

HOSPITAL AND HOSPITAL HEALTH
CARE COMPLEX COST REPORT
FORM CMS-2552-96
TITLE XVIII AND XIX

PHYSICIANS' MEDICAL CENTER

Year ended December 31, 2008

Accountants' Compilation Report

Board of Trustees
Physicians' Medical Center, LLC

We have compiled the accompanying Hospital and Hospital Health Care Complex Cost Report of **Physicians' Medical Center, LLC** for the year ended December 31, 2008 in accordance with standards established by the American Institute of Certified Public Accountants.

Our compilation was limited to presenting in the form prescribed by the Health Care Financing Administration information that is the representation of management. We have not audited or reviewed the cost report referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

This cost report is presented in accordance with the requirements of the Health Care Financing Administration, which differ from generally accepted accounting principles. Accordingly, this cost report is not designed for those who are not informed about such differences.

Grant Thornton LLP

Wichita, Kansas
May 28, 2009

SUPPORTING WORKPAPERS FOR:

PHYSICIANS' MEDICAL CENTER, LLC

HOSPITAL AND HOSPITAL HEALTH

CARE COMPLEX COST REPORT

FORM CMS-2552-96

TITLE XVIII AND XIX

Year ended December 31, 2008

Date Prepared: 5/27/2009 6:59:00 PM

Data File: Z:\Prexus Health, L.L.C\Cost Report\Medicare CR Files\Physicians MCR 2008\Program\PMC.mcr

Fiscal Year: 10/30/2008 To 12/31/2008

Provider Name: PHYSICIANS MEDICAL CENTER

Health Financial Systems

Provider No: 150172

MCRIF32

EXHIBIT 1

FORM APPROVED

OMB NO. 0938-0301

This questionnaire is required under the authority of sections 1815(a) and 1833(e) of the Social Security Act. Failure to submit this questionnaire will result in suspension of Medicare payments.

To the degree that the information in CMS-339: 1) constitutes commercial or financial information which is confidential, and/or 2) is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0301. The time required to complete this information collection is estimated to average 17 hours and 20 minutes per response, including the time to review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

PROVIDER COST REPORT REIMBERSEMENT QUESTIONNAIRE
(You MUST USE Instructions For Completing This Form
Located In PRM-II, § § 1100ff.)

Provider Name: PHYSICIANS MEDICAL CENTER

Provider Number(s): 150172

Filed with Form CMS-2552-96

Period: From: 10/30/2008

To: 12/31/2008

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying information prepared by 150172 : PHYSICIANS MEDICAL CENTER (Provider name(s) and number(s)) for the cost report period beginning 10/30/2008 and ending 12/31/2008 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signed)

Officer or Administrator of Provider(s)

Date

Title

Name and Telephone Number of Person to Contact for More Information

Street: 4023 REAS LANE	State: IN
PO Box:	Zip Code: 47150-
City: NEW ALBANY	County: FLOYD

Contact: JEFF CARRAWAY
Phone: 812-206-7619 **Ext.**

YES/NO

A. Provider Organization and Operation

NOTE: Section A to be completed by all providers.

1. The provider has:
 - a. Changed ownership. NO
 If "yes", submit name and address of new owner, date of change, copy of sales agreement, or any similar agreement affecting change of ownership.
 - b. Terminated participation. NO
 If "yes", list date of termination, and reason (Voluntary/Involuntary).
2. The provider, members of the board of directors, officers, medical staff or management personnel are associated with or involved in business transactions with the following:
 - a. Related organizations, management contracts and services under arrangements as owners (stockholders), management, by family relationship, or any other similar type relationship. YES
 - b. Management personnel of major suppliers of the provider (drug, medical supply companies, etc.). If "yes" to question 2a and/or 2b, attach a list of the individuals, the organizations involved, and description of the transactions. NO

B. Financial Data and Reports

NOTE: Section B to be completed by all providers.

1. During this cost reporting period, the financial statements are prepared by Certified Public Accountants or Public Accountants (submit complete copy or indicate available date) and are:

a. Audited;	<i>FS are for all of 2008 cost reports is for period 10/30/08 to 12/31. They will be forwarded when ready</i>	YES
b. Compiled; and		NO
c. Reviewed.		NO

NOTE: Where there is no affirmative response to the above described financial statements, attach a copy of the financial statements prepared and a description of the changes in accounting policies and practices if not mentioned in those statements.
2. Cost report total expenses and total revenues differ from those on the filed financial statement. If "yes", submit reconciliation. YES

C. Capital Related Cost

NOTE: Section C to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.

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YES/NO

1. Assets have been relifed for Medicare purposes. If "yes", attach detailed listing of these specific assets, by classes, as shown in the Fixed Asset Register. N/A

NOTE: For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, under the capital - PPS consistency rule (42 CFR 412.302 (d)), PPS hospitals are precluded from relifing old capital.

2. Due to appraisals made during this cost reporting period, changes have occurred to Medicare depreciation expense. If "yes", attach copy of Appraisal Report and Appraisal Summary by class of asset. N/A

3. New leases and/or amendments to existing leases for land, equipment, or facilities with annual rental payment in excess of the amounts listed in the instructions, have been entered into during this cost reporting period. If "yes", submit a listing of these new leases and/or amendments to existing leases that have the following information: N/A

- o A new lease or lease renewal;
- o Parties to the lease;
- o Period covered by the lease;
- o Description of the asset being leased; and
- o Annual charge by the lessor.

NOTE: Providers are required to submit copies of the lease, or significant extracts, upon request from the intermediary.

4. There have been new capitalized leases entered into during the current cost reporting period. If "yes", attach a list of the individual assets by class, the department assigned to, and respective dollar amounts for all capitalized leases in accordance with the thresholds discussed in the instructions. N/A

5. Assets which were subject to §2314 of DEFRA were acquired during the period. If "yes", supply a computation of the basis. N/A

6. Provider's capitalization policy changed during cost reporting period. If "yes", submit copy. N/A

7. Obligated capital has been placed into use during the cost reporting period. If "yes", attach schedule listing each project, the cost of these projects and the date placed into service for patient care. N/A

D. Interest Expense

NOTE: Section D to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.

1. New loan, mortgage agreements or letters of credit were entered into during the cost reporting period. N/A

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Fiscal Year: 10/30/2008 To 12/31/2008

Provider Name: PHYSICIANS MEDICAL CENTER

Health Financial Systems

Provider No: 150172

MCRIF32

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YES/NO

If "yes", state the purpose and submit copies of debt documents and amortization schedules.

2. The provider has a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. N/A

If "yes", submit a detailed analysis of the funded depreciation account for the cost reporting period. (See PRM-1, §226.4.)

3. Provider replaced existing debt prior to its scheduled maturity with new debt. N/A

If "yes", submit support for new debt and calculation of allowable cost. (See §233.3 for description of allowable cost.)

4. Provider recalled debt before scheduled maturity without issuance of new debt. N/A

If "yes", submit detail of debt cancellation costs. (See §215 for description and treatment of debt cancellation costs.)

E. Approved Educational Activities

NOTE: Section E to be completed by all providers.

1. Costs were claimed for Nursing School and Allied Health Programs. N/A

If "yes", attach list of the programs and annotate for each whether the provider is the legal operator of the program.

2. Approvals and/or renewals were obtained during this cost reporting period for Nursing School and/or Allied Health Programs. NO

If "yes", submit copies.

3. Provider has claimed Intern-Resident costs on the current cost report. N/A

If "yes", submit the current year Intern-Resident Information System (IRIS) on diskette.

4. Provider has initiated an Intern-Resident program in the current year or obtained a renewal of an existing program. N/A

If "yes", submit certification/program approval.

5. Graduate Medical Education costs have been directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program, on Worksheet A, Form CMS-2552. NO

If "yes", submit appropriate workpapers indicating to which cost centers assigned and the amounts.

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Ext.

YES/NO

F. Purchased Services

NOTE: Questions 1 and 2 to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS. Question 3 to be completed only by Inpatient PPS (IPPS) hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.

- 1. Changes or new agreements have occurred in patient care services furnished through contractual arrangements with suppliers of services. N/A

If "yes", submit copies of changes or contracts, or where there are no written agreements, attach description.

NOTE: Hospitals are only required to submit such information where the cost of the individual's services exceeds \$25,000 per year.

- 2. The requirements of §2135.2 were applied pertaining to competitive bidding. N/A

If "no", attach explanation.

- 3. Contract services are reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs). N/A

If "yes", submit a schedule showing the total direct patient care related contract labor, hours and calculated rate for each invoice paid during the year for the direct patient care related contract labor reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs). Contracted labor will include any wage related costs. The contracted amounts for the top four management personnel (CEO, CFO, COO and Nursing Administrator) are not required to be reported by individuals. The total aggregate wage and hours will be reported for these management contracts. Other contracts or contracts for other management personnel should NOT be reported as they are not allowed in the computation of the wage index.

G. Provider-Based Physicians

NOTE: Section G to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.

- 1. Services are furnished at the provider facility under an arrangement with provider-based physicians. N/A

If "yes", submit completed provider-based physician questionnaire (Exhibits 2 through 4A).

- 2. The provider has entered into new agreements or amended existing agreements with provider-based physicians during this cost reporting period.

If "yes", submit copies of new agreements or amendments to existing agreements and assignment authorizations. N/A

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Ext.

YES/NO

H. Home Office Costs

NOTE: Questions 1 through 6 to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS. Question 7 to be completed only by IPPS hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.

- 1. The provider is part of a chain organization. N/A
If "yes", give full name and address of the home office:

Name:

Address:

City:

State:

Zip:

Designated Intermediary:

- 2. A home office cost statement has been prepared by the home office. N/A
If "yes", submit a schedule displaying the entire chain's direct, functional and pooled cost as provided to the designated home office intermediary as part of the home office cost statement.

