THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/28/2018 Time: 16:59 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THOREK MEMORIAL HOSPITAL (14-0115) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
Chief Financial Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-174,372	-77,094			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		-174,372	-77,094			200

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

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 06 / 30 / 2018	20
21	Type of control (see instructions)	2		21

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,744	311		1	8,722	12	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1,665,088	3,690,041		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

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

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2012	09 / 30 / 2013	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

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	12/31/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	11/15/2015	Y	11/15/2015	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

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

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

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

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

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

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

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	146	53,290			5,458	2,003	19,768	1
2	HMO and other (see instructions)						1,429	8,734		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		146	53,290			5,458	2,003	19,768	7
8	Intensive Care Unit	31	10	3,650			50	53	161	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		156	56,940			5,508	2,056	19,929	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							4	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		156							27
28	Observation Bed Days								908	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,057	497	4,155	1
2	HMO and other (see instructions)					255	1,940		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		297.00			1,057	497	4,155	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		297.00						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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	21,361,667		21,361,667	642,681.00	33.24	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		121,011		121,011	579.00	209.00	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B		2,095,495		2,095,495	17,340.00	120.85	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		1,912,907		1,912,907	48,205.00	39.68	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		731,938		731,938	8,996.00	81.36	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		224,075		224,075	1,587.00	141.19	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		2,716,754		2,716,754			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		194,792		194,792			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		2,510		2,510			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B		75,182		75,182			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		88,607		88,607	2,247.00	39.43	26
27	Administrative & General		4,342,147		4,342,147	112,799.46	38.49	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		514,451		514,451	16,428.00	31.32	30
31	Laundry & Linen Service							31
32	Housekeeping							32
33	Housekeeping under contract (see instructions)							33
34	Dietary		565,991	-113,880	452,111	43,431.00	10.41	34
35	Dietary under contract (see instructions)		250,350		250,350	4,160.00	60.18	35
36	Cafeteria			113,880	113,880	9,023.00	12.62	36
37	Maintenance of Personnel							37
38	Nursing Administration		373,360		373,360	8,616.00	43.33	38
39	Central Services and Supply		77,886		77,886	15,683.00	4.97	39
40	Pharmacy		736,970		736,970	17,428.00	42.29	40
41	Medical Records & Medical Records Library		436,953		436,953	17,756.00	24.61	41
42	Social Service		284,098		284,098	4,820.00	58.94	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		19,516,522		19,516,522	629,501.00	31.00	1
2	Excluded area salaries (see instructions)		1,912,907		1,912,907	48,205.00	39.68	2
3	Subtotal salarles (line 1 minus line 2)		17,603,615		17,603,615	581,296.00	30.28	3
4	Subtotal other wages & related costs (see instructions)		956,013		956,013	10,583.00	90.33	4
5	Subtotal wage-related costs (see instructions)		2,719,264		2,719,264		15.45%	5
6	Total (sum of lines 3 through 5)		21,278,892		21,278,892	591,879.00	35.95	6
7	Total overhead cost (see instructions)		7,670,813		7,670,813	252,391.46	30.39	7

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	21,002	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	1,223,390	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	39,652	10
11	Life Insurance (If employee is owner or beneficiary)	11,877	11
12	Accident Insurance (If employee is owner or beneficiary)	1,485	12
13	Disability Insurance (If employee is owner or beneficiary)	80,390	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	128,358	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	1,472,118	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	2,772	19
20	State or Federal Unemployment Taxes		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	8,832	23
24	Total Wage Related cost (Sum of lines 1-23)	2,989,876	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

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)	0.319246	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	12,157,585	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	30,566,354	6
7	Medicaid cost (line 1 times line 6)	9,758,186	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)	2,649,274	13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)	8,126,559	14
15	State or local indigent care program cost (line 1 times line 14)	2,594,371	15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

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

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

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	588,427	565,507	1,153,934	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	187,853	565,507	753,360	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	187,853	565,507	753,360	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,518,177	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	624,982	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	961,512	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,556,665	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	833,489	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,586,849	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,586,849	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		3,909,284	3,909,284	-1,288,705	2,620,579	-6,296	2,614,283	1
2	00200	Cap Rel Costs-Mvble Equip				1,594,222	1,594,222		1,594,222	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	88,607	3,062,315	3,150,922		3,150,922		3,150,922	4
5	00500	Administrative & General	4,342,147	13,033,362	17,375,509	-197,900	17,177,609	-5,507,665	11,669,944	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	514,451	1,544,356	2,058,807		2,058,807	-648	2,058,159	7
8	00800	Laundry & Linen Service				149,646	149,646		149,646	8
9	00900	Housekeeping		590,424	590,424		590,424		590,424	9
10	01000	Dietary	565,991	780,753	1,346,744	-276,725	1,070,019		1,070,019	10
11	01100	Cafeteria				276,725	276,725	-92,486	184,239	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	373,360	107,116	480,476		480,476		480,476	13
14	01400	Central Services & Supply	77,886	135,674	213,560	-86,959	126,601		126,601	14
15	01500	Pharmacy	736,970	4,619,538	5,356,508	-4,537,615	818,893		818,893	15
16	01600	Medical Records & Library	436,953	306,810	743,763		743,763	-137,617	606,146	16
17	01700	Social Service	284,098	5,004	289,102	-2,683	286,419	-66,852	219,567	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,394,960	1,048,165	5,443,125	-175,987	5,267,138	-14,296	5,252,842	30
31	03100	Intensive Care Unit	455,913	79,557	535,470	-10,291	525,179	-6,243	518,936	31
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	694,979	2,066,838	2,761,817	-818,007	1,943,810	-73,411	1,870,399	50
53	05300	Anesthesiology		545,177	545,177	-20,191	524,986	-522,800	2,186	53
54	05400	Radiology-Diagnostic	733,310	624,696	1,358,006	-78,295	1,279,711	-51,834	1,227,877	54
54.01	03630	ULTRASOUND	154,666	10,436	165,102	-8,168	156,934		156,934	54.01
60	06000	Laboratory	1,164,388	1,893,758	3,058,146	-14,391	3,043,755	-17,722	3,026,033	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	479,935	93,894	573,829	-33,876	539,953	-4,831	535,122	65
66	06600	Physical Therapy		133,941	133,941		133,941		133,941	66
69	06900	Electrocardiology	67,182	26,643	93,825	-3,329	90,496		90,496	69
69.01	03140	CARDIAC CATH LAB	4,990	9,579	14,569	-2,446	12,123		12,123	69.01
70.01	07001	SLEEP LAB								70.01
71	07100	Medical Supplies Charged to Patients				1,111,942	1,111,942		1,111,942	71
72	07200	Impl. Dev. Charged to Patients				381,801	381,801		381,801	72
73	07300	Drugs Charged to Patients				4,516,133	4,516,133		4,516,133	73
74	07400	Renal Dialysis		131,090	131,090		131,090		131,090	74
75	07500	ASC (Non-Distinct Part)	286,400	21,853	308,253	-14,884	293,369		293,369	75
75.01	03480	ONCOLOGY	337,455	71,237	408,692	-36,886	371,806	-87,728	284,078	75.01
75.02	03340	GI LAB		50,829	50,829	-49,418	1,411		1,411	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	1,648,300	127,347	1,775,647	-11,029	1,764,618	-1,059,612	705,006	90
90.01	09001	WOUND CARE CENTER	44,153	30,983	75,136	-27,985	47,151		47,151	90.01
91	09100	Emergency	1,561,666	1,267,265	2,828,931	-77,436	2,751,495	-1,917,377	834,118	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		257,263	257,263	-257,263				113
118		SUBTOTALS (sum of lines 1-117)	19,448,760	36,585,187	56,033,947		56,033,947	-9,567,418	46,466,529	118
		NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH								190.01
192	19200	Physicians' Private Offices	1,638,484	1,586,654	3,225,138		3,225,138		3,225,138	192
192.01	19201	RETAIL PHARMACY	169,975	972,759	1,142,734		1,142,734		1,142,734	192.01
192.02	19202	CHA SITES	98,691	25,047	123,738		123,738		123,738	192.02
192.03	19203	OTHER NON REIMBURSABLE		131,905	131,905		131,905		131,905	192.03
194	07950	SENIOR HEALTH	5,757		5,757		5,757		5,757	194
200		TOTAL (sum of lines 118-199)	21,361,667	39,301,552	60,663,219		60,663,219	-9,567,418	51,095,801	200

