIFICATIONS					2,362,507	500
	CODE LETTER - D						
1	CAFETERIA COSTS	E	CAFETERIA	11	117,645	187,954	1
500	TOTAL RECLASSIFICATIONS				117,645	187,954	500
	CODE LETTER - E						
1	INTEREST	F	CAP REL COSTS-BLDG & FIXT	1		1,298,745	1
500	TOTAL RECLASSIFICATIONS					1,298,745	500
	CODE LETTER - F						
1	LAUNDRY EXP	I	LAUNDRY & LINEN SERVICE	8		249,736	1
500	TOTAL RECLASSIFICATIONS					249,736	500
	CODE LETTER - I						
	GRAND TOTAL (INCREASES)				117,645	11,132,342	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DEPRECIATION GL CC 8850-8581	A	CAP REL COSTS-BLDG & FIXT	1		2,339,525	9	1
500	TOTAL RECLASSIFICATIONS					2,339,525		500
	CODE LETTER - A							
1	INSURANCE	B	ADMINISTRATIVE & GENERAL	5		58,900	12	1
500	TOTAL RECLASSIFICATIONS					58,900		500
	CODE LETTER - B							
1	DRUGS CHARGED	C	PHARMACY	15		4,634,975		1
500	TOTAL RECLASSIFICATIONS					4,634,975		500
	CODE LETTER - C							
1	SUPPLIES CHARGED	D	CENTRAL SERVICES & SUPPLY	14		225,407		1
2			PHARMACY	15		53,543		2
3			ADULTS & PEDIATRICS	30		245,954		3
4			INTENSIVE CARE UNIT	31		53,463		4
5			OPERATING ROOM	50		1,095,064		5
6			ANESTHESIOLOGY	53		34,283		6
7			RADIOLOGY-DIAGNOSTIC	54		104,334		7
8			ULTRASOUND	54.01		3,796		8
9			LABORATORY	60		7,907		9
10			RESPIRATORY THERAPY	65		39,951		10
11			PHYSICAL THERAPY	66		195		11
12			ELECTROCARDIOLOGY	69		2,766		12
13			CARDIAC CATH LAB	69.01		201,077		13
14			ASC (NON-DISTINCT PART)	75		17,749		14
15			ONCOLOGY	75.01		35,253		15
16			GI LAB	75.02		91,974		16
17			CLINIC	90		13,627		17
18			WOUND CARE CENTER	90.01		28,612		18
19			EMERGENCY	91		107,552		19
500	TOTAL RECLASSIFICATIONS					2,362,507		500
	CODE LETTER - D							
1	CAFETERIA COSTS	E	DIETARY	10	117,645	187,954		1
500	TOTAL RECLASSIFICATIONS				117,645	187,954		500
	CODE LETTER - E							
1	INTEREST	F	INTEREST EXPENSE	113		1,298,745	11	1
500	TOTAL RECLASSIFICATIONS					1,298,745		500
	CODE LETTER - F							
1	LAUNDRY EXP	I	ADMINISTRATIVE & GENERAL	5		249,736		1
500	TOTAL RECLASSIFICATIONS					249,736		500
	CODE LETTER - I							
	GRAND TOTAL (DECREASES)				117,645	11,132,342		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	12,022,957	1,311,259		1,311,259		13,334,216		1
2	LAND IMPROVEMENTS	1,474,458				9,500	1,464,958		2
3	BUILDINGS AND FIXTURES	33,930,949	8,163,891		8,163,891		42,094,840		3
4	BUILDING IMPROVEMENTS	22,906,775				591,639	22,315,136		4
5	FIXED EQUIPMENT	6,309,564				501,879	5,807,685		5
6	MOVABLE EQUIPMENT	23,158,107	1,435,779		1,435,779		24,593,886		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	99,802,810	10,910,929		10,910,929	1,103,018	109,610,721		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	99,802,810	10,910,929		10,910,929	1,103,018	109,610,721		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	4,357,701						4,357,701	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (sum of lines 1-2)	4,357,701						4,357,701	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	71,682,620		71,682,620	0.744549					1
2	CAP REL COSTS-MVBLE EQU	24,593,886		24,593,886	0.255451					2
3	TOTAL (sum of lines 1-2)	96,276,506		96,276,506	1.000000					3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	2,018,176		380,792	58,900			2,457,868	1
2	CAP REL COSTS-MVBLE EQUIP	2,339,525						2,339,525	2
3	TOTAL (sum of lines 1-2)	4,357,701		380,792	58,900			4,797,393	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-726,370	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-551	ADMINISTRATIVE & GENERAL	5		4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-17,841	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	-3,225,724				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	-88,483	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	-7,303	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-4,501	CAFETERIA	11		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34	PHY PRACTICE REIMB INCOME	B	-4,595	ADMINISTRATIVE & GENERAL	5		34
35							35
36							36
37							37
38							38
39							39
40	1985 SERIES E BOND INTEREST	A	-191,583	CAP REL COSTS-BLDG & FIXT	1	11	40
41	HOSPITALITY EXP	A	-55,786	ADMINISTRATIVE & GENERAL	5		41
41.01	HOSPITALITY EXP	A	-2,482	NURSING ADMINISTRATION	13		41.01
41.02	HOSPITALITY EXP	A	-4,018	OPERATING ROOM	50		41.02
41.03	HOSPITALITY EXP	A	-447	LABORATORY	60		41.03
41.04	HOSPITALITY EXP	A	-421	EMPLOYEE BENEFITS DEPARTMENT	4		41.04
41.05	HOSPITALITY EXP	A	-247	CLINIC	90		41.05
42							42
42.01	LDUES -LOBBYING PORTION	A	-20,817	ADMINISTRATIVE & GENERAL	5		42.01
42.02	MARKETING EXP	A	-318,168	ADMINISTRATIVE & GENERAL	5		42.02
42.03	MEDICARE PREMIUM FOR RETIRED EMP	A	-4,721	EMPLOYEE BENEFITS DEPARTMENT	4		42.03
43	DONATION	A	-20,000	ADMINISTRATIVE & GENERAL	5		43
44	ADVERTISING EXP	A	-96,909	ADMINISTRATIVE & GENERAL	5		44
44.01	ADVERTISING EXP	A	-1,140	RADIOLOGY-DIAGNOSTIC	54		44.01
44.02	ADVERTISING EXP	A	-1,193	ADULTS & PEDIATRICS	30		44.02
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-4,793,300				50

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

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

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

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

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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 ADJUST-MENTS (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.