- 3. The fiscal year end of the home office is different from that of the provider. N/A

If "yes", indicate the fiscal year end of the home office.

FYE

NOTE: Where the year ends of the provider and home office are not the same (nonconcurrent year ends), the summary listing, as described in number 2 above, will be necessary to support the provider's cost report.

- 4. Describe the operation of the intercompany accounts. Include in this description the types of costs included from these intercompany accounts and their location on the cost report. (Provide informative attachments not shown on Worksheet A-8-1). N/A

- 5. Actual expense amounts are transferred by the home office to the provider components on an interim basis. (Provide informative attachments if not shown on Worksheet A-8-1.) N/A

- 6. The provider renders services to:

- a. Other chain components. N/A

- b. The home office. N/A

If "yes", to either of the above, provide informative attachments.

- 7. Home Office or Related Organization personnel cost are reported on Worksheet S-3, Part II, Line 11 (hospitals) or line 18 (SNFs). N/A

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YES/NO

If yes, submit a schedule displaying the wages, wage related costs, and hours allocated to the individual chain components as provided to the designated home office intermediary to support the amount reported on Worksheet S-3, Part II, line 11 (hospitals) or line 18 (SNFs).

I. Bad Debts

NOTE: Section I to be completed by all providers.

- 1. The provider seeks Medicare reimbursement for bad debts. NO
If "yes", complete Exhibit 5 or submit internal schedules duplicating documentation required on Exhibit 5 to support bad debts claimed. (see instructions)
- 2. The provider's bad debt collection policy changed during the cost reporting period. NO
If "yes", submit copy.
- 3. The provider waives patient deductibles and/or copayments. NO
If yes, insure that they are not included on Exhibit 5.

J. Bed Complement

NOTE: Section J to be completed by all providers.

The provider's total available beds have changed from prior cost reporting period. NO
If "yes", provide an analysis of available beds and explain any changes during the cost reporting period.

K. PS&R Data

NOTE 1: Section K to be completed by all providers.

NOTE 2: Refer to the instructions regarding required documentation and attachments.

- 1. The cost report was prepared using the PS&R only?
 - a) Part A (including subproviders, SNF, etc.)? YES
 - b) Part B (inpatient and outpatient). YES
If yes, attach a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.
- 2. The cost report was prepared using the PS&R for totals and the provider records for allocation.
 - a) Part A (including subproviders, SNF, etc). NO
 - b) Part B (inpatient and outpatient). NO

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YES/NO

If yes, include a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.

If the PS&R is used for the allocation of ASC, Radiology, Other Diagnostic, and All Other Part B, explain how the total charges are detailed to the various PS&R Medicare outpatient types. Include workpapers supporting the allocation of charges into the various cost centers. If internal records are used for either the type of service breakdown or the charge allocation, the source of this information must be included in the documentation.

3. Provider records only were used to complete the cost report?

a) Part A (including subproviders, SNF, etc.).

NO

b) Part B (inpatient and outpatient).

NO

If yes, attach detailed documentation of the system used to support the data reported on the cost report.

If the detail documentation was previously supplied, submit only necessary updated documentation.

The minimum requirements are:

- Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components, capital PPS rate components, ASC payment group rates, Radiology and Other Diagnostic prevailing rates and other claims PRICING information.
- Log summaries and log detail supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.
- Reconciliation of remittance totals to the provider consolidated log totals.

Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material.

Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

4. If yes to questions 1 or 2 above, were any of the following adjustments made to the Part A PS&R data?

Part A:

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YES/NO

a) Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log.

NO

b) Correction of other PS&R information?

NO

c) Late charges?

NO

d) Other (describe)?

NO

Part B (inpatient and outpatient):

a) Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log.

NO

b) Correction of other PS&R information?

NO

c) Late charges?

NO

d) Other (describe)?

NO

Attach documentation which provides an audit trail from the PS&R to the cost report. The documentation should include the details of the PS&R, reclassifications, adjustments, and groupings necessary to trace to the cost center totals and in addition, for outpatient services, there should be an audit trail from the PS&R to the amounts shown on the cost report for outpatient charges by ASC, radiology, other diagnostic and all other service categories including standard overhead amounts and prevailing charges.

L. Wage Related Costs

NOTE: Section L to be completed only by IPPS hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.

1. Complete EXHIBIT 6, Part I (Per instructions). Part III must be completed to reconcile any differences between any fringe benefit cost reported on Worksheet A, Column 2, using Medicare principles and the corresponding wage related costs reported under GAAP for purposes of the wage index computation.

YES

2. The individual wage related cost exceeds one percent of total adjusted salaries after removing excluded salaries. (Salaries reported on Worksheet S-3, Part III, Column 3, line 3 (CMS- 2552-96), or Worksheet S-3, Part II, Column 3, Line 26 2540-96.)

YES

3. Additional wage related costs were provided that meet ALL of the following tests:

YES

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YES/NO

- | | | |
|----|--|-----|
| a. | The cost is not listed on Part I of EXHIBIT 6. | YES |
| b. | If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test in question 2 above. | YES |
| c. | The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS. | YES |
| d. | The individual wage related cost is not included in salaries reported on Worksheet S-3, Part III, column 3, line 3, (CMS-2552-96) or Worksheet S-3, Part II, Column 3, Line 16 (CMS-2540-96). | NO |
| e. | The wage related cost is not being furnished for the convenience of the employer. | NO |

[v6.1]

PART I - Wage Related Cost (Core List)

RETIREMENT COSTS:

1.	401K Employer Contributions	1.	0.00
2.	Tax Sheltered Annuity (TSA) Employer Contribution	2.	
3.	Qualified and Non-Qualified Pension Plan Cost	3.	
4.	Prior Year Pension Service Cost	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 COSTS:

8.	Health Insurance (Purchased or Self-Funded)	8.	
9.	Prescription Drug Plan	9.	
10.	Dental, Hearing & Vision Plans	10.	
11.	Life Insurance (If employee is owner or beneficiary)	11.	6,218.48
12.	Accident Ins. (If employee is owner or beneficiary)	12.	
13.	Disability Ins. (If employee is owner or beneficiary)	13.	
14.	Long-Term Care Ins. (If employee is owner or beneficiary)	14.	
15.	Workmen's Compensation Ins.	15.	1,476.50
16.	Retiree Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. This is the non-cumulative portion.)		

16.

TAXES:

17.	FICA-Employers Portion Only	17.	32,553.12
18.	Medicare Taxes - Employers Portion Only	18.	0.00
19.	Unemployment Insurance	19.	
20.	State or Federal Unemployment Taxes	20.	0.00

OTHER:

21.	Executive Deferred Compensation	21.	
22.	Day Care Cost and Allowances	22.	
23.	Tuition Reimbursement	23.	0.00

TOTAL WAGE RELATED COST (CORE) 40,348.10

[v6.1]

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Part III - WAGE RELATED COST RECONCILIATION TO FRINGE BENEFITS REPORTED IN THE COST REPORT

DESCRIPTION	COST PER MEDICARE	COST PER GAAP
EMPLOYEE BENEFITS	66,054.23	66,054.23
PTO EXPENSE	15,403.13	15,403.13
EMPLOYEE EDUCATION AND TRAINING	19.19	19.19
RECRUITING EXPENSE	1,865.92	1,865.92
PAYROLL SERVICE FEE	1,493.46	1,493.46
	0.00	0.00
	0.00	0.00
	0.00	0.00
	0.00	0.00

[v6.1]

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

FORM APPROVED OMB NO. 0938-0050

WORKSHEET S PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY I PROVIDER NO: 15-0172 I PERIOD FROM 10/30/2008 I TO 12/31/2008 I INTERMEDIARY USE ONLY I --AUDITED --DESK REVIEW I --INITIAL --REOPENED I --FINAL 1-MCR CODE I 00 - # OF REOPENINGS I DATE RECEIVED: / / I INTERMEDIARY NO: I

ELECTRONICALLY FILED COST REPORT DATE: 5/28/2009 TIME 11:55

PART I - 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 BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY: PHYSICIANS MEDICAL CENTER 15-0172

FOR THE COST REPORTING PERIOD BEGINNING 10/30/2008 AND ENDING 12/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

Table with columns: TITLE V, A, TITLE XVIII, B, TITLE XIX, 4. Rows: 1 HOSPITAL, 100 TOTAL. Values: 0, 16,283, 0, 0.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 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: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 4023 REAS LANE P.O. BOX:
 1.01 CITY: NEW ALBANY STATE: IN ZIP CODE: 47150- COUNTY: FLOYD

ITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00	HOSPITAL	15-0172		10/30/2008	N	P	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 10/30/2008 TO: 12/31/2008 1 2
 18 TYPE OF CONTROL 4

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N
 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy) / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?

25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(b)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER NO: I PERIOD: I PREPARED 5/28/2009 I 15-0172 I FROM 10/30/2008 I WORKSHEET S-2 I TO 12/31/2008 I

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS) IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / / 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)

Table with 4 columns (1, 2, 3, 4) and 2 rows of values: 0, 0.0000, 0.0000

28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY

0.00 0

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

- 28.03 STAFFING 0.00%
28.04 RECRUITMENT 0.00%
28.05 RETENTION 0.00%
28.06 TRAINING 0.00%
28.07 0.00%
28.08 0.00%
28.09 0.00%
28.10 0.00%
28.11 0.00%
28.12 0.00%
28.13 0.00%
28.14 0.00%
28.15 0.00%
28.16 0.00%
28.17 0.00%
78 18 0.00%
9 0.00%
20 0.00%

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) N
30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N

30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N

- 31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N
33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 Y N

- 34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N
35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

Table with 3 columns (V, XVIII, XIX) and 2 rows of values: 1, 2, 3

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N
36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE N N N

WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

E XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? N
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N
 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?
 IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.
 IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y
 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
 40.02 STREET: P.O. BOX:
 40.03 CITY: STATE: ZIP CODE: -
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? N
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCMP DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 2,912
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0

54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE	Y	OR	N	LIMIT	Y	OR	N	FEE
	0	1	2	3	4	5	6	7	8
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. N 0.00 0									
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE. 0.00 0									
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0									
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0									

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N
 58.01 IF LINE 58 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0
 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-0172 I FROM 10/30/2008 I WORKSHEET S-2
I I TO 12/31/2008 I

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORT FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3. (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)

0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

Table with columns: NAME, COUNTY, STATE, ZIP CODE, CBSA, FTE/CAMPUS. Rows 62.00 through 62.09, all FTE/CAMPUS values are 0.00.