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		1,594,222	1
500	Total reclassifications					1,594,222	500
	Code Letter - A						
1	INSURANCE	B	Cap Rel Costs-Bldg & Fixt	1		48,254	1
500	Total reclassifications					48,254	500
	Code Letter - B						
1	DRUGS CHARGED	C	Drugs Charged to Patients	73		4,516,133	1
500	Total reclassifications					4,516,133	500
	Code Letter - C						
1	SUPPLIES CHARGED	D	Medical Supplies Charged to P	71		1,111,942	1
2			Impl. Dev. Charged to Patient	72		381,801	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					1,493,743	500
	Code Letter - D						
1	CAFETERIA COSTS	E	Cafeteria	11	113,880	162,845	1
500	Total reclassifications				113,880	162,845	500
	Code Letter - E						
1	INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		257,263	1
500	Total reclassifications					257,263	500
	Code Letter - F						
1	LAUNDRY EXP	I	Laundry & Linen Service	8		149,646	1
500	Total reclassifications					149,646	500
	Code Letter - I						
	GRAND TOTAL (Increases)				113,880	8,222,106	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION GL CC 8850-8581	A	Cap Rel Costs-Bldg & Fixt	1		1,594,222	9	1
500	Total reclassifications					1,594,222		500
	Code letter - A							
1	INSURANCE	B	Administrative & General	5		48,254	12	1
500	Total reclassifications					48,254		500
	Code letter - B							
1	DRUGS CHARGED	C	Pharmacy	15		4,516,133		1
500	Total reclassifications					4,516,133		500
	Code letter - C							
1	SUPPLIES CHARGED	D	Central Services & Supply	14		86,959		1
2			Pharmacy	15		21,482		2
3			Adults & Pediatrics	30		175,987		3
4			Intensive Care Unit	31		10,291		4
5			Operating Room	50		818,007		5
6			Anesthesiology	53		20,191		6
7			Radiology-Diagnostic	54		78,295		7
8			ULTRASOUND	54.01		8,168		8
9			Laboratory	60		14,391		9
10			Respiratory Therapy	65		33,876		10
11			Social Service	17		2,683		11
12			Electrocardiology	69		3,329		12
13			CARDIAC CATH LAB	69.01		2,446		13
14			ASC (Non-Distinct Part)	75		14,884		14
15			ONCOLOGY	75.01		36,886		15
16			GI LAB	75.02		49,418		16
17			Clinic	90		11,029		17
18			WOUND CARE CENTER	90.01		27,985		18
19			Emergency	91		77,436		19
500	Total reclassifications					1,493,743		500
	Code letter - D							
1	CAFETERIA COSTS	E	Dietary	10	113,880	162,845		1
500	Total reclassifications				113,880	162,845		500
	Code letter - E							
1	INTEREST	F	Interest Expense	113		257,263	11	1
500	Total reclassifications					257,263		500
	Code letter - F							
1	LAUNDRY EXP	I	Administrative & General	5		149,646		1
500	Total reclassifications					149,646		500
	Code letter - I							
	GRAND TOTAL (Decreases)				113,880	8,222,106		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	14,137,215					14,137,215		1
2	Land Improvements	1,628,948					1,628,948		2
3	Buildings and Fixtures	35,338,132	449,229		449,229		35,787,361		3
4	Building Improvements	24,548,916				218,113	24,330,803		4
5	Fixed Equipment	13,254,056	853,755		853,755		14,107,811		5
6	Movable Equipment	26,739,749	24,213		24,213		26,763,962		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	115,647,016	1,327,197		1,327,197	218,113	116,756,100		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	115,647,016	1,327,197		1,327,197	218,113	116,756,100		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	3,909,284						3,909,284	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	3,909,284						3,909,284	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	60,118,163		60,118,163	0.691951					1
2	Cap Rel Costs-Mvble Equ	26,763,962		26,763,962	0.308049					2
3	Total (sum of lines 1-2)	86,882,125		86,882,125	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	2,315,062		250,967	48,254			2,614,283	1
2	Cap Rel Costs-Mvble Equip	1,594,222						1,594,222	2
3	Total (sum of lines 1-2)	3,909,284		250,967	48,254			4,208,505	3

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

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-6,296	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-16,360	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	-4,001,489				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	-92,486	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	-2,480	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
40							40
41	HOSPITALITY EXP	A	-141,628	Administrative & General	5		41
41.01	HOSPITALITY EXP	A	-648	Operation of Plant	7		41.01
41.03	HOSPITALITY EXP	A	-468	Laboratory	60		41.03
41.05	HOSPITALITY EXP	A	-1,563	Clinic	90		41.05
42							42
42.01	LDUES -LOBBYING PORTION	A	-9,293	Administrative & General	5		42.01
42.02	MARKETING EXP	A	-153,528	Administrative & General	5		42.02
42.03	MEDICARE PREMIUM FOR RETIRED EM	A	-4,300	Administrative & General	5		42.03
43							43
44	ADVERTISING EXP	A	-15,193	Administrative & General	5		44
45	MEDICAID ASSESSMENT TAX	A	-5,121,686	Administrative & General	5		45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-9,567,418				50

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

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	

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

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

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

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

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

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

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

				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:

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	4	Employee Benefits De AGGREGATE								1
2	5	Administrative & Gen AGGREGATE	84,354		84,354	177,200	454	38,677	1,934	2
3	15	Pharmacy AGGREGATE								3
4	16	Medical Records & Li AGGREGATE	135,137	135,137		177,200				4
5										5
6	17	Social Service AGGREGATE	112,771		112,771	177,200	539	45,919	2,296	6
7										7
8	30	Adults & Pediatrics AGGREGATE	60,300		60,300	177,200	540	46,004	2,300	8
9	31	Intensive Care Unit AGGREGATE	14,421		14,421	177,200	96	8,178	409	9
10	50	Operating Room AGGREGATE	73,411	73,411		177,200				10
11										11
12	53	Anesthesiology AGGREGATE	522,800	522,800		177,200				12
13	54	Radiology-Diagnostic AGGREGATE	51,834	51,834						13
14										14
15										15
16	60	Laboratory AGGREGATE	40,000		40,000	177,200	267	22,746	1,137	16
17										17
18	65	Respiratory Therapy AGGREGATE	8,239		8,239	177,200	40	3,408	170	18
19										19
20	75.01	ONCOLOGY AGGREGATE	107,407	82,407	25,000	177,200	231	19,679	984	20
22	90	Clinic AGGREGATE	1,058,049	1,058,049						22
24	91	Emergency AGGREGATE	1,917,377	1,917,377						24
200		TOTAL	4,186,100	3,841,015	345,085		2,167	184,611	9,230	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	4	Employee Benefits De AGGREGATE								1
2	5	Administrative & Gen AGGREGATE					38,677	45,677	45,677	2
3	15	Pharmacy AGGREGATE								3
4	16	Medical Records & Li AGGREGATE							135,137	4
5										5
6	17	Social Service AGGREGATE					45,919	66,852	66,852	6
7										7
8	30	Adults & Pediatrics AGGREGATE					46,004	14,296	14,296	8
9	31	Intensive Care Unit AGGREGATE					8,178	6,243	6,243	9
10	50	Operating Room AGGREGATE							73,411	10
11										11
12	53	Anesthesiology AGGREGATE							522,800	12
13	54	Radiology-Diagnostic AGGREGATE							51,834	13
14										14
15										15
16	60	Laboratory AGGREGATE					22,746	17,254	17,254	16
17										17
18	65	Respiratory Therapy AGGREGATE					3,408	4,831	4,831	18
19										19
20	75.01	ONCOLOGY AGGREGATE					19,679	5,321	87,728	20
22	90	Clinic AGGREGATE							1,058,049	22
24	91	Emergency AGGREGATE							1,917,377	24
200		TOTAL					184,611	160,474	4,001,489	200