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6							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	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	4	EMPLOYEE BENEFITS DE AGGREGATE	320	320						1
2	5	ADMINISTRATIVE & GEN AGGREGATE	115,417	57,784	57,633	177,200	683	58,186	2,909	2
3										3
4	16	MEDICAL RECORDS & LI AGGREGATE	1,200	1,200						4
5										5
6	17	SOCIAL SERVICE AGGREGATE	182,767	182,767						6
7										7
8	30	ADULTS & PEDIATRICS AGGREGATE	64,400	32,000	32,400	177,200	216	18,402	920	8
9	31	INTENSIVE CARE UNIT AGGREGATE	19,574		19,574	177,200	121	10,308	515	9
10	50	OPERATING ROOM AGGREGATE	200,596	188,446	12,150	177,200	81	6,901	345	10
11										11
12	53	ANESTHESIOLOGY AGGREGATE	522,300	522,300						12
13										13
14										14
15										15
16	60	LABORATORY AGGREGATE	36,682		36,682	177,200	245	20,872	1,044	16
17										17
18	65	RESPIRATORY THERAPY AGGREGATE	13,119	4,000	9,119	177,200	61	5,197	260	18
19										19
20	75	ASC (NON-DISTINCT PA AGGREGATE	1,923	1,923						20
22	90	CLINIC AGGREGATE	698,340	698,340						22
24	91	EMERGENCY AGGREGATE	1,488,399	1,488,399						24
200		TOTAL	3,345,037	3,177,479	167,558		1,407	119,866	5,993	200

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	4	EMPLOYEE BENEFITS DE AGGREGATE							320	1
2	5	ADMINISTRATIVE & GEN AGGREGATE					58,186		57,784	2
3										3
4	16	MEDICAL RECORDS & LI AGGREGATE							1,200	4
5										5
6	17	SOCIAL SERVICE AGGREGATE							182,767	6
7										7
8	30	ADULTS & PEDIATRICS AGGREGATE					18,402	13,998	45,998	8
9	31	INTENSIVE CARE UNIT AGGREGATE					10,308	9,266	9,266	9
10	50	OPERATING ROOM AGGREGATE					6,901	5,249	193,695	10
11										11
12	53	ANESTHESIOLOGY AGGREGATE							522,300	12
13										13
14										14
15										15
16	60	LABORATORY AGGREGATE					20,872	15,810	15,810	16
17										17
18	65	RESPIRATORY THERAPY AGGREGATE					5,197	3,922	7,922	18
19										19
20	75	ASC (NON-DISTINCT PA AGGREGATE							1,923	20
22	90	CLINIC AGGREGATE							698,340	22
24	91	EMERGENCY AGGREGATE							1,488,399	24
200		TOTAL					119,866	48,245	3,225,724	200

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	2,457,868	2,457,868					1
2	CAP REL COSTS-MVBLE EQUIP	2,339,525		2,339,525				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,099,809	4,122	3,923	3,107,854			4
5	ADMINISTRATIVE & GENERAL	12,620,633	135,080	128,576	588,569	13,472,858	13,472,858	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	2,077,217	847,918	807,092	66,703	3,798,930	1,239,804	7
8	LAUNDRY & LINEN SERVICE	249,736				249,736	81,503	8
9	HOUSEKEEPING	819,942	6,425	6,116	416	832,899	271,822	9
10	DIETARY	966,130	59,981	57,093	55,758	1,138,962	371,707	10
11	CAFETERIA	212,615	18,976	18,062	17,637	267,290	87,232	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	576,700	3,151	2,999	76,795	659,645	215,279	13
14	CENTRAL SERVICES & SUPPLY	112,161	63,334	60,285	11,803	247,583	80,800	14
15	PHARMACY	1,027,818	9,708	9,241	86,417	1,133,184	369,821	15
16	MEDICAL RECORDS & LIBRARY	1,173,637	24,227	23,060	81,957	1,302,881	425,203	16
17	SOCIAL SERVICE	317,652			69,161	386,813	126,239	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	4,804,556	371,621	353,728	647,426	6,177,331	2,016,026	30
31	INTENSIVE CARE UNIT	812,624	28,119	26,765	110,698	978,206	319,243	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,699,836	65,770	62,604	147,085	1,975,295	644,649	50
53	ANESTHESIOLOGY	25,315	2,851	2,713		30,879	10,078	53
54	RADIOLOGY-DIAGNOSTIC	1,366,091	71,207	67,778	120,034	1,625,110	530,364	54
54.01	ULTRASOUND	175,950	1,986	1,890	25,718	205,544	67,081	54.01
60	LABORATORY	2,768,961	38,401	36,552	152,854	2,996,768	978,013	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	651,825	26,504	25,228	86,737	790,294	257,917	65
66	PHYSICAL THERAPY	107,296	22,894	21,792		151,982	49,600	66
69	ELECTROCARDIOLOGY	145,764			16,201	161,965	52,858	69
69.01	CARDIAC CATH LAB	118,683	13,680	13,021	10,551	155,935	50,890	69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,758,650				1,758,650	573,946	71
72	IMPL. DEV. CHARGED TO PATIENTS	603,857				603,857	197,072	72
73	DRUGS CHARGED TO PATIENTS	4,634,975				4,634,975	1,512,652	73
74	RENAL DIALYSIS	189,519	618	588		190,725	62,244	74
75	ASC (NON-DISTINCT PART)	503,427	72,301	68,820	70,867	715,415	233,480	75
75.01	ONCOLOGY	290,002	26,478	25,203	41,599	383,282	125,086	75.01
75.02	GI LAB	20,744	15,869	15,105		51,718	16,878	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	739,337	61,331	58,378	182,667	1,041,713	339,969	90
90.01	WOUND CARE CENTER	95,204	7,502	7,141	11,350	121,197	39,553	90.01
91	EMERGENCY	742,835	44,306	42,173	213,059	1,042,373	340,185	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	50,306,894	2,044,360	1,945,926	2,892,062	49,283,995	11,687,194	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES	2,276,161	23,953	22,800	154,984	2,477,898	808,677	192
192.01	RETAIL PHARMACY	1,755,740	12,003	11,425	12,702	1,791,870	584,788	192.01
192.02	CHA SITES	197,101	377,552	359,374	23,008	957,035	312,334	192.02
192.03	OTHER NON REIMBURSABLE	42,975				42,975	14,025	192.03
194	SENIOR HEALTH	176,645			25,098	201,743	65,840	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	54,755,516	2,457,868	2,339,525	3,107,854	54,755,516	13,472,858	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 ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	5,038,734						7
8	LAUNDRY & LINEN SERVICE		331,239					8
9	HOUSEKEEPING	22,013		1,126,734				9
10	DIETARY	205,491		46,152	1,762,312			10
11	CAFETERIA	65,010		14,601		434,133		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	10,795		2,424		9,485	897,628	13
14	CENTRAL SERVICES & SUPPLY	216,981		48,733		4,999		14
15	PHARMACY	33,261		7,470		15,631		15
16	MEDICAL RECORDS & LIBRARY	83,001		18,642		20,442		16
17	SOCIAL SERVICE					7,978	28,019	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,273,162	223,006	285,947	1,702,963	151,246	531,157	30
31	INTENSIVE CARE UNIT	96,335	16,349	21,636	13,572	23,079	81,050	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	225,327	42,869	50,607		21,675	76,120	50
53	ANESTHESIOLOGY	9,767		2,194		805		53
54	RADIOLOGY-DIAGNOSTIC	243,953	25,137	54,791		22,514		54
54.01	ULTRASOUND	6,803		1,528		3,835		54.01
60	LABORATORY	131,561		29,548		35,115		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	90,802		20,394		18,696		65
66	PHYSICAL THERAPY	78,435		17,616				66
69	ELECTROCARDIOLOGY					3,767		69
69.01	CARDIAC CATH LAB	46,867		10,526		1,918		69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	2,117		475				74
75	ASC (NON-DISTINCT PART)	247,702	17,748	55,633		9,279	32,589	75
75.01	ONCOLOGY	90,711		20,373	45,777	6,300	22,127	75.01
75.02	GI LAB	54,366		12,210				75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	210,117		47,191		28,010		90
90.01	WOUND CARE CENTER	25,702		5,772		3,219	11,304	90.01
91	EMERGENCY	151,790	6,130	34,091		27,205	95,541	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	3,622,069	331,239	808,554	1,762,312	415,198	877,907	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES	82,063		18,431		15,220		192
192.01	RETAIL PHARMACY	41,122		9,236		3,150		192.01
192.02	CHA SITES	1,293,480		290,513			19,721	192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					565		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	5,038,734	331,239	1,126,734	1,762,312	434,133	897,628	202