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY).

Y 3/31/2009

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH N/A	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	1	12	2.01	3	4	10	5
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS		12				10	
6 INTENSIVE CARE UNIT							
12 TOTAL		12				10	
13 RPCH VISITS							
25 TOTAL		12					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION NOT ADMITTED	BEDS ALL PATS	O/P VISITS TOTAL	TRIPS TOTAL ADMITTED	OBSERVATION NOT ADMITTED	INTERNS & RES. FTES TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	36	6.01	6.02	7	8
2 HMO								
2 01 HMO - (IRF PPS SUBPROVIDER)								
3 ADULTS & PED-SB SNF								
4 ADULTS & PED-SB NF								
5 TOTAL ADULTS AND PEDS			6	36				
6 INTENSIVE CARE UNIT								
12 TOTAL			6	36				
13 RPCH VISITS								
25 TOTAL								
26 OBSERVATION BED DAYS				19		19		
27 AMBULANCE TRIPS								
28 EMPLOYEE DISCOUNT DAYS								
28 01 EMP DISCOUNT DAYS -IRF								

COMPONENT	I & R FTES NET	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO						10	54
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
12 TOTAL		39.53				10	54
13 RPCH VISITS							
25 TOTAL		39.53					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HOSPITAL WAGE INDEX INFORMATION

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET S-3
 I I TO 12/31/2008 I PARTS II & III

PART II - WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
SALARIES						
1 TOTAL SALARY	401,375		401,375	42,572.00	9.43	
2 NON-PHYSICIAN ANESTHETIST PART A						
3 NON-PHYSICIAN ANESTHETIST PART B						
4 PHYSICIAN - PART A						
4.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5 PHYSICIAN - PART B						
5.01 NON-PHYSICIAN - PART B						
6 INTERNS & RESIDENTS (APPRVD)						
6.01 CONTRACT SERVICES, I&R						
7 HOME OFFICE PERSONNEL						
8 SNF						
8.01 EXCLUDED AREA SALARIES						
OTHER WAGES & RELATED COSTS						
9 CONTRACT LABOR:						
9.01 PHARMACY SERVICES UNDER CONTRACT						
9.02 LABORATORY SERVICES UNDER CONTRACT						
9.03 MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10 CONTRACT LABOR: PHYS PART A						
10.01 TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11 HOME OFFICE SALARIES & WAGE RELATED COSTS						
12 HOME OFFICE: PHYS PART A						
12.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
WAGE RELATED COSTS						
13 WAGE-RELATED COSTS (CORE)	40,348		40,348			CMS 339
14 WAGE-RELATED COSTS (OTHER)	84,836		84,836			CMS 339
15 EXCLUDED AREAS						CMS 339
16 NON-PHYS ANESTHETIST PART A						CMS 339
17 NON-PHYS ANESTHETIST PART B						CMS 339
18 PHYSICIAN PART A						CMS 339
18.01 PART A TEACHING PHYSICIANS						CMS 339
19 PHYSICIAN PART B						CMS 339
19.01 WAGE-RELATD COSTS (RHC/FQHC)						CMS 339
20 INTERNS & RESIDENTS (APPRVD)						CMS 339
OVERHEAD COSTS - DIRECT SALARIES						
21 EMPLOYEE BENEFITS						
22 ADMINISTRATIVE & GENERAL	70,045	-13,333	56,712	1,985.00	28.57	
22.01 A & G UNDER CONTRACT						
23 MAINTENANCE & REPAIRS						
24 OPERATION OF PLANT	7,360		7,360	320.00	23.00	
25 LAUNDRY & LINEN SERVICE						
26 HOUSEKEEPING						
26.01 HOUSEKEEPING UNDER CONTRACT						
27 DIETARY						
27.01 DIETARY UNDER CONTRACT						
28 CAFETERIA						
29 MAINTENANCE OF PERSONNEL		13,333	13,333	347.00	38.42	
30 NURSING ADMINISTRATION			15,806	531.00	29.77	
31 CENTRAL SERVICE AND SUPPLY	15,806					
32 PHARMACY						
33 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY						
34 SOCIAL SERVICE						
35 OTHER GENERAL SERVICE						
PART III - HOSPITAL WAGE INDEX SUMMARY						
1 NET SALARIES	401,375		401,375	42,572.00	9.43	
2 EXCLUDED AREA SALARIES						
3 SUBTOTAL SALARIES	401,375		401,375	42,572.00	9.43	
4 SUBTOTAL OTHER WAGES & RELATED COSTS						
5 SUBTOTAL WAGE-RELATED COSTS	125,184		125,184		31.19	
6 TOTAL	526,559		526,559	42,572.00	12.37	
7 NET SALARIES						
8 EXCLUDED AREA SALARIES						
9 SUBTOTAL SALARIES						
10 SUBTOTAL OTHER WAGES & RELATED COSTS						
11 SUBTOTAL WAGE-RELATED COSTS						
12 TOTAL						
13 TOTAL OVERHEAD COSTS	93,211		93,211	3,183.00	29.28	

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET S-10
 I I TO 12/31/2008 I
 I I I

DESCRIPTION

- UNCOMPENSATED CARE INFORMATION
- 1 DO YOU HAVE A WRITTEN CHARITY CARE POLICY?
- 2 ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04
- 2.01 IS IT AT THE TIME OF ADMISSION?
- 2.02 IS IT AT THE TIME OF FIRST BILLING?
- 2.03 IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?
- 2.04
- 3 ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?
- 4 ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?
- 5 ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?
- 6 ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?
- 7 ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?
- 8 DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01
- 8.01 DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?
- 9 IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04
- 9.01 IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?
- 9.02 IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?
- 9.03 IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?
- 9.04 IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?
- 10 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?
- 11 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04
- .1.01 IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?
- 11.02 IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?
- 11.03 IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?
- 11.04 IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?
- 12 ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?
- 13 IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?
- 14 IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02
- 14.01 DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?
- 14.02 WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?
- 15 DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?
- 16 ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?

- UNCOMPENSATED CARE REVENUES
- 17 REVENUE FROM UNCOMPENSATED CARE
- 17.01 GROSS MEDICAID REVENUES
- 18 REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS
- 19 REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)
- 20 RESTRICTED GRANTS
- 21 NON-RESTRICTED GRANTS
- 22 TOTAL GROSS UNCOMPENSATED CARE REVENUES

- UNCOMPENSATED CARE COST
- 23 TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS
- 24 COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103) .197691
- 5 TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)
- 26 TOTAL SCHIP CHARGES FROM YOUR RECORDS
- 27 TOTAL SCHIP COST, (LINE 24 * LINE 26)
- 28 TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS

HOSPITAL UNCOMPENSATED CARE DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/28/2009
I	15-0172	I	FROM 10/30/2008	I	WORKSHEET S-10
I		I	TO 12/31/2008	I	
I		I		I	

DESCRIPTION

- 29 TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)
- 30 OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS
- 31 UNCOMPENSATED CARE COST (LINE 24 * LINE 30)
- 32 TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL
(SUM OF LINES 25, 27, AND 29)

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 15-0172
II PERIOD:
I FROM 10/30/2008
I TO 12/31/2008
II PREPARED 5/28/2009
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
	0300 NEW CAP REL COSTS-BLDG & FIXT		296,879	296,879		296,879
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		7,581	7,581		7,581
5	0500 EMPLOYEE BENEFITS		125,184	125,184		125,184
6	0600 ADMINISTRATIVE & GENERAL	70,045	370,433	440,478	-13,333	427,145
8	0800 OPERATION OF PLANT	7,360	50,403	57,763		57,763
9	0900 LAUNDRY & LINEN SERVICE		5,430	5,430		5,430
10	1000 HOUSEKEEPING		27,378	27,378		27,378
11	1100 DIETARY		4,521	4,521		4,521
14	1400 NURSING ADMINISTRATION				13,333	13,333
15	1500 CENTRAL SERVICES & SUPPLY	15,806		15,806		15,806
16	1600 PHARMACY					
17	1700 MEDICAL RECORDS & LIBRARY		10,395	10,395		10,395
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	83,779	52	83,831		83,831
26	2600 INTENSIVE CARE UNIT					
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	214,272		214,272		214,272
38	3800 RECOVERY ROOM					
40	4000 ANESTHESIOLOGY					
41	4100 RADIOLOGY-DIAGNOSTIC	10,113		10,113		10,113
44	4400 LABORATORY					
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY					
49	4900 RESPIRATORY THERAPY					
50	5000 PHYSICAL THERAPY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		178,249	178,249	-15,572	162,677
56	5600 DRUGS CHARGED TO PATIENTS		-15,572	-15,572	15,572	
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY					
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		-55,533	-55,533		-55,533
90	9000 OTHER CAPITAL RELATED COSTS					
95	9500 SUBTOTALS	401,375	1,005,400	1,406,775	-0-	1,406,775
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
96.01	9601 SHELLED SPACE					
97	9700 RESEARCH					
98	9800 PHYSICIANS' PRIVATE OFFICES					
99	9900 NONPAID WORKERS					
	TOTAL	401,375	1,005,400	1,406,775	-0-	1,406,775