	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	2,614,283	2,614,283					1
2	Cap Rel Costs-Mvble Equip	1,594,222		1,594,222				2
4	Employee Benefits Department	3,150,922	4,083	2,490	3,157,495			4
5	Administrative & General	11,669,944	147,782	90,119	644,492	12,552,337	12,552,337	5
6	Maintenance & Repairs							6
7	Operation of Plant	2,058,159	551,360	336,228	76,358	3,022,105	984,200	7
8	Laundry & Linen Service	149,646				149,646	48,735	8
9	Housekeeping	590,424	8,257	5,035		603,716	196,610	9
10	Dietary	1,070,019	70,494	42,988	67,105	1,250,606	407,281	10
11	Cafeteria	184,239	30,976	18,890	16,903	251,008	81,745	11
12	Maintenance of Personnel							12
13	Nursing Administration	480,476			55,417	535,893	174,523	13
14	Central Services & Supply	126,601	86,112	52,512	11,560	276,785	90,140	14
15	Pharmacy	818,893	11,343	6,917	109,386	946,539	308,257	15
16	Medical Records & Library	606,146	33,891	20,667	64,856	725,560	236,291	16
17	Social Service	219,567			42,168	261,735	85,238	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	5,252,842	477,362	291,101	652,331	6,673,636	2,173,385	30
31	Intensive Care Unit	518,936	36,137	22,037	67,670	644,780	209,984	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,870,399	84,525	51,544	103,154	2,109,622	687,034	50
53	Anesthesiology	2,186	3,664	2,234		8,084	2,633	53
54	Radiology-Diagnostic	1,227,877	98,771	60,232	108,843	1,495,723	487,108	54
54.01	ULTRASOUND	156,934	2,552	1,556	22,957	183,999	59,922	54.01
60	Laboratory	3,026,033	62,191	37,925	172,827	3,298,976	1,074,368	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	535,122	34,062	20,771	71,235	661,190	215,328	65
66	Physical Therapy	133,941	29,423	17,942		181,306	59,045	66
69	Electrocardiology	90,496	2,212	1,349	9,972	104,029	33,879	69
69.01	CARDIAC CATH LAB	12,123	17,581	10,721	741	41,166	13,406	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	1,111,942				1,111,942	362,123	71
72	Impl. Dev. Charged to Patients	381,801				381,801	124,340	72
73	Drugs Charged to Patients	4,516,133				4,516,133	1,470,755	73
74	Renal Dialysis	131,090	794	484		132,368	43,108	74
75	ASC (Non-Distinct Part)	293,369	92,918	56,663	42,509	485,459	158,098	75
75.01	ONCOLOGY	284,078	51,427	31,361	50,087	416,953	135,788	75.01
75.02	GI LAB	1,411	20,394	12,436		34,241	11,151	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	705,006	66,422	40,505	244,652	1,056,585	344,095	90
90.01	WOUND CARE CENTER	47,151	9,641	5,879	6,553	69,224	22,544	90.01
91	Emergency	834,118	39,132	23,863	231,793	1,128,906	367,647	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)	46,466,529	2,073,506	1,264,449	2,873,569	45,312,053	10,668,761	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	3,225,138	14,450	8,812	243,195	3,491,595	1,137,097	192
192.01	RETAIL PHARMACY	1,142,734	4,083	2,490	25,229	1,174,536	382,508	192.01
192.02	CHA SITES	123,738	522,244	318,471	14,648	979,101	318,861	192.02
192.03	OTHER NON REIMBURSABLE	131,905				131,905	42,957	192.03
194	SENIOR HEALTH	5,757			854	6,611	2,153	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	51,095,801	2,614,283	1,594,222	3,157,495	51,095,801	12,552,337	202

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	4,006,305						7
8	Laundry & Linen Service		198,381					8
9	Housekeeping	17,311		817,637				9
10	Dietary	147,782		30,227	1,835,896			10
11	Cafeteria	64,938		13,282		410,973		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,736		7,493	719,645	13
14	Central Services & Supply	180,525		36,924		4,636		14
15	Pharmacy	23,778		4,864		13,940		15
16	Medical Records & Library	71,049		14,532		14,123		16
17	Social Service					3,954		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	1,000,732	140,888	204,688	1,815,735	149,352	488,808	30
31	Intensive Care Unit	75,758	3,767	15,495	20,161	10,617	34,748	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	177,196	26,543	36,243		16,897	55,303	50
53	Anesthesiology	7,680		1,571				53
54	Radiology-Diagnostic	207,061	18,012	42,352		18,110		54
54.01	ULTRASOUND	5,350		1,094		7,792		54.01
60	Laboratory	130,376		26,667		43,099		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	71,406		14,605		14,738		65
66	Physical Therapy	61,681		12,616				66
69	Electrocardiology	4,637		948		1,745		69
69.01	CARDIAC CATH LAB	36,856		7,539		100		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	1,664		340				74
75	ASC (Non-Distinct Part)	194,792	9,051	39,842		6,530	21,371	75
75.01	ONCOLOGY	107,811		22,051		8,906	29,147	75.01
75.02	GI LAB	42,753		8,745				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	139,246		28,481		25,471		90
90.01	WOUND CARE CENTER	20,212		4,134		1,180	3,861	90.01
91	Emergency	82,035	120	16,779		26,401	86,407	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)	2,872,629	198,381	585,755	1,835,896	375,084	719,645	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	30,294		6,196		27,681		192
192.01	RETAIL PHARMACY	8,560		1,751		4,553		192.01
192.02	CHA SITES	1,094,822		223,935		3,373		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					282		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,006,305	198,381	817,637	1,835,896	410,973	719,645	202

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	589,010						14
15	Pharmacy		1,297,378					15
16	Medical Records & Library			1,061,555				16
17	Social Service				350,927			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			225,415	210,556	13,083,195		30
31	Intensive Care Unit			4,917	70,185	1,090,412		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			23,069		3,131,907		50
53	Anesthesiology			9,464		29,432		53
54	Radiology-Diagnostic		9,706	104,571		2,382,643		54
54.01	ULTRASOUND			16,886		275,043		54.01
60	Laboratory			187,267		4,760,753		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			56,794		1,034,061		65
66	Physical Therapy			2,006		316,654		66
69	Electrocardiology			19,755		164,993		69
69.01	CARDIAC CATH LAB			2,811		101,878		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	438,459		35,238		1,947,762		71
72	Impl. Dev. Charged to Patients	150,551		24,850		681,542		72
73	Drugs Charged to Patients		1,078,585	241,231		7,306,704		73
74	Renal Dialysis			2,870		180,350		74
75	ASC (Non-Distinct Part)			12,399		927,542		75
75.01	ONCOLOGY			24,179	35,093	779,928		75.01
75.02	GI LAB			10,468		107,358		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			12,174		1,606,052		90
90.01	WOUND CARE CENTER			3,628		124,783		90.01
91	Emergency			41,563	35,093	1,784,951		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)	589,010	1,088,291	1,061,555	350,927	41,817,943		118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices					4,692,863		192
192.01	RETAIL PHARMACY		209,087			1,780,995		192.01
192.02	CHA SITES					2,620,092		192.02
192.03	OTHER NON REIMBURSABLE					174,862		192.03
194	SENIOR HEALTH					9,046		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	589,010	1,297,378	1,061,555	350,927	51,095,801		202

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	13,083,195						30
31	Intensive Care Unit	1,090,412						31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,131,907						50
53	Anesthesiology	29,432						53
54	Radiology-Diagnostic	2,382,643						54
54.01	ULTRASOUND	275,043						54.01
60	Laboratory	4,760,753						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,034,061						65
66	Physical Therapy	316,654						66
69	Electrocardiology	164,993						69
69.01	CARDIAC CATH LAB	101,878						69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	1,947,762						71
72	Impl. Dev. Charged to Patients	681,542						72
73	Drugs Charged to Patients	7,306,704						73
74	Renal Dialysis	180,350						74
75	ASC (Non-Distinct Part)	927,542						75
75.01	ONCOLOGY	779,928						75.01
75.02	GI LAB	107,358						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	1,606,052						90
90.01	WOUND CARE CENTER	124,783						90.01
91	Emergency	1,784,951						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)	41,817,943						118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	4,692,863						192
192.01	RETAIL PHARMACY	1,780,995						192.01
192.02	CHA SITES	2,620,092						192.02
192.03	OTHER NON REIMBURSABLE	174,862						192.03
194	SENIOR HEALTH	9,046						194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	51,095,801						202