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	599,096						14
15	PHARMACY		1,559,367					15
16	MEDICAL RECORDS & LIBRARY			1,850,169				16
17	SOCIAL SERVICE				549,049			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		5,043	343,999	329,429	13,039,309		30
31	INTENSIVE CARE UNIT		1,784	35,642	109,810	1,696,706		31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		3,978	42,158		3,082,678		50
53	ANESTHESIOLOGY		2,347	26,803		82,873		53
54	RADIOLOGY-DIAGNOSTIC		19,222	243,380		2,764,471		54
54.01	ULTRASOUND			34,893		319,684		54.01
60	LABORATORY			273,090		4,444,095		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			44,995		1,223,098		65
66	PHYSICAL THERAPY			2,315		299,948		66
69	ELECTROCARDIOLOGY		234	42,681		261,505		69
69.01	CARDIAC CATH LAB		2,099	18,998		287,233		69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	445,967		80,617		2,859,180		71
72	IMPL. DEV. CHARGED TO PATIENTS	153,129		35,385		989,443		72
73	DRUGS CHARGED TO PATIENTS		1,136,361	427,044		7,711,032		73
74	RENAL DIALYSIS			6,566		262,127		74
75	ASC (NON-DISTINCT PART)		353	21,164		1,333,363		75
75.01	ONCOLOGY		1,437	50,165	54,905	800,163		75.01
75.02	GI LAB		84	14,980		150,236		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		4,086	37,980		1,709,066		90
90.01	WOUND CARE CENTER		507	8,748		216,002		90.01
91	EMERGENCY		1,397	58,566	54,905	1,812,183		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	599,096	1,178,932	1,850,169	549,049	45,344,395		118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES		22,994			3,425,283		192
192.01	RETAIL PHARMACY		356,805			2,786,971		192.01
192.02	CHA SITES		636			2,873,719		192.02
192.03	OTHER NON REIMBURSABLE					57,000		192.03
194	SENIOR HEALTH					268,148		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	599,096	1,559,367	1,850,169	549,049	54,755,516		202

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	13,039,309						30
31	INTENSIVE CARE UNIT	1,696,706						31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,082,678						50
53	ANESTHESIOLOGY	82,873						53
54	RADIOLOGY-DIAGNOSTIC	2,764,471						54
54.01	ULTRASOUND	319,684						54.01
60	LABORATORY	4,444,095						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,223,098						65
66	PHYSICAL THERAPY	299,948						66
69	ELECTROCARDIOLOGY	261,505						69
69.01	CARDIAC CATH LAB	287,233						69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,859,180						71
72	IMPL. DEV. CHARGED TO PATIENTS	989,443						72
73	DRUGS CHARGED TO PATIENTS	7,711,032						73
74	RENAL DIALYSIS	262,127						74
75	ASC (NON-DISTINCT PART)	1,333,363						75
75.01	ONCOLOGY	800,163						75.01
75.02	GI LAB	150,236						75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,709,066						90
90.01	WOUND CARE CENTER	216,002						90.01
91	EMERGENCY	1,812,183						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	45,344,395						118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES	3,425,283						192
192.01	RETAIL PHARMACY	2,786,971						192.01
192.02	CHA SITES	2,873,719						192.02
192.03	OTHER NON REIMBURSABLE	57,000						192.03
194	SENIOR HEALTH	268,148						194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	54,755,516						202