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:	I PERIOD:	I PREPARED
I 15-0172	I FROM 10/30/2008	I 5/28/2009
I	I TO 12/31/2008	I WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
	0300 NEW CAP REL COSTS-BLDG & FIXT		296,879
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		7,581
5	0500 EMPLOYEE BENEFITS		125,184
6	0600 ADMINISTRATIVE & GENERAL	-144,513	282,632
8	0800 OPERATION OF PLANT		57,763
9	0900 LAUNDRY & LINEN SERVICE		5,430
10	1000 HOUSEKEEPING		27,378
11	1100 DIETARY		4,521
14	1400 NURSING ADMINISTRATION		13,333
15	1500 CENTRAL SERVICES & SUPPLY		15,806
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY		10,395
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		83,831
26	2600 INTENSIVE CARE UNIT		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		214,272
38	3800 RECOVERY ROOM		
40	4000 ANESTHESIOLOGY		
41	4100 RADIOLOGY-DIAGNOSTIC		10,113
44	4400 LABORATORY		
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY		
49	4900 RESPIRATORY THERAPY		
50	5000 PHYSICAL THERAPY		
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		162,677
56	5600 DRUGS CHARGED TO PATIENTS		
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY		
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE	55,533	-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-88,980	1,317,795
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
96.01	9601 SHELLLED SPACE		
97	9700 RESEARCH		
98	9800 PHYSICIANS' PRIVATE OFFICES		
99	9900 NONPAID WORKERS		
	TOTAL	-88,980	1,317,795

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I NOT A CMS WORKSHEET
 I I TO 12/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
	NEW CAP REL COSTS-BLDG & FIXT	0300	
	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
45	PBP CLINICAL LAB SERVICES-PRGM ONLY	4500	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
96.01	SHELLED SPACE	9601	GIFT, FLOWER, COFFEE SHOP & CANTEEN
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
150172	FROM 10/30/2008	5/28/2009
	TO 12/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	INCREASE				
	CODE (1) COST CENTER	LINE NO	SALARY	OTHER	
	1	2	3	4	
1 PHARMACY RECLASS	B	DRUGS CHARGED TO PATIENTS	56		14,629
2		DRUGS CHARGED TO PATIENTS	56		943
3 NURSING ADM RECLASS	C	NURSING ADMINISTRATION	14	13,333	
36 TOTAL RECLASSIFICATIONS				13,333	15,572

(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.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
150172	FROM 10/30/2008	5/28/2009
	TO 12/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1) COST CENTER	DECREASE			A-7 REF 10
		6	LINE NO 7	SALARY 8	
1 PHARMACY RECLASS	B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		14,629
2 NURSING ADM RECLASS		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		943
3 TOTAL RECLASSIFICATIONS	C	ADMINISTRATIVE & GENERAL	6	13,333	15,572
				13,333	

(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.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
150172	FROM 10/30/2008	5/28/2009
	TO 12/31/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: B
 EXPLANATION : PHARMACY RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	14,629	MEDICAL SUPPLIES CHARGED TO PA	55	14,629
2.00	DRUGS CHARGED TO PATIENTS	943	MEDICAL SUPPLIES CHARGED TO PA	55	943
TOTAL RECLASSIFICATIONS FOR CODE B		15,572			

RECLASS CODE: C
 EXPLANATION : NURSING ADM RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	13,333	ADMINISTRATIVE & GENERAL	6	13,333
TOTAL RECLASSIFICATIONS FOR CODE C		13,333			

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3				
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3				
1	LAND	850,190					850,190	
2	LAND IMPROVEMENTS		768,718		768,718		768,718	
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN		7,340,255		7,340,255		7,340,255	
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT		3,450,378		3,450,378		3,450,378	
7	SUBTOTAL	850,190	11,559,351		11,559,351		12,409,541	
8	RECONCILING ITEMS							
9	TOTAL	850,190	11,559,351		11,559,351		12,409,541	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS		ALLOCATION OF OTHER CAPITAL			TOTAL 8
			CAPITIALIZED ASSETS LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	
3	NEW CAP REL COSTS-BL	8,959,163		8,959,163	.721958			
4	NEW CAP REL COSTS-MV	3,450,378		3,450,378	.278042			
5	TOTAL	12,409,541		12,409,541	1.000000			

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	296,329				550		296,879
4	NEW CAP REL COSTS-MV		1,921				5,660	7,581
5	TOTAL	296,329	1,921			550	5,660	304,460

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	296,329				550		296,879
4	NEW CAP REL COSTS-MV		1,921				5,660	7,581
5	TOTAL	296,329	1,921			550	5,660	304,460

* All lines numbers except line 5 are to be consistent with workshseet A line numbers for capital cost centers.
 (1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.
 Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO 4	WKST. A-7 REF. 5
			COST CENTER 3			
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	
5 INVESTMENT INCOME-OTHER						
6 TRADE, QUANTITY AND TIME DISCOUNTS						
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES						
10 TELEVISION AND RADIO SERVICE						
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2					
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	1				
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS						
17 RENTAL OF QTRS TO EMPLOYEE AND OTHERS						
18 SALE OF MED AND SURG SUPPLIES						
19 SALE OF DRUGS TO OTHER THAN PATIENTS						
20 SALE OF MEDICAL RECORDS & ABSTRACTS						
21 NURSG SCHOOL (TUITN, FEES, BOOKS, ETC.)						
22 VENDING MACHINES						
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY		49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY		50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**		89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**		20	
34 PHYSICIANS' ASSISTANT						
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**		51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**		52	
37 REMOVAL OF SUITE LEASE	A	-143,252	ADMINISTRATIVE & GENERAL		6	
38 MARKETING COSTS	A	-1,262	ADMINISTRATIVE & GENERAL		6	
39 INTEREST EXPENSE	A	55,533	INTEREST EXPENSE		88	11
40						
41						
42 OTHER ADJUSTMENTS (SPECIFY)						
43 OTHER ADJUSTMENTS (SPECIFY)						
44 OTHER ADJUSTMENTS (SPECIFY)						
45 OTHER ADJUSTMENTS (SPECIFY)						
46 OTHER ADJUSTMENTS (SPECIFY)						
47 OTHER ADJUSTMENTS (SPECIFY)						
48 OTHER ADJUSTMENTS (SPECIFY)						
49 OTHER ADJUSTMENTS (SPECIFY)						
50 TOTAL (SUM OF LINES 1 THRU 49)		-88,980				

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.
 (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 37 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to worksheet A-7

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL		1		1
2						
3						
4						
5	TOTALS			1		1

* THE AMOUNTS ON LINES 1-4 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 ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: THE SECRETARY, BY VIRTUE OF 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 & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	C	100.00	PHYSICIANS MEDICAL CENTER	0.00	HOSPITAL
2	A	100.00	PHYSICIANS SURG PROP, LLC	0.00	PROPERTY COMPANY
3		0.00		0.00	
4		0.00		0.00	
5		0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE 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 A 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.
 COMMON OWNERSHIP IN HOSP AND ENTITY

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I NOT A CMS WORKSHEET
 I I TO 12/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	PATIENT	DAYS	ENTERED
10	HOUSEKEEPING	3	SQUARE	FEET	ENTERED
11	DIETARY	10	PATIENT	DAYS	ENTERED
14	NURSING ADMINISTRATION	14	NURSING	HOURS	ENTERED
15	CENTRAL SERVICES & SUPPLY	15	COSTED	REQUIS.	ENTERED
16	PHARMACY	16	COSTED	REQUISITION	ENTERED
17	MEDICAL RECORDS & LIBRARY	17	PATIENT	REVENUE	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & OSTS-MVBLE E	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &	296,879	296,879					
004 NEW CAP REL COSTS-MVBLE E	7,581		7,581				
005 EMPLOYEE BENEFITS	125,184			125,184			
006 ADMINISTRATIVE & GENERAL	282,632	51,086	1,305	17,688	352,711	352,711	
008 OPERATION OF PLANT	57,763	18,967	484	2,295	79,509	29,058	108,567
009 LAUNDRY & LINEN SERVICE	5,430				5,430	1,985	
010 HOUSEKEEPING	27,378	4,215	108		31,701	11,586	2,017
011 DIETARY	4,521	4,586	117		9,224	3,371	2,195
014 NURSING ADMINISTRATION	13,333			4,158	17,491	6,392	
015 CENTRAL SERVICES & SUPPLY	15,806	47,476	1,212	4,930	69,424	25,373	22,724
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	10,395	4,664	119		15,178	5,547	2,232
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	83,831	77,098	1,969	26,130	189,028	69,084	36,902
026 INTENSIVE CARE UNIT							
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	214,272	87,402	2,232	66,829	370,735	135,493	41,834
038 RECOVERY ROOM							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	10,113	1,385	35	3,154	14,687	5,368	663
044 LABORATORY							
045 PBP CLINICAL LAB SERVICES							
049 RESPIRATORY THERAPY							
050 PHYSICAL THERAPY							
055 MEDICAL SUPPLIES CHARGED	162,677				162,677	59,454	
056 DRUGS CHARGED TO PATIENTS							
OUTPAT SERVICE COST CNTRS							
061 EMERGENCY							
062 OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	1,317,795	296,879	7,581	125,184	1,317,795	352,711	108,567
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
096 01 SHELLED SPACE							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENT							
NEGATIVE COST CENTER							
3 TOTAL	1,317,795	296,879	7,581	125,184	1,317,795	352,711	108,567