	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		4,083	2,490	6,573	6,573		4
5	Administrative & General		147,782	90,119	237,901	1,342	239,243	5
6	Maintenance & Repairs							6
7	Operation of Plant		551,360	336,228	887,588	159	18,758	7
8	Laundry & Linen Service						929	8
9	Housekeeping		8,257	5,035	13,292		3,747	9
10	Dietary		70,494	42,988	113,482	140	7,763	10
11	Cafeteria		30,976	18,890	49,866	35	1,558	11
12	Maintenance of Personnel							12
13	Nursing Administration					115	3,326	13
14	Central Services & Supply		86,112	52,512	138,624	24	1,718	14
15	Pharmacy		11,343	6,917	18,260	228	5,875	15
16	Medical Records & Library		33,891	20,667	54,558	135	4,504	16
17	Social Service					88	1,625	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		477,362	291,101	768,463	1,356	41,426	30
31	Intensive Care Unit		36,137	22,037	58,174	141	4,002	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		84,525	51,544	136,069	215	13,094	50
53	Anesthesiology		3,664	2,234	5,898		50	53
54	Radiology-Diagnostic		98,771	60,232	159,003	227	9,284	54
54.01	ULTRASOUND		2,552	1,556	4,108	48	1,142	54.01
60	Laboratory		62,191	37,925	100,116	360	20,477	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		34,062	20,771	54,833	148	4,104	65
66	Physical Therapy		29,423	17,942	47,365		1,125	66
69	Electrocardiology		2,212	1,349	3,561	21	646	69
69.01	CARDIAC CATH LAB		17,581	10,721	28,302	2	256	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients						6,902	71
72	Impl. Dev. Charged to Patients						2,370	72
73	Drugs Charged to Patients						28,032	73
74	Renal Dialysis		794	484	1,278		822	74
75	ASC (Non-Distinct Part)		92,918	56,663	149,581	88	3,013	75
75.01	ONCOLOGY		51,427	31,361	82,788	104	2,588	75.01
75.02	GI LAB		20,394	12,436	32,830		213	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		66,422	40,505	106,927	509	6,558	90
90.01	WOUND CARE CENTER		9,641	5,879	15,520	14	430	90.01
91	Emergency		39,132	23,863	62,995	483	7,007	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)		2,073,506	1,264,449	3,337,955	5,982	203,344	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		14,450	8,812	23,262	506	21,672	192
192.01	RETAIL PHARMACY		4,083	2,490	6,573	53	7,290	192.01
192.02	CHA SITES		522,244	318,471	840,715	30	6,077	192.02
192.03	OTHER NON REIMBURSABLE						819	192.03
194	SENIOR HEALTH					2	41	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,614,283	1,594,222	4,208,505	6,573	239,243	202

	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	906,505						7
8	Laundry & Linen Service		929					8
9	Housekeeping	3,917		20,956				9
10	Dietary	33,439		775	155,599			10
11	Cafeteria	14,694		340		66,493		11
12	Maintenance of Personnel							12
13	Nursing Administration			45		1,212	4,698	13
14	Central Services & Supply	40,847		946		750		14
15	Pharmacy	5,380		125		2,255		15
16	Medical Records & Library	16,076		372		2,285		16
17	Social Service					640		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	226,435	660	5,246	153,890	24,164	3,191	30
31	Intensive Care Unit	17,142	18	397	1,709	1,718	227	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	40,094	124	929		2,734	361	50
53	Anesthesiology	1,738		40				53
54	Radiology-Diagnostic	46,852	84	1,085		2,930		54
54.01	ULTRASOUND	1,211		28		1,261		54.01
60	Laboratory	29,500		683		6,973		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	16,157		374		2,384		65
66	Physical Therapy	13,956		323				66
69	Electrocardiology	1,049		24		282		69
69.01	CARDIAC CATH LAB	8,339		193		16		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	377		9				74
75	ASC (Non-Distinct Part)	44,075	42	1,021		1,056	140	75
75.01	ONCOLOGY	24,394		565		1,441	190	75.01
75.02	GI LAB	9,674		224				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	31,507		730		4,121		90
90.01	WOUND CARE CENTER	4,573		106		191	25	90.01
91	Emergency	18,562	1	430		4,272	564	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)	649,988	929	15,010	155,599	60,685	4,698	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	6,855		159		4,479		192
192.01	RETAIL PHARMACY	1,937		45		737		192.01
192.02	CHA SITES	247,725		5,742		546		192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH					46		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	906,505	929	20,956	155,599	66,493	4,698	202

	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	182,909						14
15	Pharmacy		32,123					15
16	Medical Records & Library			77,930				16
17	Social Service				2,353			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			16,550	1,412	1,242,793		30
31	Intensive Care Unit			361	471	84,360		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			1,694		195,314		50
53	Anesthesiology			695		8,421		53
54	Radiology-Diagnostic		240	7,678		227,383		54
54.01	ULTRASOUND			1,240		9,038		54.01
60	Laboratory			13,749		171,858		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			4,170		82,170		65
66	Physical Therapy			147		62,916		66
69	Electrocardiology			1,450		7,033		69
69.01	CARDIAC CATH LAB			206		37,314		69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	136,157		2,587		145,646		71
72	Impl. Dev. Charged to Patients	46,752		1,824		50,946		72
73	Drugs Charged to Patients		26,706	17,702		72,440		73
74	Renal Dialysis			211		2,697		74
75	ASC (Non-Distinct Part)			910		199,926		75
75.01	ONCOLOGY			1,775	235	114,080		75.01
75.02	GI LAB			769		43,710		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			894		151,246		90
90.01	WOUND CARE CENTER			266		21,125		90.01
91	Emergency			3,052	235	97,601		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)	182,909	26,946	77,930	2,353	3,028,017		118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices					56,933		192
192.01	RETAIL PHARMACY		5,177			21,812		192.01
192.02	CHA SITES					1,100,835		192.02
192.03	OTHER NON REIMBURSABLE					819		192.03
194	SENIOR HEALTH					89		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	182,909	32,123	77,930	2,353	4,208,505		202

	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	1,242,793						30
31	Intensive Care Unit	84,360						31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	195,314						50
53	Anesthesiology	8,421						53
54	Radiology-Diagnostic	227,383						54
54.01	ULTRASOUND	9,038						54.01
60	Laboratory	171,858						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	82,170						65
66	Physical Therapy	62,916						66
69	Electrocardiology	7,033						69
69.01	CARDIAC CATH LAB	37,314						69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	145,646						71
72	Impl. Dev. Charged to Patients	50,946						72
73	Drugs Charged to Patients	72,440						73
74	Renal Dialysis	2,697						74
75	ASC (Non-Distinct Part)	199,926						75
75.01	ONCOLOGY	114,080						75.01
75.02	GI LAB	43,710						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	151,246						90
90.01	WOUND CARE CENTER	21,125						90.01
91	Emergency	97,601						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)	3,028,017						118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	56,933						192
192.01	RETAIL PHARMACY	21,812						192.01
192.02	CHA SITES	1,100,835						192.02
192.03	OTHER NON REIMBURSABLE	819						192.03
194	SENIOR HEALTH	89						194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,208,505						202