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		4,122	3,923	8,045	8,045		4
5	ADMINISTRATIVE & GENERAL		135,080	128,576	263,656	1,523	265,179	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		847,918	807,092	1,655,010	173	24,401	7
8	LAUNDRY & LINEN SERVICE						1,604	8
9	HOUSEKEEPING		6,425	6,116	12,541	1	5,350	9
10	DIETARY		59,981	57,093	117,074	144	7,316	10
11	CAFETERIA		18,976	18,062	37,038	46	1,717	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		3,151	2,999	6,150	199	4,237	13
14	CENTRAL SERVICES & SUPPLY		63,334	60,285	123,619	31	1,590	14
15	PHARMACY		9,708	9,241	18,949	224	7,278	15
16	MEDICAL RECORDS & LIBRARY		24,227	23,060	47,287	212	8,368	16
17	SOCIAL SERVICE					179	2,484	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		371,621	353,728	725,349	1,676	39,699	30
31	INTENSIVE CARE UNIT		28,119	26,765	54,884	286	6,283	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		65,770	62,604	128,374	381	12,687	50
53	ANESTHESIOLOGY		2,851	2,713	5,564		198	53
54	RADIOLOGY-DIAGNOSTIC		71,207	67,778	138,985	311	10,438	54
54.01	ULTRASOUND		1,986	1,890	3,876	67	1,320	54.01
60	LABORATORY		38,401	36,552	74,953	396	19,248	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		26,504	25,228	51,732	224	5,076	65
66	PHYSICAL THERAPY		22,894	21,792	44,686		976	66
69	ELECTROCARDIOLOGY					42	1,040	69
69.01	CARDIAC CATH LAB		13,680	13,021	26,701	27	1,002	69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						11,296	71
72	IMPL. DEV. CHARGED TO PATIENTS						3,879	72
73	DRUGS CHARGED TO PATIENTS						29,770	73
74	RENAL DIALYSIS		618	588	1,206		1,225	74
75	ASC (NON-DISTINCT PART)		72,301	68,820	141,121	183	4,595	75
75.01	ONCOLOGY		26,478	25,203	51,681	108	2,462	75.01
75.02	GI LAB		15,869	15,105	30,974		332	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		61,331	58,378	119,709	473	6,691	90
90.01	WOUND CARE CENTER		7,502	7,141	14,643	29	778	90.01
91	EMERGENCY		44,306	42,173	86,479	551	6,695	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		2,044,360	1,945,926	3,990,286	7,486	230,035	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES		23,953	22,800	46,753	401	15,916	192
192.01	RETAIL PHARMACY		12,003	11,425	23,428	33	11,509	192.01
192.02	CHA SITES		377,552	359,374	736,926	60	6,147	192.02
192.03	OTHER NON REIMBURSABLE						276	192.03
194	SENIOR HEALTH					65	1,296	194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		2,457,868	2,339,525	4,797,393	8,045	265,179	202

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,679,584						7
8	LAUNDRY & LINEN SERVICE		1,604					8
9	HOUSEKEEPING	7,338		25,230				9
10	DIETARY	68,497		1,033	194,064			10
11	CAFETERIA	21,670		327		60,798		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,598		54		1,328	15,566	13
14	CENTRAL SERVICES & SUPPLY	72,327		1,091		700		14
15	PHARMACY	11,087		167		2,189		15
16	MEDICAL RECORDS & LIBRARY	27,667		417		2,863		16
17	SOCIAL SERVICE					1,117	486	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	424,389	1,079	6,403	187,528	21,181	9,210	30
31	INTENSIVE CARE UNIT	32,112	79	484	1,495	3,232	1,406	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	75,109	208	1,133		3,035	1,320	50
53	ANESTHESIOLOGY	3,256		49		113		53
54	RADIOLOGY-DIAGNOSTIC	81,318	122	1,227		3,153		54
54.01	ULTRASOUND	2,268		34		537		54.01
60	LABORATORY	43,854		662		4,918		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	30,267		457		2,618		65
66	PHYSICAL THERAPY	26,145		394				66
69	ELECTROCARDIOLOGY					527		69
69.01	CARDIAC CATH LAB	15,623		236		269		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	706		11				74
75	ASC (NON-DISTINCT PART)	82,568	86	1,246		1,300	565	75
75.01	ONCOLOGY	30,237		456	5,041	882	384	75.01
75.02	GI LAB	18,122		273				75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	70,039		1,057		3,923		90
90.01	WOUND CARE CENTER	8,567		129		451	196	90.01
91	EMERGENCY	50,597	30	763		3,810	1,657	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,207,361	1,604	18,103	194,064	58,146	15,224	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES	27,355		413		2,132		192
192.01	RETAIL PHARMACY	13,708		207		441		192.01
192.02	CHA SITES	431,160		6,507			342	192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					79		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,679,584	1,604	25,230	194,064	60,798	15,566	202

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	199,358						14
15	PHARMACY		39,894					15
16	MEDICAL RECORDS & LIBRARY			86,814				16
17	SOCIAL SERVICE				4,266			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		129	16,135	2,559	1,435,337		30
31	INTENSIVE CARE UNIT		46	1,672	853	102,832		31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		102	1,977		224,326		50
53	ANESTHESIOLOGY		60	1,257		10,497		53
54	RADIOLOGY-DIAGNOSTIC		492	11,416		247,462		54
54.01	ULTRASOUND			1,637		9,739		54.01
60	LABORATORY			12,809		156,840		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			2,111		92,485		65
66	PHYSICAL THERAPY			109		72,310		66
69	ELECTROCARDIOLOGY		6	2,002		3,617		69
69.01	CARDIAC CATH LAB		54	891		44,803		69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	148,402		3,781		163,479		71
72	IMPL. DEV. CHARGED TO PATIENTS	50,956		1,660		56,495		72
73	DRUGS CHARGED TO PATIENTS		29,071	20,062		78,903		73
74	RENAL DIALYSIS			308		3,456		74
75	ASC (NON-DISTINCT PART)		9	993		232,666		75
75.01	ONCOLOGY		37	2,353	427	94,068		75.01
75.02	GI LAB		2	703		50,406		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		105	1,781		203,778		90
90.01	WOUND CARE CENTER		13	410		25,216		90.01
91	EMERGENCY		36	2,747	427	153,792		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	199,358	30,162	86,814	4,266	3,462,507		118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES		588			93,558		192
192.01	RETAIL PHARMACY		9,128			58,454		192.01
192.02	CHA SITES		16			1,181,158		192.02
192.03	OTHER NON REIMBURSABLE					276		192.03
194	SENIOR HEALTH					1,440		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	199,358	39,894	86,814	4,266	4,797,393		202

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,435,337						30
31	INTENSIVE CARE UNIT	102,832						31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	224,326						50
53	ANESTHESIOLOGY	10,497						53
54	RADIOLOGY-DIAGNOSTIC	247,462						54
54.01	ULTRASOUND	9,739						54.01
60	LABORATORY	156,840						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	92,485						65
66	PHYSICAL THERAPY	72,310						66
69	ELECTROCARDIOLOGY	3,617						69
69.01	CARDIAC CATH LAB	44,803						69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,479						71
72	IMPL. DEV. CHARGED TO PATIENTS	56,495						72
73	DRUGS CHARGED TO PATIENTS	78,903						73
74	RENAL DIALYSIS	3,456						74
75	ASC (NON-DISTINCT PART)	232,666						75
75.01	ONCOLOGY	94,068						75.01
75.02	GI LAB	50,406						75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	203,778						90
90.01	WOUND CARE CENTER	25,216						90.01
91	EMERGENCY	153,792						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	3,462,507						118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES	93,558						192
192.01	RETAIL PHARMACY	58,454						192.01
192.02	CHA SITES	1,181,158						192.02
192.03	OTHER NON REIMBURSABLE	276						192.03
194	SENIOR HEALTH	1,440						194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,797,393						202