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	9	10	11	14	15	16	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	7,415						
011 HOUSEKEEPING		45,304					
014 DIETARY			15,723				
015 NURSING ADMINISTRATION				23,883			
016 CENTRAL SERVICES & SUPPLY		9,662			127,183		
017 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		949					23,906
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	7,415	15,690	15,723	5,781			80
037 INTENSIVE CARE UNIT							
038 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM		17,788		17,382			17,535
041 RECOVERY ROOM							
044 ANESTHESIOLOGY							
045 RADIOLOGY-DIAGNOSTIC		282		720			452
049 LABORATORY							
050 PBP CLINICAL LAB SERVICES							
055 RESPIRATORY THERAPY							
056 PHYSICAL THERAPY							
061 MEDICAL SUPPLIES CHARGED						127,183	5,053
062 DRUGS CHARGED TO PATIENTS							786
095 OUTPAT SERVICE COST CNTRS							
096 EMERGENCY							
096 01 OBSERVATION BEDS (NON-DIS							
097 SPEC PURPOSE COST CENTERS							
098 SUBTOTALS	7,415	45,304	15,723	23,883	127,183		23,906
099 NONREIMBURS COST CENTERS							
101 GIFT, FLOWER, COFFEE SHOP							
101 01 SHELLED SPACE							
101 RESEARCH							
101 PHYSICIANS' PRIVATE OFFIC							
101 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENT							
101 NEGATIVE COST CENTER							
101 TOTAL	7,415	45,304	15,723	23,883	127,183		23,906

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET B
 I TO 12/31/2008 I PART I

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	25	26	27
GENERAL SERVICE COST CNTR			
003 NEW CAP REL COSTS-BLDG &			
004 NEW CAP REL COSTS-MVBLE E			
005 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENERAL			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
014 NURSING ADMINISTRATION			
015 CENTRAL SERVICES & SUPPLY			
016 PHARMACY			
017 MEDICAL RECORDS & LIBRARY			
INPAT ROUTINE SRVC CNTRS			
025 ADULTS & PEDIATRICS	339,703		339,703
026 INTENSIVE CARE UNIT			
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	600,767		600,767
038 RECOVERY ROOM			
040 ANESTHESIOLOGY			
041 RADIOLOGY-DIAGNOSTIC	22,172		22,172
044 LABORATORY			
045 PBP CLINICAL LAB SERVICES			
049 RESPIRATORY THERAPY			
050 PHYSICAL THERAPY			
055 MEDICAL SUPPLIES CHARGED	354,367		354,367
056 DRUGS CHARGED TO PATIENTS	786		786
OUTPAT SERVICE COST CNTRS			
061 EMERGENCY			
062 OBSERVATION BEDS (NON-DIS			
SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	1,317,795		1,317,795
NONREIMBURS COST CENTERS			
096 GIFT, FLOWER, COFFEE SHOP			
096 01 SHELLED SPACE			
097 RESEARCH			
098 PHYSICIANS' PRIVATE OFFIC			
099 NONPAID WORKERS			
101 CROSS FOOT ADJUSTMENT			
NEGATIVE COST CENTER			
3 TOTAL	1,317,795		1,317,795

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	0	3	4	4a	5	6	8
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		51,086	1,305	52,391		52,391	
008 OPERATION OF PLANT		18,967	484	19,451		4,316	23,767
009 LAUNDRY & LINEN SERVICE						295	
010 HOUSEKEEPING		4,215	108	4,323		1,721	442
011 DIETARY		4,586	117	4,703		501	480
014 NURSING ADMINISTRATION						950	
015 CENTRAL SERVICES & SUPPLY		47,476	1,212	48,688		3,769	4,975
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		4,664	119	4,783		824	489
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		77,098	1,969	79,067		10,262	8,078
026 INTENSIVE CARE UNIT							
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		87,402	2,232	89,634		20,125	9,158
038 RECOVERY ROOM							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		1,385	35	1,420		797	145
044 LABORATORY							
045 PBP CLINICAL LAB SERVICES							
049 RESPIRATORY THERAPY							
050 PHYSICAL THERAPY							
055 MEDICAL SUPPLIES CHARGED						8,831	
056 DRUGS CHARGED TO PATIENTS							
OUTPAT SERVICE COST CNTRS							
061 EMERGENCY							
062 OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		296,879	7,581	304,460		52,391	23,767
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
096 01 SHELLED SPACE							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENTS							
NEGATIVE COST CENTER							
TOTAL		296,879	7,581	304,460		52,391	23,767

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	9	10	11	14	15	16	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	295						
011 HOUSEKEEPING		6,486					
014 DIETARY		134	5,818				
015 NURSING ADMINISTRATION				950			
016 CENTRAL SERVICES & SUPPLY		1,383			58,815		
017 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		136					6,232
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	295	2,246	5,818	230			21
037 INTENSIVE CARE UNIT							
038 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		2,547		691			4,570
038 RECOVERY ROOM							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		40		29			118
044 LABORATORY							
045 PBP CLINICAL LAB SERVICES							
049 RESPIRATORY THERAPY							
050 PHYSICAL THERAPY							
055 MEDICAL SUPPLIES CHARGED						58,815	1,318
056 DRUGS CHARGED TO PATIENTS							205
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY							
095 OBSERVATION BEDS (NON-DIS							
095 SPEC PURPOSE COST CENTERS	295	6,486	5,818	950	58,815		6,232
096 SUBTOTALS							
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
096 01 SHELLED SPACE							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENTS							
101 NEGATIVE COST CENTER							
3 TOTAL	295	6,486	5,818	950	58,815		6,232

ALLOCATION OF NEW CAPITAL RELATED COSTS

I 15-0172 I FROM 10/30/2008 I WORKSHEET B

I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	25	26	27
GENERAL SERVICE COST CNTR			
003 NEW CAP REL COSTS-BLDG &			
004 NEW CAP REL COSTS-MVBLE E			
005 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENERAL			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
014 NURSING ADMINISTRATION			
015 CENTRAL SERVICES & SUPPLY			
016 PHARMACY			
017 MEDICAL RECORDS & LIBRARY			
INPAT ROUTINE SRVC CNTRS			
025 ADULTS & PEDIATRICS	106,017		106,017
026 INTENSIVE CARE UNIT			
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	126,725		126,725
038 RECOVERY ROOM			
040 ANESTHESIOLOGY			
041 RADIOLOGY-DIAGNOSTIC	2,549		2,549
044 LABORATORY			
045 PBP CLINICAL LAB SERVICES			
049 RESPIRATORY THERAPY			
050 PHYSICAL THERAPY			
055 MEDICAL SUPPLIES CHARGED	68,964		68,964
056 DRUGS CHARGED TO PATIENTS	205		205
OUTPAT SERVICE COST CNTRS			
061 EMERGENCY			
062 OBSERVATION BEDS (NON-DIS			
SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	304,460		304,460
NONREIMBURS COST CENTERS			
096 GIFT, FLOWER, COFFEE SHOP			
096 01 SHELLED SPACE			
097 RESEARCH			
098 PHYSICIANS' PRIVATE OFFIC			
099 NONPAID WORKERS			
101 CROSS FOOT ADJUSTMENTS			
NEGATIVE COST CENTER			
3 TOTAL	304,460		304,460

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: 15-0172
 I PERIOD: FROM 10/30/2008 TO 12/31/2008
 I PREPARED 5/28/2009
 I WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCILIATION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	OSTS-BLDG & (SQUARE FEET)	OSTS-MVBLE (SQUARE FEET)	E FITS (GROSS SALARIES)		(ACCUM. COST)	(SQUARE FEET)
	3	4	5	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	30,428					
005 NEW CAP REL COSTS-MVB		30,428				
006 EMPLOYEE BENEFITS			401,375			
008 ADMINISTRATIVE & GENE	5,236	5,236	56,712	-352,711	965,084	
009 OPERATION OF PLANT	1,944	1,944	7,360		79,509	23,248
010 LAUNDRY & LINEN SERVI					5,430	
011 HOUSEKEEPING	432	432			31,701	432
014 DIETARY	470	470			9,224	470
015 NURSING ADMINISTRATIO			13,333		17,491	
016 CENTRAL SERVICES & SU	4,866	4,866	15,806		69,424	4,866
017 PHARMACY						
025 MEDICAL RECORDS & LIB	478	478			15,178	478
026 INPAT ROUTINE SRVC CN						
037 ADULTS & PEDIATRICS	7,902	7,902	83,779		189,028	7,902
038 INTENSIVE CARE UNIT						
040 ANCILLARY SRVC COST C						
041 OPERATING ROOM	8,958	8,958	214,272		370,735	8,958
044 RECOVERY ROOM						
045 ANESTHESIOLOGY						
049 RADIOLOGY-DIAGNOSTIC	142	142	10,113		14,687	142
050 LABORATORY						
055 PBP CLINICAL LAB SERV						
056 RESPIRATORY THERAPY						
061 PHYSICAL THERAPY						
062 MEDICAL SUPPLIES CHAR					162,677	
095 DRUGS CHARGED TO PATI						
096 OUTPAT SERVICE COST C						
099 EMERGENCY						
101 OBSERVATION BEDS (NON						
102 SPEC PURPOSE COST CEN						
103 SUBTOTALS	30,428	30,428	401,375	-352,711	965,084	23,248
104 NONREIMBURS COST CENT						
106 GIFT, FLOWER, COFFEE						
108 01 SHELLED SPACE						
109 RESEARCH						
103 PHYSICIANS' PRIVATE O						
109 NONPAID WORKERS						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	296,879	7,581	125,184		352,711	108,567
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	9.756770		.311888		.365472	
105 (WRKSHT B, PT I)		.249146				4.669950
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED					52,391	23,767
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER					.054286	
108 (WRKSHT B, PT III)						1.022325