	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	230,485						1
2	Cap Rel Costs-Mvble Equip		230,485					2
4	Employee Benefits Department	360	360	21,273,060				4
5	Administrative & General	13,029	13,029	4,342,147	-12,552,337	38,543,464		5
6	Maintenance & Repairs							6
7	Operation of Plant	48,610	48,610	514,451		3,022,105	168,486	7
8	Laundry & Linen Service					149,646		8
9	Housekeeping	728	728			603,716	728	9
10	Dietary	6,215	6,215	452,111		1,250,606	6,215	10
11	Cafeteria	2,731	2,731	113,880		251,008	2,731	11
12	Maintenance of Personnel							12
13	Nursing Administration			373,360		535,893		13
14	Central Services & Supply	7,592	7,592	77,886		276,785	7,592	14
15	Pharmacy	1,000	1,000	736,970		946,539	1,000	15
16	Medical Records & Library	2,988	2,988	436,953		725,560	2,988	16
17	Social Service			284,098		261,735		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	42,086	42,086	4,394,960		6,673,636	42,086	30
31	Intensive Care Unit	3,186	3,186	455,913		644,780	3,186	31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,452	7,452	694,979		2,109,622	7,452	50
53	Anesthesiology	323	323			8,084	323	53
54	Radiology-Diagnostic	8,708	8,708	733,310		1,495,723	8,708	54
54.01	ULTRASOUND	225	225	154,666		183,999	225	54.01
60	Laboratory	5,483	5,483	1,164,388		3,298,976	5,483	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,003	3,003	479,935		661,190	3,003	65
66	Physical Therapy	2,594	2,594			181,306	2,594	66
69	Electrocardiology	195	195	67,182		104,029	195	69
69.01	CARDIAC CATH LAB	1,550	1,550	4,990		41,166	1,550	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients					1,111,942		71
72	Impl. Dev. Charged to Patients					381,801		72
73	Drugs Charged to Patients					4,516,133		73
74	Renal Dialysis	70	70			132,368	70	74
75	ASC (Non-Distinct Part)	8,192	8,192	286,400		485,459	8,192	75
75.01	ONCOLOGY	4,534	4,534	337,455		416,953	4,534	75.01
75.02	GI LAB	1,798	1,798			34,241	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	5,856	5,856	1,648,300		1,056,585	5,856	90
90.01	WOUND CARE CENTER	850	850	44,153		69,224	850	90.01
91	Emergency	3,450	3,450	1,561,666		1,128,906	3,450	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)	182,808	182,808	19,360,153	-12,552,337	32,759,716	120,809	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices	1,274	1,274	1,638,484		3,491,595	1,274	192
192.01	RETAIL PHARMACY	360	360	169,975		1,174,536	360	192.01
192.02	CHA SITES	46,043	46,043	98,691		979,101	46,043	192.02
192.03	OTHER NON REIMBURSABLE					131,905		192.03
194	SENIOR HEALTH			5,757		6,611		194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,614,283	1,594,222	3,157,495		12,552,337	4,006,305	202
203	Unit Cost Multiplier (Wkst. B, Part I)	11.342530	6.916815	0.148427		0.325667	23.778266	203
204	Cost to be allocated (Per Wkst. B, Part II)			6,573		239,243	906,505	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000309		0.006207	5.380299	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	COST 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	315,278						8
9	Housekeeping		168,115					9
10	Dietary		6,215	71,756				10
11	Cafeteria		2,731		24,735			11
12	Maintenance of Personnel							12
13	Nursing Administration		357		451	13,234		13
14	Central Services & Supply		7,592		279		1,493,743	14
15	Pharmacy		1,000		839			15
16	Medical Records & Library		2,988		850			16
17	Social Service				238			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	223,907	42,086	70,968	8,989	8,989		30
31	Intensive Care Unit	5,986	3,186	788	639	639		31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	42,183	7,452		1,017	1,017		50
53	Anesthesiology		323					53
54	Radiology-Diagnostic	28,626	8,708		1,090			54
54.01	ULTRASOUND		225		469			54.01
60	Laboratory		5,483		2,594			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,003		887			65
66	Physical Therapy		2,594					66
69	Electrocardiology		195		105			69
69.01	CARDIAC CATH LAB		1,550		6			69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients						1,111,942	71
72	Impl. Dev. Charged to Patients						381,801	72
73	Drugs Charged to Patients							73
74	Renal Dialysis		70					74
75	ASC (Non-Distinct Part)	14,385	8,192		393	393		75
75.01	ONCOLOGY		4,534		536	536		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		5,856		1,533			90
90.01	WOUND CARE CENTER		850		71	71		90.01
91	Emergency	191	3,450		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)	315,278	120,438	71,756	22,575	13,234	1,493,743	118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices		1,274		1,666			192
192.01	RETAIL PHARMACY		360		274			192.01
192.02	CHA SITES		46,043		203			192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH				17			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	198,381	817,637	1,835,896	410,973	719,645	589,010	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.629226	4.863558	25.585261	16.615039	54.378495	0.394318	203
204	Cost to be allocated (Per Wkst. B, Part II)	929	20,956	155,599	66,493	4,698	182,909	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.002947	0.124653	2.168446	2.688215	0.354995	0.122450	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	COST 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	5,432,242						15
16	Medical Records & Library		130,989,871					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		27,815,328	60				30
31	Intensive Care Unit		606,732	20				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,846,626					50
53	Anesthesiology		1,167,828					53
54	Radiology-Diagnostic	40,642	12,903,641					54
54.01	ULTRASOUND		2,083,656					54.01
60	Laboratory		23,107,960					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		7,008,122					65
66	Physical Therapy		247,576					66
69	Electrocardiology		2,437,633					69
69.01	CARDIAC CATH LAB		346,853					69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients		4,348,167					71
72	Impl. Dev. Charged to Patients		3,066,326					72
73	Drugs Charged to Patients	4,516,133	29,765,349					73
74	Renal Dialysis		354,137					74
75	ASC (Non-Distinct Part)		1,530,036					75
75.01	ONCOLOGY		2,983,612	10				75.01
75.02	GI LAB		1,291,741					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		1,502,185					90
90.01	WOUND CARE CENTER		447,627					90.01
91	Emergency		5,128,736	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)	4,556,775	130,989,871	100				118
	NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH							190.01
192	Physicians' Private Offices							192
192.01	RETAIL PHARMACY	875,467						192.01
192.02	CHA SITES							192.02
192.03	OTHER NON REIMBURSABLE							192.03
194	SENIOR HEALTH							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,297,378	1,061,555	350,927				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.238829	0.008104	3,509.270000				203
204	Cost to be allocated (Per Wkst. B, Part II)	32,123	77,930	2,353				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.005913	0.000595	23.530000				205

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				
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C**
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	13,083,195		13,083,195	14,296	13,097,491	30
31	Intensive Care Unit	1,090,412		1,090,412	6,243	1,096,655	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,131,907		3,131,907		3,131,907	50
53	Anesthesiology	29,432		29,432		29,432	53
54	Radiology-Diagnostic	2,382,643		2,382,643		2,382,643	54
54.01	ULTRASOUND	275,043		275,043		275,043	54.01
60	Laboratory	4,760,753		4,760,753	17,254	4,778,007	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,034,061		1,034,061	4,831	1,038,892	65
66	Physical Therapy	316,654		316,654		316,654	66
69	Electrocardiology	164,993		164,993		164,993	69
69.01	CARDIAC CATH LAB	101,878		101,878		101,878	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	1,947,762		1,947,762		1,947,762	71
72	Impl. Dev. Charged to Patients	681,542		681,542		681,542	72
73	Drugs Charged to Patients	7,306,704		7,306,704		7,306,704	73
74	Renal Dialysis	180,350		180,350		180,350	74
75	ASC (Non-Distinct Part)	927,542		927,542		927,542	75
75.01	ONCOLOGY	779,928		779,928	5,321	785,249	75.01
75.02	GI LAB	107,358		107,358		107,358	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	1,606,052		1,606,052		1,606,052	90
90.01	WOUND CARE CENTER	124,783		124,783		124,783	90.01
91	Emergency	1,784,951		1,784,951		1,784,951	91
92	Observation Beds (Non-Distinct Part)	575,182		575,182		575,182	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 (sum of lines 30 thru 199)	42,393,125		42,393,125	47,945	42,441,070	200
201	Less Observation Beds	575,182		575,182		575,182	201
202	Total (line 200 minus line 201)	41,817,943		41,817,943		41,865,888	202