KPMG LLP

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	278,485						1
2	CAP REL COSTS-MVBLE EQUIP		278,485					2
4	EMPLOYEE BENEFITS DEPARTMENT	467	467	20,730,541				4
5	ADMINISTRATIVE & GENERAL	15,305	15,305	3,925,969	-13,472,858	41,282,658		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	96,072	96,072	444,932		3,798,930	166,641	7
8	LAUNDRY & LINEN SERVICE					249,736		8
9	HOUSEKEEPING	728	728	2,775		832,899	728	9
10	DIETARY	6,796	6,796	371,926		1,138,962	6,796	10
11	CAFETERIA	2,150	2,150	117,645		267,290	2,150	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	357	357	512,247		659,645	357	13
14	CENTRAL SERVICES & SUPPLY	7,176	7,176	78,730		247,583	7,176	14
15	PHARMACY	1,100	1,100	576,429		1,133,184	1,100	15
16	MEDICAL RECORDS & LIBRARY	2,745	2,745	546,680		1,302,881	2,745	16
17	SOCIAL SERVICE			461,330		386,813		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	42,106	42,106	4,318,617		6,177,331	42,106	30
31	INTENSIVE CARE UNIT	3,186	3,186	738,393		978,206	3,186	31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	7,452	7,452	981,111		1,975,295	7,452	50
53	ANESTHESIOLOGY	323	323			30,879	323	53
54	RADIOLOGY-DIAGNOSTIC	8,068	8,068	800,668		1,625,110	8,068	54
54.01	ULTRASOUND	225	225	171,548		205,544	225	54.01
60	LABORATORY	4,351	4,351	1,019,590		2,996,768	4,351	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,003	3,003	578,568		790,294	3,003	65
66	PHYSICAL THERAPY	2,594	2,594			151,982	2,594	66
69	ELECTROCARDIOLOGY			108,069		161,965		69
69.01	CARDIAC CATH LAB	1,550	1,550	70,380		155,935	1,550	69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					1,758,650		71
72	IMPL. DEV. CHARGED TO PATIENTS					603,857		72
73	DRUGS CHARGED TO PATIENTS					4,634,975		73
74	RENAL DIALYSIS	70	70			190,725	70	74
75	ASC (NON-DISTINCT PART)	8,192	8,192	472,705		715,415	8,192	75
75.01	ONCOLOGY	3,000	3,000	277,481		383,282	3,000	75.01
75.02	GI LAB	1,798	1,798			51,718	1,798	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	6,949	6,949	1,218,456		1,041,713	6,949	90
90.01	WOUND CARE CENTER	850	850	75,707		121,197	850	90.01
91	EMERGENCY	5,020	5,020	1,421,179		1,042,373	5,020	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	231,633	231,633	19,291,135	-13,472,858	35,811,137	119,789	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES	2,714	2,714	1,033,798		2,477,898	2,714	192
192.01	RETAIL PHARMACY	1,360	1,360	84,726		1,791,870	1,360	192.01
192.02	CHA SITES	42,778	42,778	153,471		957,035	42,778	192.02
192.03	OTHER NON REIMBURSABLE					42,975		192.03
194	SENIOR HEALTH			167,411		201,743		194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,457,868	2,339,525	3,107,854		13,472,858	5,038,734	202
203	UNIT COST MULT-WS B PT I	8.825854	8.400901	0.149917		0.326356	30.237061	203
204	COST TO BE ALLOC PER B PT II			8,045		265,179	1,679,584	204
205	UNIT COST MULT-WS B PT II			0.000388		0.006423	10.079056	205

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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 ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	378,688						8
9	HOUSEKEEPING		165,913					9
10	DIETARY		6,796	96,475				10
11	CAFETERIA		2,150		25,357			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		357		554	14,929		13
14	CENTRAL SERVICES & SUPPLY		7,176		292		2,362,507	14
15	PHARMACY		1,100		913			15
16	MEDICAL RECORDS & LIBRARY		2,745		1,194			16
17	SOCIAL SERVICE				466	466		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	254,951	42,106	93,226	8,834	8,834		30
31	INTENSIVE CARE UNIT	18,691	3,186	743	1,348	1,348		31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	49,010	7,452		1,266	1,266		50
53	ANESTHESIOLOGY		323		47			53
54	RADIOLOGY-DIAGNOSTIC	28,738	8,068		1,315			54
54.01	ULTRASOUND		225		224			54.01
60	LABORATORY		4,351		2,051			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		3,003		1,092			65
66	PHYSICAL THERAPY		2,594					66
69	ELECTROCARDIOLOGY				220			69
69.01	CARDIAC CATH LAB		1,550		112			69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						1,758,650	71
72	IMPL. DEV. CHARGED TO PATIENTS						603,857	72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		70					74
75	ASC (NON-DISTINCT PART)	20,290	8,192		542	542		75
75.01	ONCOLOGY		3,000	2,506	368	368		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
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		6,949		1,636			90
90.01	WOUND CARE CENTER		850		188	188		90.01
91	EMERGENCY	7,008	5,020		1,589	1,589		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	378,688	119,061	96,475	24,251	14,601	2,362,507	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES		2,714		889			192
192.01	RETAIL PHARMACY		1,360		184			192.01
192.02	CHA SITES		42,778			328		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH				33			194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	331,239	1,126,734	1,762,312	434,133	897,628	599,096	202
203	UNIT COST MULT-WS B PT I	0.874702	6.791113	18.267033	17.120834	60.126465	0.253585	203
204	COST TO BE ALLOC PER B PT II	1,604	25,230	194,064	60,798	15,566	199,358	204
205	UNIT COST MULT-WS B PT II	0.004236	0.152068	2.011547	2.397681	1.042669	0.084384	205