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE		DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
		(PATIENT DAYS)	(SQUARE FEET)	(PATIENT DAYS)	(NURSING HOURS)	(COSTED)EQUIS.	R(COSTED)UISITION	REQ(PATIENT)EVENUE
		9	10	11	14	15	16	17
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVI	36						
010	HOUSEKEEPING		22,816					
011	DIETARY		470	36				
014	NURSING ADMINISTRATIO				10,522			
015	CENTRAL SERVICES & SU		4,866					
016	PHARMACY					100		
017	MEDICAL RECORDS & LIB		478				100	6,632,104
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	36	7,902	36	2,547			22,244
026	INTENSIVE CARE UNIT							
	ANCILLARY SRVC COST C							
037	OPERATING ROOM		8,958		7,658			4,864,829
038	RECOVERY ROOM							
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC		142		317			125,437
044	LABORATORY							
045	PBP CLINICAL LAB SERV							
049	RESPIRATORY THERAPY							
050	PHYSICAL THERAPY							
055	MEDICAL SUPPLIES CHAR					100		1,401,626
056	DRUGS CHARGED TO PATI						100	217,968
	OUTPAT SERVICE COST C							
061	EMERGENCY							
062	OBSERVATION BEDS (NON							
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	36	22,816	36	10,522	100	100	6,632,104
096	NONREIMBURS COST CENT							
	GIFT, FLOWER, COFFEE							
096	01 SHELLED SPACE							
	RESEARCH							
	PHYSICIANS' PRIVATE O							
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	7,415	45,304	15,723	23,883	127,183		23,906
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		1.985624		2.269816			
	(WRKSHT B, PT I)							
105	COST TO BE ALLOCATED	205.972222		436.750000		1,271.830000		.003605
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	295	6,486	5,818	950	58,815		6,232
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER	8.194444	.284274	161.611111	.090287	588.150000		.000940
	(WRKSHT B, PT III)							

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	339,703		339,703		339,703
26	INTENSIVE CARE UNIT					
	ANCILLARY SRVC COST CNTRS	600,767		600,767		600,767
37	OPERATING ROOM					
38	RECOVERY ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	22,172		22,172		22,172
44	LABORATORY					
45	PBP CLINICAL LAB SERVICES					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
55	MEDICAL SUPPLIES CHARGED	354,367		354,367		354,367
56	DRUGS CHARGED TO PATIENTS	786		786		786
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	117,352		117,352		117,352
101	SUBTOTAL	1,435,147		1,435,147		1,435,147
102	LESS OBSERVATION BEDS	117,352		117,352		117,352
103	TOTAL	1,317,795		1,317,795		1,317,795

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS INTENSIVE CARE UNIT	22,244		22,244			
26	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	906,602	3,958,227	4,864,829	.123492	.123492	.123492
38	RECOVERY ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,660	123,777	125,437	.176758	.176758	.176758
44	LABORATORY						
45	PBP CLINICAL LAB SERVICES						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED	369,476	1,032,149	1,401,625	.252826	.252826	.252826
56	DRUGS CHARGED TO PATIENTS	38,027	179,940	217,967	.003606	.003606	.003606
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	28,836	5,005	33,841	3.467746	3.467746	3.467746
101	SUBTOTAL	1,366,845	5,299,098	6,665,943			
102	LESS OBSERVATION BEDS						
103	TOTAL	1,366,845	5,299,098	6,665,943			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEETI PROVIDER NO:
I 15-0172
II PERIOD:
I FROM 10/30/2008
I TO 12/31/2008
II PREPARED 5/28/2009
I WORKSHEET C
I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	339,703		339,703		339,703
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	600,767		600,767		600,767
37	OPERATING ROOM					
38	RECOVERY ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	22,172		22,172		22,172
44	LABORATORY					
45	PBP CLINICAL LAB SERVICES					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
55	MEDICAL SUPPLIES CHARGED	354,367		354,367		354,367
56	DRUGS CHARGED TO PATIENTS	786		786		786
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	117,352		117,352		117,352
101	SUBTOTAL	1,435,147		1,435,147		1,435,147
102	LESS OBSERVATION BEDS	117,352		117,352		117,352
103	TOTAL	1,317,795		1,317,795		1,317,795

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	22,244		22,244			
26	INTENSIVE CARE UNIT						
37	ANCILLARY SRVC COST CNTRS	906,602	3,958,227	4,864,829	.123492	.123492	.123492
38	OPERATING ROOM						
40	RECOVERY ROOM						
41	ANESTHESIOLOGY						
44	RADIOLOGY-DIAGNOSTIC LABORATORY	1,660	123,777	125,437	.176758	.176758	.176758
45	PBP CLINICAL LAB SERVICES						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED	369,476	1,032,149	1,401,625	.252826	.252826	.252826
56	DRUGS CHARGED TO PATIENTS	38,027	179,940	217,967	.003606	.003606	.003606
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	28,836	5,005	33,841	3.467746	3.467746	3.467746
101	SUBTOTAL	1,366,845	5,299,098	6,665,943			
102	LESS OBSERVATION BEDS						
103	TOTAL	1,366,845	5,299,098	6,665,943			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	600,767	126,725	474,042			600,767
38	RECOVERY ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	22,172	2,549	19,623			22,172
44	LABORATORY						
45	PBP CLINICAL LAB SERVICES						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED	354,367	68,964	285,403			354,367
56	DRUGS CHARGED TO PATIENTS	786	205	581			786
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	117,352	36,624	80,728			117,352
101	SUBTOTAL	1,095,444	235,067	860,377			1,095,444
102	LESS OBSERVATION BEDS	117,352	36,624	80,728			117,352
103	TOTAL	978,092	198,443	779,649			978,092

WKST A LTNE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPUT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	4,864,829	.123492	.123492
38	RECOVERY ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	125,437	.176758	.176758
44	LABORATORY			
45	PBP CLINICAL LAB SERVICES			
49	RESPIRATORY THERAPY			
50	PHYSICAL THERAPY			
55	MEDICAL SUPPLIES CHARGED	1,401,625	.252826	.252826
56	DRUGS CHARGED TO PATIENTS	217,967	.003606	.003606
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	33,841	3.467746	3.467746
101	SUBTOTAL	6,643,699		
102	LESS OBSERVATION BEDS	33,841		
103	TOTAL	6,609,858		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	600,767	126,725	474,042	12,673	27,494	560,600
38	RECOVERY ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	22,172	2,549	19,623	255	1,138	20,779
44	LABORATORY						
45	PBP CLINICAL LAB SERVICES						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED	354,367	68,964	285,403	6,896	16,553	330,918
56	DRUGS CHARGED TO PATIENTS	786	205	581	21	34	731
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS	117,352	36,624	80,728	3,662	4,682	109,008
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	1,095,444	235,067	860,377	23,507	49,901	1,022,036
102	LESS OBSERVATION BEDS	117,352	36,624	80,728	3,662	4,682	109,008
103	TOTAL	978,092	198,443	779,649	19,845	45,219	913,028

Health Financial Systems MCRIF32 FOR PHYSICIANS MEDICAL CENTER
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS
 SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET C
 I I TO 12/31/2008 I PART II

**NOT A CMS WORKSHEET **

(09/2000)

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	4,864,829	.115235	.120887
38	RECOVERY ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	125,437	.165653	.174725
44	LABORATORY			
45	PBP CLINICAL LAB SERVICES			
49	RESPIRATORY THERAPY			
50	PHYSICAL THERAPY			
55	MEDICAL SUPPLIES CHARGED	1,401,625	.236096	.247906
56	DRUGS CHARGED TO PATIENTS	217,967	.003354	.003510
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DIS	33,841	3.221181	3.359534
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	6,643,699		
102	LESS OBSERVATION BEDS	33,841		
103	TOTAL	6,609,858		

WKST A NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				106,017		106,017
26	INTENSIVE CARE UNIT						
101	TOTAL				106,017		106,017

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET D
 I I TO 12/31/2008 I PART I

TITLE XVIII, PART A

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		55	10		1,927.58	19,276
26	INTENSIVE CARE UNIT		55	10			19,276
101	TOTAL						

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART II
 I 15-0172 I I

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	CAPITAL COSTS 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		126,725	4,864,829	91,374		
38	RECOVERY ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC		2,549	125,437	75		
44	LABORATORY						
45	PBP CLINICAL LAB SERVICES						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED		68,964	1,401,625	44,258		
56	DRUGS CHARGED TO PATIENTS		205	217,967	5,968		
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS		36,624	33,841			
	OTHER REIMBURS COST CNTRS						
101	TOTAL		235,067	6,643,699	141,675		

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART II
 I 15-0172 I PPS

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XVIII, PART A		HOSPITAL	
WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM	.026049	2,380
38	RECOVERY ROOM		
40	ANESTHESIOLOGY		
41	RADIOLOGY-DIAGNOSTIC	.020321	2
44	LABORATORY		
45	PBP CLINICAL LAB SERVICES		
49	RESPIRATORY THERAPY		
50	PHYSICAL THERAPY		
55	MEDICAL SUPPLIES CHARGED	.049203	2,178
56	DRUGS CHARGED TO PATIENTS	.000941	6
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DIS	1.082238	
	OTHER REIMBURS COST CNTRS		
101	TOTAL		4,566

APPORTIONMENT OF INPATIENT ROUTINE
 SERVICE OTHER PASS THROUGH COSTS
 TITLE XVIII, PART A

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET D
 I I TO 12/31/2008 I PART III
 PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					55	
26	INTENSIVE CARE UNIT						
101	TOTAL					55	

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/28/2009
I	15-0172	I	FROM 10/30/2008	I	WORKSHEET D	
I		I	TO 12/31/2008	I	PART III	