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	26,290,978		26,290,978				30
31	Intensive Care Unit	606,732		606,732				31
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,120,833	1,725,793	2,846,626	1.100217	1.100217	1.100217	50
53	Anesthesiology	352,662	815,166	1,167,828	0.025202	0.025202	0.025202	53
54	Radiology-Diagnostic	2,816,551	10,087,090	12,903,641	0.184649	0.184649	0.184649	54
54.01	ULTRASOUND	391,372	1,692,284	2,083,656	0.132000	0.132000	0.132000	54.01
60	Laboratory	7,994,826	15,113,134	23,107,960	0.206022	0.206022	0.206769	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,141,439	866,683	7,008,122	0.147552	0.147552	0.148241	65
66	Physical Therapy	233,839	13,737	247,576	1.279017	1.279017	1.279017	66
69	Electrocardiology	856,940	1,580,693	2,437,633	0.067686	0.067686	0.067686	69
69.01	CARDIAC CATH LAB	8,497	338,356	346,853	0.293721	0.293721	0.293721	69.01
70.01	SLEEP LAB							70.01
71	Medical Supplies Charged to Patients	1,766,386	2,581,781	4,348,167	0.447950	0.447950	0.447950	71
72	Impl. Dev. Charged to Patients	2,303,510	762,816	3,066,326	0.222267	0.222267	0.222267	72
73	Drugs Charged to Patients	10,009,337	19,756,012	29,765,349	0.245477	0.245477	0.245477	73
74	Renal Dialysis	306,255	47,882	354,137	0.509266	0.509266	0.509266	74
75	ASC (Non-Distinct Part)	236,178	1,293,858	1,530,036	0.606222	0.606222	0.606222	75
75.01	ONCOLOGY	259,623	2,723,989	2,983,612	0.261404	0.261404	0.263187	75.01
75.02	GI LAB	178,555	1,113,186	1,291,741	0.083111	0.083111	0.083111	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	4,211	1,497,974	1,502,185	1.069144	1.069144	1.069144	90
90.01	WOUND CARE CENTER	6,093	441,534	447,627	0.278766	0.278766	0.278766	90.01
91	Emergency	1,549,121	3,579,615	5,128,736	0.348029	0.348029	0.348029	91
92	Observation Beds (Non-Distinct Part)		1,524,350	1,524,350	0.377329	0.377329	0.377329	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 (sum of lines 30 thru 199)	63,433,938	67,555,933	130,989,871				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	63,433,938	67,555,933	130,989,871				202

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	13,083,195		13,083,195		13,083,195	30
31	Intensive Care Unit	1,090,412		1,090,412		1,090,412	31
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,131,907		3,131,907		3,131,907	50
53	Anesthesiology	29,432		29,432		29,432	53
54	Radiology-Diagnostic	2,382,643		2,382,643		2,382,643	54
54.01	ULTRASOUND	275,043		275,043		275,043	54.01
60	Laboratory	4,760,753		4,760,753		4,760,753	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,034,061		1,034,061		1,034,061	65
66	Physical Therapy	316,654		316,654		316,654	66
69	Electrocardiology	164,993		164,993		164,993	69
69.01	CARDIAC CATH LAB	101,878		101,878		101,878	69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Patients	1,947,762		1,947,762		1,947,762	71
72	Impl. Dev. Charged to Patients	681,542		681,542		681,542	72
73	Drugs Charged to Patients	7,306,704		7,306,704		7,306,704	73
74	Renal Dialysis	180,350		180,350		180,350	74
75	ASC (Non-Distinct Part)	927,542		927,542		927,542	75
75.01	ONCOLOGY	779,928		779,928		779,928	75.01
75.02	GI LAB	107,358		107,358		107,358	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	1,606,052		1,606,052		1,606,052	90
90.01	WOUND CARE CENTER	124,783		124,783		124,783	90.01
91	Emergency	1,784,951		1,784,951		1,784,951	91
92	Observation Beds (Non-Distinct Part)	574,555		574,555		574,555	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 (sum of lines 30 thru 199)	42,392,498		42,392,498		42,392,498	200
201	Less Observation Beds	574,555		574,555		574,555	201
202	Total (line 200 minus line 201)	41,817,943		41,817,943		41,817,943	202

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							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
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	3,131,907	195,314	2,936,593		50
53	Anesthesiology	29,432	8,421	21,011		53
54	Radiology-Diagnostic	2,382,643	227,383	2,155,260		54
54.01	ULTRASOUND	275,043	9,038	266,005		54.01
60	Laboratory	4,760,753	171,858	4,588,895		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,034,061	82,170	951,891		65
66	Physical Therapy	316,654	62,916	253,738		66
69	Electrocardiology	164,993	7,033	157,960		69
69.01	CARDIAC CATH LAB	101,878	37,314	64,564		69.01
70.01	SLEEP LAB					70.01
71	Medical Supplies Charged to Patients	1,947,762	145,646	1,802,116		71
72	Impl. Dev. Charged to Patients	681,542	50,946	630,596		72
73	Drugs Charged to Patients	7,306,704	72,440	7,234,264		73
74	Renal Dialysis	180,350	2,697	177,653		74
75	ASC (Non-Distinct Part)	927,542	199,926	727,616		75
75.01	ONCOLOGY	779,928	114,080	665,848		75.01
75.02	GI LAB	107,358	43,710	63,648		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	1,606,052	151,246	1,454,806		90
90.01	WOUND CARE CENTER	124,783	21,125	103,658		90.01
91	Emergency	1,784,951	97,601	1,687,350		91
92	Observation Beds (Non-Distinct Part)	574,555	54,578	519,977		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	28,218,891	1,755,442	26,463,449		200
201	Less Observation Beds	574,555	54,578	519,977		201
202	Total	27,644,336	1,700,864	25,943,472		202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		3,131,907			50
53	Anesthesiology		29,432			53
54	Radiology-Diagnostic		2,382,643			54
54.01	ULTRASOUND		275,043			54.01
60	Laboratory		4,760,753			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,034,061			65
66	Physical Therapy		316,654			66
69	Electrocardiology		164,993			69
69.01	CARDIAC CATH LAB		101,878			69.01
70.01	SLEEP LAB					70.01
71	Medical Supplies Charged to Patients		1,947,762			71
72	Impl. Dev. Charged to Patients		681,542			72
73	Drugs Charged to Patients		7,306,704			73
74	Renal Dialysis		180,350			74
75	ASC (Non-Distinct Part)		927,542			75
75.01	ONCOLOGY		779,928			75.01
75.02	GI LAB		107,358			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		1,606,052			90
90.01	WOUND CARE CENTER		124,783			90.01
91	Emergency		1,784,951			91
92	Observation Beds (Non-Distinct Part)		574,555	1,524,350	0.376918	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		28,218,891	1,524,350		200
201	Less Observation Beds		574,555	1,524,350		201
202	Total		27,644,336			202

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 SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,242,793		1,242,793	20,676	60.11	5,458	328,080	30
31	Intensive Care Unit	84,360		84,360	161	523.98	50	26,199	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)	1,327,153		1,327,153	20,837		5,508	354,279	200

(A) Worksheet A line numbers

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**

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	195,314	2,846,626	0.068612	475,403	32,618	50
53	Anesthesiology	8,421	1,167,828	0.007211	112,418	811	53
54	Radiology-Diagnostic	227,383	12,903,641	0.017622	1,197,347	21,100	54
54.01	ULTRASOUND	9,038	2,083,656	0.004338	178,674	775	54.01
60	Laboratory	171,858	23,107,960	0.007437	3,009,104	22,379	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	82,170	7,008,122	0.011725	2,335,455	27,383	65
66	Physical Therapy	62,916	247,576	0.254128	61,653	15,668	66
69	Electrocardiology	7,033	2,437,633	0.002885	384,521	1,109	69
69.01	CARDIAC CATH LAB	37,314	346,853	0.107579			69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	145,646	4,348,167	0.033496	679,826	22,771	71
72	Impl. Dev. Charged to Patients	50,946	3,066,326	0.016615	638,837	10,614	72
73	Drugs Charged to Patients	72,440	29,765,349	0.002434	3,968,508	9,659	73
74	Renal Dialysis	2,697	354,137	0.007616	119,102	907	74
75	ASC (Non-Distinct Part)	199,926	1,530,036	0.130668			75
75.01	ONCOLOGY	114,080	2,983,612	0.038236			75.01
75.02	GI LAB	43,710	1,291,741	0.033838	41,928	1,419	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	151,246	1,502,185	0.100684	3,837	386	90
90.01	WOUND CARE CENTER	21,125	447,627	0.047193			90.01
91	Emergency	97,601	5,128,736	0.019030	396,818	7,551	91
92	Observation Beds (Non-Distinct	54,578	1,524,350	0.035804			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,755,442	104,092,161		13,603,431	175,150	200

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	20,676		5,458		30
31	Intensive Care Unit	161		50		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	20,837		5,508		200