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT				
		15	16	17				
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	6,360,317						15
16	MEDICAL RECORDS & LIBRARY		134,545,801					16
17	SOCIAL SERVICE			100				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	20,568	25,016,274	60				30
31	INTENSIVE CARE UNIT	7,275	2,591,921	20				31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	16,227	3,065,792					50
53	ANESTHESIOLOGY	9,574	1,949,168					53
54	RADIOLOGY-DIAGNOSTIC	78,402	17,699,056					54
54.01	ULTRASOUND		2,537,495					54.01
60	LABORATORY		19,859,655					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		3,272,123					65
66	PHYSICAL THERAPY		168,378					66
69	ELECTROCARDIOLOGY	953	3,103,862					69
69.01	CARDIAC CATH LAB	8,563	1,381,580					69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		5,862,592					71
72	IMPL. DEV. CHARGED TO PATIENTS		2,573,251					72
73	DRUGS CHARGED TO PATIENTS	4,634,975	31,053,485					73
74	RENAL DIALYSIS		477,500					74
75	ASC (NON-DISTINCT PART)	1,438	1,539,108					75
75.01	ONCOLOGY	5,860	3,648,067	10				75.01
75.02	GI LAB	341	1,089,341					75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	16,665	2,761,986					90
90.01	WOUND CARE CENTER	2,066	636,166					90.01
91	EMERGENCY	5,697	4,259,001	10				91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,808,604	134,545,801	100				118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	PHYSICIANS' PRIVATE OFFICES	93,788						192
192.01	RETAIL PHARMACY	1,455,330						192.01
192.02	CHA SITES	2,595						192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH							194
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,559,367	1,850,169	549,049				202
203	UNIT COST MULT-WS B PT I	0.245171	0.013751	5,490.490000				203

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT				
		15	16	17				
204	COST TO BE ALLOC PER B PT II	39,894	86,814	4,266				204
205	UNIT COST MULT-WS B PT II	0.006272	0.000645	42.660000				205

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	13,039,309		13,039,309	13,998	13,053,307	30
31	INTENSIVE CARE UNIT	1,696,706		1,696,706	9,266	1,705,972	31
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,082,678		3,082,678	5,249	3,087,927	50
53	ANESTHESIOLOGY	82,873		82,873		82,873	53
54	RADIOLOGY-DIAGNOSTIC	2,764,471		2,764,471		2,764,471	54
54.01	ULTRASOUND	319,684		319,684		319,684	54.01
60	LABORATORY	4,444,095		4,444,095	15,810	4,459,905	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,223,098		1,223,098	3,922	1,227,020	65
66	PHYSICAL THERAPY	299,948		299,948		299,948	66
69	ELECTROCARDIOLOGY	261,505		261,505		261,505	69
69.01	CARDIAC CATH LAB	287,233		287,233		287,233	69.01
70.01	SLEEP LAB						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,859,180		2,859,180		2,859,180	71
72	IMPL. DEV. CHARGED TO PATIENTS	989,443		989,443		989,443	72
73	DRUGS CHARGED TO PATIENTS	7,711,032		7,711,032		7,711,032	73
74	RENAL DIALYSIS	262,127		262,127		262,127	74
75	ASC (NON-DISTINCT PART)	1,333,363		1,333,363		1,333,363	75
75.01	ONCOLOGY	800,163		800,163		800,163	75.01
75.02	GI LAB	150,236		150,236		150,236	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,709,066		1,709,066		1,709,066	90
90.01	WOUND CARE CENTER	216,002		216,002		216,002	90.01
91	EMERGENCY	1,812,183		1,812,183		1,812,183	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	595,269		595,269		595,269	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	45,939,664		45,939,664	48,245	45,987,909	200
201	LESS OBSERVATION BEDS	595,269		595,269		595,269	201
202	TOTAL (SEE INSTRUCTIONS)	45,344,395		45,344,395		45,392,640	202

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	23,573,410		23,573,410				30
31	INTENSIVE CARE UNIT	2,591,921		2,591,921				31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,243,738	1,822,054	3,065,792	1.005508	1.005508	1.007220	50
53	ANESTHESIOLOGY	653,282	1,295,886	1,949,168	0.042517	0.042517	0.042517	53
54	RADIOLOGY-DIAGNOSTIC	4,842,990	12,856,066	17,699,056	0.156193	0.156193	0.156193	54
54.01	ULTRASOUND	553,924	1,983,571	2,537,495	0.125984	0.125984	0.125984	54.01
60	LABORATORY	7,678,850	12,180,805	19,859,655	0.223775	0.223775	0.224571	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,874,942	397,181	3,272,123	0.373793	0.373793	0.374992	65
66	PHYSICAL THERAPY	159,007	9,371	168,378	1.781397	1.781397	1.781397	66
69	ELECTROCARDIOLOGY	1,293,885	1,809,977	3,103,862	0.084251	0.084251	0.084251	69
69.01	CARDIAC CATH LAB	671,191	710,389	1,381,580	0.207902	0.207902	0.207902	69.01
70.01	SLEEP LAB							70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,042,404	2,820,188	5,862,592	0.487699	0.487699	0.487699	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,820,701	752,550	2,573,251	0.384511	0.384511	0.384511	72
73	DRUGS CHARGED TO PATIENTS	12,460,634	18,592,851	31,053,485	0.248315	0.248315	0.248315	73
74	RENAL DIALYSIS	457,445	20,055	477,500	0.548957	0.548957	0.548957	74
75	ASC (NON-DISTINCT PART)	325,411	1,213,697	1,539,108	0.866322	0.866322	0.866322	75
75.01	ONCOLOGY	550,021	3,098,046	3,648,067	0.219339	0.219339	0.219339	75.01
75.02	GI LAB	195,302	894,039	1,089,341	0.137915	0.137915	0.137915	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	25,639	2,736,347	2,761,986	0.618782	0.618782	0.618782	90
90.01	WOUND CARE CENTER	84,373	551,793	636,166	0.339537	0.339537	0.339537	90.01
91	EMERGENCY	1,325,129	2,933,872	4,259,001	0.425495	0.425495	0.425495	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	16,616	1,426,248	1,442,864	0.412561	0.412561	0.412561	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	66,440,815	68,104,986	134,545,801				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	66,440,815	68,104,986	134,545,801				202

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,435,337		1,435,337	21,117	67.97	8,006	544,168	30
31	INTENSIVE CARE UNIT	102,832		102,832	1,201	85.62	427	36,560	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)	1,538,169		1,538,169	22,318		8,433	580,728	200

(A) Worksheet A line numbers

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COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0115** **WORKSHEET D PART II**