APPORTIONMENT OF INPATIENT ROUTINE
 SERVICE OTHER PASS THROUGH COSTS
 TITLE XVIII, PART A

WKST A	COST CENTER DESCRIPTION	INPATIENT	INPAT PROGRAM
LTNE NO.		PROG DAYS	PASS THRU COST
		7	8
/	ADULTS & PEDIATRICS		10
26	INTENSIVE CARE UNIT		
101	TOTAL	10	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LTNE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	HOSPITAL	MED ED SCHOOL	NRS COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1		2		2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS		1.01					
37	OPERATING ROOM							
38	RECOVERY ROOM							
40	ANESTHESIOLOGY							
41	RADIOLOGY-DIAGNOSTIC							
44	LABORATORY							
45	PBP CLINICAL LAB SERVICES							
49	RESPIRATORY THERAPY							
50	PHYSICAL THERAPY							
55	MEDICAL SUPPLIES CHARGED							
56	DRUGS CHARGED TO PATIENTS							
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY							
62	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
101	TOTAL							

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			4,864,829			91,374	
38	RECOVERY ROOM							
40	ANESTHESIOLOGY							
41	RADIOLOGY-DIAGNOSTIC			125,437			75	
44	LABORATORY							
45	PBP CLINICAL LAB SERVICES							
49	RESPIRATORY THERAPY							
50	PHYSICAL THERAPY							
55	MEDICAL SUPPLIES CHARGED			1,401,625			44,258	
56	DRUGS CHARGED TO PATIENTS			217,967			5,968	
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY							
62	OBSERVATION BEDS (NON-DIS			33,841				
	OTHER REIMBURS COST CNTRS							
101	TOTAL			6,643,699			141,675	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LTNE NO.	COST CENTER DESCRIPTION	OUTPUT PROG CHARGES 8	OUTPUT PROG D,V COL 5.03 8.01	OUTPUT PROG D,V COL 5.04 8.02	OUTPUT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	510,091					
38	RECOVERY ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	21,935					
44	LABORATORY						
45	PBP CLINICAL LAB SERVICES						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
55	MEDICAL SUPPLIES CHARGED	205,355					
56	DRUGS CHARGED TO PATIENTS	25,788					
	OUTPUT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS	1,502					
	OTHER REIMBURS COST CNTRS						
101	TOTAL	764,671					

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	1	1.02	2	3	4
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.123492	.123492			
38 RECOVERY ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.176758	.176758			
44 LABORATORY					
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.252826	.252826			
56 DRUGS CHARGED TO PATIENTS	.003606	.003606			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)	3.467746	3.467746			
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-0172 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other (1)	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr
	5	5.01	5.02	5.03	6
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		510,091			
38 RECOVERY ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		21,935			
44 LABORATORY					
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		205,355			
56 DRUGS CHARGED TO PATIENTS		25,788			
61 OUTPAT SERVICE COST CNTRS					
62 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)		1,502			
101 SUBTOTAL		764,671			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		764,671			

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-0172 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Outpatient Radiology	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services
	7	8	9	9.01	9.02
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM				62,992	
38 RECOVERY ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC				3,877	
44 LABORATORY					
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS				51,919	
56 DRUGS CHARGED TO PATIENTS				93	
61 OUTPAT SERVICE COST CNTRS					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)				5,209	
101 SUBTOTAL				124,090	
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES				124,090	

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/28/2009
I	15-0172	I	FROM 10/30/2008	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 12/31/2008	I	PART I
I	15-0172	I		I	

TITLE XVIII PART A

HOSPITAL

PPS

T I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	55
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	55
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	55
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	10
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
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)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	339,703
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	339,703

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	22,244
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	22,244
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	15.271669
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	404.44
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	339,703

TITLE XVIII PART A HOSPITAL PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	6,176.42
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	61,764
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	61,764

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				22,509
49	TOTAL PROGRAM INPATIENT COSTS				84,273

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	19,276
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	4,566
52	TOTAL PROGRAM EXCLUDABLE COST	23,842
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	60,431

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XVIII PART A HOSPITAL PPS

.T III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

1

- 66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST
- 67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
- 68 PROGRAM ROUTINE SERVICE COST
- 69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM
- 70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS
- 71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS
- 72 PER DIEM CAPITAL-RELATED COSTS
- 73 PROGRAM CAPITAL-RELATED COSTS
- 74 INPATIENT ROUTINE SERVICE COST
- 75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS
- 76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION
- 77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION
- 78 INPATIENT ROUTINE SERVICE COST LIMITATION
- 79 REASONABLE INPATIENT ROUTINE SERVICE COSTS
- 80 PROGRAM INPATIENT ANCILLARY SERVICES
- 81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION
- 82 TOTAL PROGRAM INPATIENT OPERATING COSTS

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS 19
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 6,176.42
- 85 OBSERVATION BED COST 117,352

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		339,703		117,352	
87 NEW CAPITAL-RELATED COST	106,017	339,703	.312087	117,352	36,624
88 NON PHYSICIAN ANESTHETIST		339,703		117,352	
89 MEDICAL EDUCATION		339,703		117,352	
9.01 MEDICAL EDUCATION - ALLIED HEA					
9.02 MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-0172 I I

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		5,460	
26	INTENSIVE CARE UNIT			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.123492	91,374	11,284
38	RECOVERY ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.176758	75	13
44	LABORATORY			
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
49	RESPIRATORY THERAPY			
50	PHYSICAL THERAPY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.252826	44,258	11,190
56	DRUGS CHARGED TO PATIENTS	.003606	5,968	22
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY			
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	3.467746		
101	TOTAL		141,675	22,509
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		141,675	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS HOSPITAL

DESCRIPTION	1	1.01
DRG AMOUNT		
1 OTHER THAN OUTLIER PAYMENTS OCCURRING PRIOR TO OCTOBER 1		
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1	47,522	
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1		
MANAGED CARE PATIENTS		
1.03 PAYMENTS PRIOR TO MARCH 1ST OR OCTOBER 1ST		
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1		
1.05 PAYMENTS ON OR AFTER JANUARY 1ST BUT BEFORE 4/1 / 10/1		
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED (SEE INSTR)		
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001.		
1.08 SIMULATED PAYMENTS FROM PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001.		
2 OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO 10/1/97		
2.01 OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 1997 (SEE INSTRUCTIONS)		
3 BED DAYS AVAILABLE DIVIDED BY # DAYS IN COST RPTG PERIOD		11.70
INDIRECT MEDICAL EDUCATION ADJUSTMENT		
3.01 NUMBER OF INTERNS & RESIDENTS FROM WKST S-3, PART I		
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT		
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996.		
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)		
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)		
		FOR CR PERIODS ENDING ON OR AFTER 7/1/2005 E-3 PT 6 LN 15 PLUS LN 3.06
3.07 SUM OF LINES 3.04 THROUGH 3.06 (SEE INSTRUCTIONS)		
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		
3.09 FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1.		
3.10 FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCTOBER 1		
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09		
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10		
3.13 FTE COUNT FOR RESIDENTS IN DENTAL AND PODIATRIC PROGRAMS.		
3.14 CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE		
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE		
3.17 SUM OF LINES 3.14 THRU 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO (SEE INSTRUCTIONS).		
3.18 CURRENT YEAR RESIDENT TO BED RATIO (LN 3.17 DIVIDED BY LN 3)		
3.19 PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		
3.20 FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19 (SEE INST)		
3.21 IME PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCT 1		
3.22 IME PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCT 1, BUT BEFORE JANUARY 1 (SEE INSTRUCTIONS)		
3.23 IME PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER JANUARY 1		
	SUM OF LINES 3.21 - 3.23	PLUS E-3, PT VI, LINE 23
3.24 SUM OF LINES 3.21 THROUGH 3.23 (SEE INSTRUCTIONS).		
DISPROPORTIONATE SHARE ADJUSTMENT		
4 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)		
4.01 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I		
4.02 SUM OF LINES 4 AND 4.01		
4.03 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUC)		
4.04 DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)		
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
5 TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGS 302, 316, 317 OR MS-DRGS 652, 682 - 685.(SEE INSTRUCTIONS)		
5.01 TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGS 302, 316, 317 OR MS-DRGS 652 AND 682 - 685. (SEE INSTRUCTIONS)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2008 I PART A
 I 15-0172 I I

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL

DESCRIPTION	1	1.01
5.02 DIVIDE LINE 5.01 BY LINE 5 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		
5.03 TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGS 302, 316, 317, OR MS-DRGS 652, 682-685. (SEE INSTRUCTIONS)		
5.04 RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK		
5.05 AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUC)		
5.06 TOTAL ADDITIONAL PAYMENT		
6 SUBTOTAL (SEE INSTRUCTIONS)	47,522	
7 HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY, SEE INSTRUCTIONS)		
7.01 HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY, SEE INSTRUCTIONS FY BEG. 10/1/2000)		
8 TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	47,522	
9 PAYMENT FOR INPATIENT PROGRAM CAPITAL	20,266	
10 EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WORKSHEET L, PART IV, SEE INSTRUCTIONS)		
11 DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WORKSHEET E-3, PART IV, SEE INSTRUCTIONS)		
11.01 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		
11.02 SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		
12 NET ORGAN ACQUISITION COST		
13 COST OF TEACHING PHYSICIANS		
14 ROUTINE SERVICE OTHER PASS THROUGH COSTS		
15 ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
16 TOTAL	67,788	
17 PRIMARY PAYER PAYMENTS		
18 TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES	67,788	
19 DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	8,192	
20 COINSURANCE BILLED TO PROGRAM BENEFICIARIES		
21 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
21.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
21.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
22 SUBTOTAL	59,596	
23 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
24 OTHER ADJUSTMENTS (SPECIFY)		
24.98 CREDIT FOR MANUFACTURER REPLACED MEDICAL DEVICES		
24.99 OUTLIER RECONCILIATION ADJUSTMENT		
25 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
26 AMOUNT DUE PROVIDER	59,596	
27 SEQUESTRATION ADJUSTMENT		
28 INTERIM PAYMENTS	43,313	
28.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
29 BALANCE DUE PROVIDER (PROGRAM)	16,283	
30 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		
----- FI ONLY -----		
50 OPERATING OUTLIER AMOUNT FROM WKS E, A, L2.01		
51 CAPITAL OUTLIER AMOUNT FROM WKS L, I, L3.01		
52 OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)		
53 CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)		
54 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		
55 TIME VALUE OF MONEY (SEE INSTRUCTIONS)		
56 CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/28/2009
I	15-0172	I	FROM 10/30/2008	I	WORKSHEET E	
I	COMPONENT NO:	I	TO 12/31/2008	I	PART B	
I	15-0172	I		I		