(A) Worksheet A line numbers

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0115** | **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/IID | [XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,846,626			475,403		510,838		50
53	Anesthesiology	1,167,828			112,418		116,372		53
54	Radiology-Diagnostic	12,903,641			1,197,347		2,909,487		54
54.01	ULTRASOUND	2,083,656			178,674		240,942		54.01
60	Laboratory	23,107,960			3,009,104		1,347,144		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	7,008,122			2,335,455		114,588		65
66	Physical Therapy	247,576			61,653				66
69	Electrocardiology	2,437,633			384,521		414,010		69
69.01	CARDIAC CATH LAB	346,853					70,299		69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	4,348,167			679,826		402,355		71
72	Impl. Dev. Charged to Patients	3,066,326			638,837		199,184		72
73	Drugs Charged to Patients	29,765,349			3,968,508		9,799,803		73
74	Renal Dialysis	354,137			119,102				74
75	ASC (Non-Distinct Part)	1,530,036							75
75.01	ONCOLOGY	2,983,612					174,933		75.01
75.02	GI LAB	1,291,741			41,928		149,928		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	1,502,185			3,837		611,624		90
90.01	WOUND CARE CENTER	447,627							90.01
91	Emergency	5,128,736			396,818		273,851		91
92	Observation Beds (Non-Distinct	1,524,350					265,404		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	104,092,161			13,603,431		17,600,762		200

(A) Worksheet A line numbers

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/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1.100217	510,838			562,033			50
53	Anesthesiology	0.025202	116,372			2,933			53
54	Radiology-Diagnostic	0.184649	2,909,487			537,234			54
54.01	ULTRASOUND	0.132000	240,942			31,804			54.01
60	Laboratory	0.206022	1,347,144			277,541			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.147552	114,588			16,908			65
66	Physical Therapy	1.279017							66
69	Electrocardiology	0.067686	414,010			28,023			69
69.01	CARDIAC CATH LAB	0.293721	70,299			20,648			69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat	0.447950	402,355			180,235			71
72	Impl. Dev. Charged to Patients	0.222267	199,184			44,272			72
73	Drugs Charged to Patients	0.245477	9,799,803		100,167	2,405,626		24,589	73
74	Renal Dialysis	0.509266							74
75	ASC (Non-Distinct Part)	0.606222							75
75.01	ONCOLOGY	0.261404	174,933			45,728			75.01
75.02	GI LAB	0.083111	149,928			12,461			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	1.069144	611,624			653,914			90
90.01	WOUND CARE CENTER	0.278766							90.01
91	Emergency	0.348029	273,851			95,308			91
92	Observation Beds (Non-Distinct	0.377329	265,404			100,145			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		17,600,762		100,167	5,014,813		24,589	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		17,600,762		100,167	5,014,813		24,589	202

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,242,793		1,242,793	20,676	60.11	2,003	120,400	30
31	Intensive Care Unit	84,360		84,360	161	523.98	53	27,771	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)	1,327,153		1,327,153	20,837		2,056	148,171	200

(A) Worksheet A line numbers

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** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	195,314	2,846,626	0.068612	178,089	12,219	50
53	Anesthesiology	8,421	1,167,828	0.007211	31,133	225	53
54	Radiology-Diagnostic	227,383	12,903,641	0.017622	309,962	5,462	54
54.01	ULTRASOUND	9,038	2,083,656	0.004338	30,372	132	54.01
60	Laboratory	171,858	23,107,960	0.007437	810,204	6,025	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	82,170	7,008,122	0.011725	800,394	9,385	65
66	Physical Therapy	62,916	247,576	0.254128	19,049	4,841	66
69	Electrocardiology	7,033	2,437,633	0.002885	92,924	268	69
69.01	CARDIAC CATH LAB	37,314	346,853	0.107579			69.01
70.01	SLEEP LAB						70.01
71	Medical Supplies Charged to Pat	145,646	4,348,167	0.033496	16,100	539	71
72	Impl. Dev. Charged to Patients	50,946	3,066,326	0.016615			72
73	Drugs Charged to Patients	72,440	29,765,349	0.002434	964,038	2,346	73
74	Renal Dialysis	2,697	354,137	0.007616	22,134	169	74
75	ASC (Non-Distinct Part)	199,926	1,530,036	0.130668	19,631	2,565	75
75.01	ONCOLOGY	114,080	2,983,612	0.038236	3,770	144	75.01
75.02	GI LAB	43,710	1,291,741	0.033838	48,020	1,625	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	151,246	1,502,185	0.100684	374	38	90
90.01	WOUND CARE CENTER	21,125	447,627	0.047193	205	10	90.01
91	Emergency	97,601	5,128,736	0.019030	159,228	3,030	91
92	Observation Beds (Non-Distinct	54,578	1,524,350	0.035804			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,755,442	104,092,161		3,505,627	49,023	200

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	20,676		2,003		30
31	Intensive Care Unit	161		53		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	20,837		2,056		200

(A) Worksheet A line numbers

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 [XX] Title XIX [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

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

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room				178,089				50
53	Anesthesiology				31,133				53
54	Radiology-Diagnostic				309,962				54
54.01	ULTRASOUND				30,372				54.01
60	Laboratory				810,204				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy				800,394				65
66	Physical Therapy				19,049				66
69	Electrocardiology				92,924				69
69.01	CARDIAC CATH LAB								69.01
70.01	SLEEP LAB								70.01
71	Medical Supplies Charged to Pat				16,100				71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients				964,038				73
74	Renal Dialysis				22,134				74
75	ASC (Non-Distinct Part)				19,631				75
75.01	ONCOLOGY				3,770				75.01
75.02	GI LAB				48,020				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				374				90
90.01	WOUND CARE CENTER				205				90.01
91	Emergency				159,228				91
92	Observation Beds (Non-Distinct								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)				3,505,627				200

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

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

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

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,676	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,676	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,768	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,458	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	13,097,491	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,097,491	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,097,491	37

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)	633.46	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,457,425	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	3,457,425	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	1,096,655	161	6,811.52	50	340,576	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,470,877	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	7,268,878	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	354,279	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	175,150	51
52	Total Program excludable cost (sum of lines 50 and 51)	529,429	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	6,739,449	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					908	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					633.46	88
89	Observation bed cost (line 87 x line 88) (see instructions)					575,182	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,242,793	13,097,491	0.094888	575,182	54,578	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,676	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,676	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	19,768	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,003	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	13,083,195	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,083,195	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,083,195	37

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					632.77	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,267,438	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,267,438	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	1,090,412	161	6,772.75	53	358,956	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,626,394	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	148,171	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	49,023	51
52	Total Program excludable cost (sum of lines 50 and 51)	197,194	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					908	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					632.77	88
89	Observation bed cost (line 87 x line 88) (see instructions)					574,555	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,242,793	13,083,195	0.094992	574,555	54,578	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		7,157,817		30
31	Intensive Care Unit		114,800		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	1.100217	475,403	523,046	50
53	Anesthesiology	0.025202	112,418	2,833	53
54	Radiology-Diagnostic	0.184649	1,197,347	221,089	54
54.01	ULTRASOUND	0.132000	178,674	23,585	54.01
60	Laboratory	0.206769	3,009,104	622,189	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.148241	2,335,455	346,210	65
66	Physical Therapy	1.279017	61,653	78,855	66
69	Electrocardiology	0.067686	384,521	26,027	69
69.01	CARDIAC CATH LAB	0.293721			69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients	0.447950	679,826	304,528	71
72	Impl. Dev. Charged to Patients	0.222267	638,837	141,992	72
73	Drugs Charged to Patients	0.245477	3,968,508	974,177	73
74	Renal Dialysis	0.509266	119,102	60,655	74
75	ASC (Non-Distinct Part)	0.606222			75
75.01	ONCOLOGY	0.263187			75.01
75.02	GI LAB	0.083111	41,928	3,485	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	1.069144	3,837	4,102	90
90.01	WOUND CARE CENTER	0.278766			90.01
91	Emergency	0.348029	396,818	138,104	91
92	Observation Beds (Non-Distinct Part)	0.377329			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		13,603,431	3,470,877	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		13,603,431		202