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26)	TOTAL CHARGES (from Wkst. C, Part I, (col. 8)	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	224,326	3,065,792	0.073171	588,404	43,054	50
53	ANESTHESIOLOGY	10,497	1,949,168	0.005385	180,225	971	53
54	RADIOLOGY-DIAGNOSTIC	247,462	17,699,056	0.013982	1,862,688	26,044	54
54.01	ULTRASOUND	9,739	2,537,495	0.003838	240,646	924	54.01
60	LABORATORY	156,840	19,859,655	0.007897	3,560,569	28,118	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	92,485	3,272,123	0.028265	1,215,388	34,353	65
66	PHYSICAL THERAPY	72,310	168,378	0.429450	59,682	25,630	66
69	ELECTROCARDIOLOGY	3,617	3,103,862	0.001165	575,757	671	69
69.01	CARDIAC CATH LAB	44,803	1,381,580	0.032429	215,473	6,988	69.01
70.01	SLEEP LAB						70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,479	5,862,592	0.027885	1,044,341	29,121	71
72	IMPL. DEV. CHARGED TO PATIENTS	56,495	2,573,251	0.021955	543,992	11,943	72
73	DRUGS CHARGED TO PATIENTS	78,903	31,053,485	0.002541	5,391,225	13,699	73
74	RENAL DIALYSIS	3,456	477,500	0.007238	185,270	1,341	74
75	ASC (NON-DISTINCT PART)	232,666	1,539,108	0.151169			75
75.01	ONCOLOGY	94,068	3,648,067	0.025786	1,816	47	75.01
75.02	GI LAB	50,406	1,089,341	0.046272	90,025	4,166	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	203,778	2,761,986	0.073780	9,869	728	90
90.01	WOUND CARE CENTER	25,216	636,166	0.039637			90.01
91	EMERGENCY	153,792	4,259,001	0.036110	320,029	11,556	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	65,456	1,442,864	0.045365	8,402	381	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	1,989,794	108,380,470		16,093,801	239,735	200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUST-MENT AMOUNT (see instruct-ions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	21,117		8,006		30
31	INTENSIVE CARE UNIT	1,201		427		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)	22,318		8,433		200

(A) Worksheet A line numbers

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COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0115** | **WORKSHEET D PART IV**

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

		NON PHYSICIAN ANESTH-ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
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
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WOUND CARE CENTER							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP

COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0115** | **WORKSHEET D PART IV**

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

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	3,065,792			588,404		665,333		50
53	ANESTHESIOLOGY	1,949,168			180,225		199,128		53
54	RADIOLOGY-DIAGNOSTIC	17,699,056			1,862,688		3,011,207		54
54.01	ULTRASOUND	2,537,495			240,646		293,657		54.01
60	LABORATORY	19,859,655			3,560,569		748,862		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	3,272,123			1,215,388		100,604		65
66	PHYSICAL THERAPY	168,378			59,682				66
69	ELECTROCARDIOLOGY	3,103,862			575,757		654,431		69
69.01	CARDIAC CATH LAB	1,381,580			215,473		320,299		69.01
70.01	SLEEP LAB								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,862,592			1,044,341		610,666		71
72	IMPL. DEV. CHARGED TO PATIENTS	2,573,251			543,992		329,851		72
73	DRUGS CHARGED TO PATIENTS	31,053,485			5,391,225		6,736,918		73
74	RENAL DIALYSIS	477,500			185,270		4,775		74
75	ASC (NON-DISTINCT PART)	1,539,108							75
75.01	ONCOLOGY	3,648,067			1,816		402,057		75.01
75.02	GI LAB	1,089,341			90,025		171,499		75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	2,761,986			9,869		914,401		90
90.01	WOUND CARE CENTER	636,166							90.01
91	EMERGENCY	4,259,001			320,029		300,217		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,442,864			8,402		462,394		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	108,380,470			16,093,801		15,926,299		200

(A) Worksheet A line numbers

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COMPU-MAX

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0115** **WORKSHEET D PART V**

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1.005508	665,333			668,998			50
53	ANESTHESIOLOGY	0.042517	199,128			8,466			53
54	RADIOLOGY-DIAGNOSTIC	0.156193	3,011,207			470,329			54
54.01	ULTRASOUND	0.125984	293,657			36,996			54.01
60	LABORATORY	0.223775	748,862			167,577			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.373793	100,604			37,605			65
66	PHYSICAL THERAPY	1.781397							66
69	ELECTROCARDIOLOGY	0.084251	654,431			55,136			69
69.01	CARDIAC CATH LAB	0.207902	320,299			66,591			69.01
70.01	SLEEP LAB								70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.487699	610,666			297,821			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.384511	329,851		1,445	126,831		556	72
73	DRUGS CHARGED TO PATIENTS	0.248315	6,736,918		9,573	1,672,878		2,377	73
74	RENAL DIALYSIS	0.548957	4,775			2,621			74
75	ASC (NON-DISTINCT PART)	0.866322							75
75.01	ONCOLOGY	0.219339	402,057			88,187			75.01
75.02	GI LAB	0.137915	171,499			23,652			75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.618782	914,401			565,815			90
90.01	WOUND CARE CENTER	0.339537							90.01
91	EMERGENCY	0.425495	300,217			127,741			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.412561	462,394			190,766			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		15,926,299		11,018	4,608,010		2,933	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		15,926,299		11,018	4,608,010		2,933	202

(A) Worksheet A line numbers

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0115** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	21,117	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	21,117	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	20,154	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	8,006	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		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)	13,053,307	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	13,053,307	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	13,053,307	37

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0115** **WORKSHEET D-1 PART II**

CHECK APPLICABLE BOXES: [ ] TITLE V - I/P [XX] TITLE XVIII, PART A [ ] TITLE XIX - I/P [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA [ ] 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)					618.14	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					4,948,829	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)					4,948,829	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	1,705,972	1,201	1,420.46	427	606,536	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					4,694,036	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					10,249,401	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					580,728	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					239,735	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					820,463	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					9,428,938	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0115** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					963	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					618.14	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					595,269	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,435,337	13,053,307	0.109960	595,269	65,456	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0115** **WORKSHEET D-3**