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	124,090
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	163,779
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	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).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	163,779
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	
8.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	35,427
19	SUBTOTAL (SEE INSTRUCTIONS)	128,352
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	128,352
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	128,352
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	128,352
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	128,352
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	128,352
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-0172 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		43,313		128,352
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01			
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50			
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
ADJUSTMENTS TO PROGRAM	.99			
SUBTOTAL			NONE	NONE
4 TOTAL INTERIM PAYMENTS		43,313		128,352
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
TENTATIVE TO PROGRAM	.99			
SUBTOTAL			NONE	NONE
6 DETERMINED NET SETTLEMENT		16,283		
AMOUNT (BALANCE DUE)				
BASED ON COST REPORT (1)				
TOTAL MEDICARE PROGRAM LIABILITY		59,596		128,352

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(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.

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	148,417			
2 TEMPORARY INVESTMENTS	80,872			
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	1,627,739			
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY	282,529			
8 PREPAID EXPENSES	59,276			
9 OTHER CURRENT ASSETS	-102,015			
10 DUE FROM OTHER FUNDS	210,000			
11 TOTAL CURRENT ASSETS	2,306,818			
FIXED ASSETS				
12 LAND	850,190			
12.01 LAND IMPROVEMENTS	768,719			
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	7,340,255			
14.01 LESS ACCUMULATED DEPRECIATION				
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	3,429,925			
18.01 LESS ACCUMULATED DEPRECIATION	-338,289			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	12,050,800			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	67,917			
26 TOTAL OTHER ASSETS	67,917			
27 TOTAL ASSETS	14,425,535			

BALANCE SHEET

I
I
I

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,588,666			
29 SALARIES, WAGES & FEES PAYABLE	205,484			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	3,751,136			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	134,020			
36 TOTAL CURRENT LIABILITIES	5,679,306			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	3,333,329			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	5,335,000			
42 TOTAL LONG-TERM LIABILITIES	8,668,329			
43 TOTAL LIABILITIES	14,347,635			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	77,900			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	77,900			
52 TOTAL LIABILITIES AND FUND BALANCES	14,425,535			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING		-799,103		
	OF PERIOD				
2	NET INCOME (LOSS)		1,020,255		
3	TOTAL		221,152		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		221,152		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM		143,252		
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS		143,252		
19	FUND BALANCE AT END OF		77,900		
	PERIOD PER BALANCE SHEET				

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCE AT BEGINNING				
	OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF				
	PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-0172 I FROM 10/30/2008 I WORKSHEET G-2
 I I TO 12/31/2008 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	22,244		22,244
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	22,244		22,244
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	22,244		22,244
17 00 ANCILLARY SERVICES	1,315,765	5,294,093	6,609,858
18 00 OUTPATIENT SERVICES	28,836	5,005	33,841
24 00			
25 00 TOTAL PATIENT REVENUES	1,366,845	5,299,098	6,665,943

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		1,406,775	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		1,406,775	

STATEMENT OF REVENUES AND EXPENSES

I
I
IPROVIDER NO:
15-0172

I PERIOD:

I FROM 10/30/2008

I TO 12/31/2008

I

I PREPARED 5/28/2009

I WORKSHEET G-3

I

DESCRIPTION		
1	TOTAL PATIENT REVENUES	6,665,943
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	4,528,838
3	NET PATIENT REVENUES	2,137,105
4	LESS: TOTAL OPERATING EXPENSES	1,406,775
5	NET INCOME FROM SERVICE TO PATIENTS	730,330
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	146,673
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	RENTAL INCOME-PSP	143,252
25	TOTAL OTHER INCOME	289,925
26	TOTAL	1,020,255
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,020,255

CALCULATION OF CAPITAL PAYMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/28/2009
I	15-0172	I	FROM 10/30/2008	I	WORKSHEET L
I	COMPONENT NO:	I	TO 12/31/2008	I	PARTS I-IV
I	15-0172	I		I	

TITLE XVIII, PART A

HOSPITAL

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS	
	CAPITAL FEDERAL AMOUNT	
2	CAPITAL DRG OTHER THAN OUTLIER	
3	CAPITAL DRG OUTLIER PAYMENTS PRIOR TO 10/01/1997	
3	.01 CAPITAL DRG OUTLIER PAYMENTS AFTER 10/01/1997	
	INDIRECT MEDICAL EDUCATION ADJUSTMENT	
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS	.00
	IN THE COST REPORTING PERIOD	
4	.01 NUMBER OF INTERNS AND RESIDENTS	.00
	(SEE INSTRUCTIONS)	
4	.02 INDIRECT MEDICAL EDUCATION PERCENTAGE	.00
4	.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT	
	(SEE INSTRUCTIONS)	
5	PERCENTAGE OF SSI RECEIPT PATIENT DAYS TO	.00
	MEDICARE PART A PATIENT DAYS	
5	.01 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL	.00
	DAYS REPORTED ON S-3, PART I	
5	.02 SUM OF 5 AND 5.01	.00
5	.03 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	.00
5	.04 DISPROPORTIONATE SHARE ADJUSTMENT	
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS	
PART II - HOLD HARMLESS METHOD		
1	NEW CAPITAL	
2	OLD CAPITAL	
3	TOTAL CAPITAL	
4	RATIO OF NEW CAPITAL TO OLD CAPITAL	.000000
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE	
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT	
7	REDUCED OLD CAPITAL AMOUNT	
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL	
9	SUBTOTAL	
10	PAYMENT UNDER HOLD HARMLESS	
PART III - PAYMENT UNDER REASONABLE COST		
1	PROGRAM INPATIENT ROUTINE CAPITAL COST	19,276
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST	4,566
3	TOTAL INPATIENT PROGRAM CAPITAL COST	23,842
4	CAPITAL COST PAYMENT FACTOR	85
5	TOTAL INPATIENT PROGRAM CAPITAL COST	20,266
PART IV - COMPUTATION OF EXCEPTION PAYMENTS		
1	PROGRAM INPATIENT CAPITAL COSTS	
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY	
	CIRCUMSTANCES	
3	NET PROGRAM INPATIENT CAPITAL COSTS	
4	APPLICABLE EXCEPTION PERCENTAGE	.00
5	CAPITAL COST FOR COMPARISON TO PAYMENTS	
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY	.00
	CIRCUMSTANCES	
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL	
	FOR EXTRAORDINARY CIRCUMSTANCES	
8	CAPITAL MINIMUM PAYMENT LEVEL	
9	CURRENT YEAR CAPITAL PAYMENTS	
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT	
	LEVEL TO CAPITAL PAYMENTS	
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT	
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL	
	TO CAPITAL PAYMENTS	
13	CURRENT YEAR EXCEPTION PAYMENT	
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD	
15	CUR YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT	
16	CURRENT YEAR OPERATING AND CAPITAL COSTS	
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT	
	(SEE INSTRUCTIONS)	

Provider No: 150172

5/28/2009

Provider Name: PHYSICIANS MEDICAL CENTER

11:55 AM

Fiscal Period: 10/30/2008 To 12/31/2008

Health Financial Systems

Data File: Z:\Prexus Health, L.L.C\Cost Report\Medicare CR Files\Physicians MCR 2008\Program\PMC.mcr

MCRIF32

Worksheet	Program	Provider	Line	Column	Explanation	Error	CMS
Serious Edits							
S-2			36.00	2.00	FOR PPS, UNLESS NEW, LINE 36 SHOULD = "Y"	462	
A-8			39.00	5.00	A-7 REFERENCE NOT APPROPRIATE FOR NON-CAPITAL COST CNTR.	274	
G-1			1.00	2.00	AMOUNTS SHOULD BE GREATER THAN ZERO	14	
Warning Edits							
A-8			14.00	2.00	ADJUSTMENTS SHOULD BE NEGATIVE	16	
A-8			39.00	2.00	ADJUSTMENTS SHOULD BE NEGATIVE	16	
<hr/>							
Total Level I Edits			0				
Total Level II Edits			0				
Total Serious Edits			3				
Total Warning Edits			2				
Total Informational Edits			0				
Total Edits			5				

Provider No: 150172

5/28/2009

Provider Name: PHYSICIANS MEDICAL CENTER

11:55 AM

Fiscal Period: 10/30/2008 To 12/31/2008

Health Financial Systems

Data File: Z:\Prexus Health, L.L.C\Cost Report\Medicare CR Files\Physicians MCR 2008\Program\PMC.mcr

MCRIF32

Worksheet	Program	Provider	Line	Column	Explanation	Error	CMS
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Total HCRIS Consistency Edits	0
Total HCRIS Relational Edits	0
Total HCRIS Serious Edits	0
Total HCRIS Warning Edits	0
Total HCRIS Informational Edi	0
Total Edits	0