(A) Worksheet A line numbers

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		4,160,266		30
31	Intensive Care Unit		15,006		31
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room		178,089		50
53	Anesthesiology		31,133		53
54	Radiology-Diagnostic		309,962		54
54.01	ULTRASOUND		30,372		54.01
60	Laboratory		810,204		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy		800,394		65
66	Physical Therapy		19,049		66
69	Electrocardiology		92,924		69
69.01	CARDIAC CATH LAB				69.01
70.01	SLEEP LAB				70.01
71	Medical Supplies Charged to Patients		16,100		71
72	Impl. Dev. Charged to Patients				72
73	Drugs Charged to Patients		964,038		73
74	Renal Dialysis		22,134		74
75	ASC (Non-Distinct Part)		19,631		75
75.01	ONCOLOGY		3,770		75.01
75.02	GI LAB		48,020		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		374		90
90.01	WOUND CARE CENTER		205		90.01
91	Emergency		159,228		91
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,505,627		200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,505,627		202

(A) Worksheet A line numbers

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,687,121			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,696,952			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	14,145			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	1,844,897			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	153.50			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) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.2303			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5414			31
32	Sum of lines 30 and 31	0.7717			32
33	Allowable disproportionate share percentage (see instructions)	0.5288			33
34	Disproportionate share adjustment (see instructions)	976,175			34
	Uncompensated Care Adjustment	**Prior to October 1 (1.00)**	**(1.01)**	**On or after October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)	5,977,483,147		6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000341979		0.000211815	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,044,174		1,433,288	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	515,244		1,072,021	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,587,265			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	9,961,658			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	9,961,658			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	704,029			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	10,665,687			59
60	Primary payer payments	4,906			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	10,660,781			61
62	Deductibles billed to program beneficiaries	692,856			62
63	Coinsurance billed to program beneficiaries	171,629			63
64	Allowable bad debts (see instructions)	494,873			64
65	Adjusted reimbursable bad debts (see instructions)	321,667			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	457,765			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,117,963			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-32,868			70.93
70.94	HRR adjustment amount (see instructions)	-43,200			70.94
70.99	HAC adjustment amount (see instructions)	80,208			70.99
71	Amount due provider (see instructions)	9,961,687			71
71.01	Sequestration adjustment (see instructions)	199,234			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	9,936,825			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-174,372			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	3,329,636			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100
	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to October 1		On or After October 1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1,687,121	1,687,121				1,687,121	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	5,696,952			5,696,952		5,696,952	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges	14,145	2,760		11,385		14,145	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,844,897	216,583		1,628,314		1,844,897	4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage	0.5288	0.5288	0.5288	0.5288	0.5288		10
11	Disproportionate share adjustment	976,175	223,038		753,137		976,175	11
11.01	Uncompensated care payments	1,587,265	515,244		1,072,021		1,587,265	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	9,961,658	2,428,163		7,533,495		9,961,658	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only	9,961,658	2,428,163		7,533,495		9,961,658	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	704,029	160,120		543,909		704,029	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	**SUBTOTAL**		2,588,283		8,077,404		10,665,687	19
20	Capital DRG other than outlier	600,543	136,555		463,988		600,543	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	1,874	460		1,414		1,874	21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage	0.1692	0.1692		0.1692			24
25	Disproportionate share adjustment	101,612	23,105		78,507		101,612	25
26	Total prospective capital payments	704,029	160,120		543,909		704,029	26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment	-32,868	-8,942		-23,926		-32,868	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-43,200	-10,510		-32,690		-43,200	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				80,208		80,208	32

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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)	24,589			1
2	Medical and other services reimbursed under OPPS (see instructions)	5,014,813			2
3	OPPS payments	4,729,661			3
4	Outlier payment (see instructions)	5,250			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.820			5
6	Line 2 times line 5	4,112,147			6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	24,589			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	100,167			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	100,167			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)	100,167			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	75,578			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	24,589			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4,734,911			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	969,477			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,790,023			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)	3,790,023			30
31	Primary payer payments	1,739			31
32	Subtotal (line 30 minus line 31)	3,788,284			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)	466,639			34
35	Adjusted reimbursable bad debts (see instructions)	303,315			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	359,436			36
37	Subtotal (see instructions)	4,091,599			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,091,599			40
40.01	Sequestration adjustment (see instructions)	81,832			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	4,086,861			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-77,094			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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				9,303,433		4,079,143	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10	06/25/2018	633,392	06/25/2018	7,718	3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		633,392		7,718	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				9,936,825		4,086,861	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		-174,372		-77,094	6.02
7	Total Medicare program liability (see instructions)				9,762,453		4,009,767	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.

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	1,626,394		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,626,394		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,626,394		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	2,843,906		8
9	Ancillary service charges	3,505,627		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	6,349,533		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	6,349,533		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,723,139		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	1,626,394		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	1,626,394		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,626,394		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	1,626,394		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	1,626,394		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	1,626,394		40
41	Interim payments	1,626,394		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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	721,164				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	13,016,966				4
5	Other receivables	1,398,433				5
6	Allowances for uncollectible notes and accounts receivable	-6,131,370				6
7	Inventory	1,245,921				7
8	Prepaid expenses	483,725				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,734,839				11
	FIXED ASSETS					
12	Land	14,137,215				12
13	Land improvements	1,628,948				13
14	Accumulated depreciation	-1,464,826				14
15	Buildings	60,073,277				15
16	Accumulated depreciation	-39,787,280				16
17	Leasehold improvements	44,885				17
18	Accumulated depreciation	-21,048				18
19	Fixed equipment	14,107,811				19
20	Accumulated depreciation	-5,368,118				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	26,763,962				23
24	Accumulated depreciation	-23,684,448				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)	46,430,378				30
	OTHER ASSETS					
31	Investments	300,108,497				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,325,037				34
35	Total other assets (sum of lines 31-34)	303,433,534				35
36	Total assets (sum of lines 11, 30 and 35)	360,598,751				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	1,302,978				37
38	Salaries, wages and fees payable	2,241,371				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	6,437,607				44
45	Total current liabilities (sum of lines 37 thru 44)	9,981,956				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	11,680,808				49
50	Total long term liabilities (sum of lines 46 thru 49)	11,680,808				50
51	Total liabilities (sum of lines 45 and 50)	21,662,764				51
	CAPITAL ACCOUNTS					
52	General fund balance	338,935,988				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	338,935,988				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	360,598,752				60

THOREK MEMORIAL HOSPITAL Provider CCN: 14-0115	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/28/2018 Run Time: 16:59 Version: 2018.04 (09/26/2018)

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		282,057,079			1
2	Net income (loss) (from Worksheet G-3, line 29)		21,084,422			2
3	Total (sum of line 1 and line 2)		303,141,501			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		303,141,501			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		303,141,501			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	26,449,537		26,449,537	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)	26,449,537		26,449,537	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	605,936		605,936	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)	605,936		605,936	16
17	Total inpatient routine care services (sum of lines 10 and 16)	27,055,473		27,055,473	17
18	Ancillary services	36,507,193		36,507,193	18
19	Outpatient services		74,301,956	74,301,956	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	63,562,666	74,301,956	137,864,622	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		60,663,219	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)		60,663,219	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	137,864,622	1
2	Less contractual allowances and discounts on patients' accounts	90,838,306	2
3	Net patient revenues (line 1 minus line 2)	47,026,316	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	60,663,219	4
5	Net income from service to patients (line 3 minus line 4)	-13,636,903	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	7,115,947	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	46	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	92,486	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	2,480	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	1,250,869	22
23	Governmental appropriations	6,606	23
24	Other (UNREEALIZED GAIN ON INVESTMENT)	-1,115,774	24
24.01	Other (MEANINGFUL USE REVENUE INCL ACCRUAL)		24.01
24.02	Other (UNREALIZED GAIN ON INVESTMENT)	16,932,410	24.02
24.03	Other (MISC OPERATING REVENUE)	367,614	24.03
24.04	Other (PROVIDER TAX REV)	10,704,712	24.04
24.05	Other (NON OPERATING EXPENSES)	-636,071	24.05
25	Total other income (sum of lines 6-24)	34,721,325	25
26	Total (line 5 plus line 25)	21,084,422	26
29	Net income (or loss) for the period (line 26 minus line 28)	21,084,422	29

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	600,543	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	1,874	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)	54.60	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2303	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5414	8
9	Sum of lines 7 and 8	0.7717	9
10	Allowable disproportionate share percentage (see instructions)	0.1692	10
11	Disproportionate share adjustment (see instructions)	101,612	11
12	Total prospective capital payments (see instructions)	704,029	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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
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 Centers							201
202	TOTAL (sum of lines 118-201)							202