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

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		9,253,942		30
31	INTENSIVE CARE UNIT		884,426		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.007220	588,404	592,652	50
53	ANESTHESIOLOGY	0.042517	180,225	7,663	53
54	RADIOLOGY-DIAGNOSTIC	0.156193	1,862,688	290,939	54
54.01	ULTRASOUND	0.125984	240,646	30,318	54.01
60	LABORATORY	0.224571	3,560,569	799,601	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.374992	1,215,388	455,761	65
66	PHYSICAL THERAPY	1.781397	59,682	106,317	66
69	ELECTROCARDIOLOGY	0.084251	575,757	48,508	69
69.01	CARDIAC CATH LAB	0.207902	215,473	44,797	69.01
70.01	SLEEP LAB				70.01
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.487699	1,044,341	509,324	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.384511	543,992	209,171	72
73	DRUGS CHARGED TO PATIENTS	0.248315	5,391,225	1,338,722	73
74	RENAL DIALYSIS	0.548957	185,270	101,705	74
75	ASC (NON-DISTINCT PART)	0.866322			75
75.01	ONCOLOGY	0.219339	1,816	398	75.01
75.02	GI LAB	0.137915	90,025	12,416	75.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.618782	9,869	6,107	90
90.01	WOUND CARE CENTER	0.339537			90.01
91	EMERGENCY	0.425495	320,029	136,171	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.412561	8,402	3,466	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		16,093,801	4,694,036	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		16,093,801		202

(A) Worksheet A line numbers

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX:

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, 2013 (see instructions)	2,470,635			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	7,130,242			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	10,557			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	55,912			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	153.36			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 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 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
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
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 (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.2075			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.4322			31
32	SUM OF LINES 30 AND 31	0.6397			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.4198			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,785,492			34
		PRIOR TO	ON OR AFTER		
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000406948		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		3,681,406		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		2,753,489		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	2,753,489			36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I 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
47	SUBTOTAL (see instructions)	14,150,415			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 SCH AND MDH ONLY (see instructions)	14,150,415			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	872,675			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part 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, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	15,023,090			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	15,023,090			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	870,752			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	296,272			63
64	ALLOWABLE BAD DEBTS (see instructions)	892,752			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	580,289			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	734,485			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	14,436,355			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-23,403			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	22,664			70.94
71	AMOUNT DUE PROVIDER (see instructions)	14,435,616			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	288,712			71.01
72	INTERIM PAYMENTS	13,470,710			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	676,194			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	173,956			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0115** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	2,933			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)	4,608,010			2
3	PPS PAYMENTS	4,275,695			3
4	OUTLIER PAYMENT (see instructions)	5,011			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.820			5
6	LINE 2 TIMES LINE 5	3,778,568			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	2,933			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	11,018			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	11,018			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	11,018			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)	8,085			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	2,933			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	4,280,706			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	236			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	945,242			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	3,338,161			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)	3,338,161			30
31	PRIMARY PAYER PAYMENTS	707			31
32	SUBTOTAL (line 30 minus line 31)	3,337,454			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	575,640			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	374,166			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	501,945			36
37	SUBTOTAL (see instructions)	3,711,620			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	3,711,620			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	74,232			40.01
41	INTERIM PAYMENTS	3,483,149			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	154,239			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0115** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				16,945,209		3,563,078	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01			02/25/2014	43,940	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	02/28/2014	1,043,221			3.51
		PROVIDER	.52	06/26/2014	2,431,278	06/26/2014	123,869	3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-3,474,499		-79,929	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)				13,470,710		3,483,149	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01					6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	4,476	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	8,433	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	31	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	21,355	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	134,545,801	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,775,814	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	809,015	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	16,180	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	792,835	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	938,483	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-145,648	32

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	4,188,886				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	17,882,142				4
5	OTHER RECEIVABLES	1,409,873				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-13,909,566				6
7	INVENTORY	1,107,321				7
8	PREPAID EXPENSES	1,239,857				8
9	OTHER CURRENT ASSETS	1,101,236				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	13,019,749				11
	FIXED ASSETS					
12	LAND	13,334,215				12
13	LAND IMPROVEMENTS	1,464,958				13
14	ACCUMULATED DEPRECIATION	-1,294,070				14
15	BUILDINGS	64,377,319				15
16	ACCUMULATED DEPRECIATION	-32,806,956				16
17	LEASEHOLD IMPROVEMENTS	32,658				17
18	ACCUMULATED AMORTIZATION	-1,908				18
19	FIXED EQUIPMENT	5,807,685				19
20	ACCUMULATED DEPRECIATION	-3,094,092				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	24,593,886				23
24	ACCUMULATED DEPRECIATION	-15,732,895				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)	56,680,800				30
	OTHER ASSETS					
31	INVESTMENTS	232,682,546				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	3,441,341				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	236,123,887				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	305,824,436				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,050,866				37
38	SALARIES, WAGES & FEES PAYABLE	1,597,484				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	15,982,038				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	18,630,388				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	12,032,986				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	6,551,838				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	18,584,824				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	37,215,212				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	268,609,224				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	268,609,224				59

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	305,824,436				60

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		228,962,186			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		39,647,038			2
3	TOTAL (sun of line 1 and line 2)		268,609,224			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		268,609,224			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		268,609,224			19

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

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	23,647,188		23,647,188	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	23,647,188		23,647,188	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	2,564,699		2,564,699	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	2,564,699		2,564,699	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	26,211,887		26,211,887	17
18	ANCILLARY SERVICES	40,135,706		40,135,706	18
19	OUTPATIENT SERVICES		73,936,015	73,936,015	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	66,347,593	73,936,015	140,283,608	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		59,548,816	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		59,548,816	43

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	140,283,608	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	86,523,019	2
3	NET PATIENT REVENUES (line 1 minus line 2)	53,760,589	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	59,548,816	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-5,788,227	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	5,637,947	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	551	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	88,483	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	7,303	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	1,082,075	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (UNREEALIZED GAIN ON INVESTMENT)	24,509,379	24
24.01	OTHER (MEANINGFUL USE REVENUE INCL ACCRUAL)	938,483	24.01
24.02	OTHER (UNREALIZED GAIN ON INVESTMENT)	4,591,902	24.02
24.03	OTHER (MISC OPERATING REVENUE)	402,524	24.03
24.04	OTHER (PROVIDER TAX REV)	8,176,618	24.04
25	TOTAL OTHER INCOME (sum of lines 6-24)	45,435,265	25
26	TOTAL (line 5 plus line 25)	39,647,038	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	39,647,038	29

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THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/26/2014 Run Time: 15:48 Version: 2014.10

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0115** **WORKSHEET L**

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [ ] TITLE XIX | [XX] HOSPITAL [ ] SUB (OTHER) | [XX] PPS [ ] COST METHOD

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	766,273	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	426	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)	58.51	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.2075	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.4322	8
9	SUM OF LINES 7 AND 8	0.6397	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1383	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	105,976	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	872,675	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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
	ANCILLARY SERVICE COST CENTERS							
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
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	WOUND CARE CENTER							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
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 CENTER							201
202	TOTAL (sum of lines 118-201)							202