



State of West Virginia
 Department of Administration
 Purchasing Division
 2019 Washington Street East
 Post Office Box 50130
 Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER
HHR90057

PAGE
1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER 304-558-0067

VENDOR

RFQ COPY
 TYPE NAME/ADDRESS HERE

SHIP TO

HEALTH AND HUMAN RESOURCES
 ACCOUNTABILITY & MGT REPORTING
 STATE CAPITOL COMPLEX
 BUILDING 3 ROOM 550
 CHARLESTON, WV
 25305 304-558-0460

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
08/27/2008				

BID OPENING DATE: 10/02/2008 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT
***** MANDATORY PRE-BID MEETING 9/11/2008 AT 1:30 PM. SAID CONFERENCE WILL BE HELD AT STATE CAPITOL COMPLEX, 1900 KANAWHA BLVD., EAST, CHARLESTON, WV 25305. BLDG. 3 ROOM 522. *****						
0001	1	JB		961-20		
PROFESSIONAL AUDITING SERVICES - CPA REQUEST FOR QUOTATION TO PROVIDE A CPA FIRM CONTRACTED AUDITS OF MEDICAID LONG TERM CARE NURSING HOME PROVIDER COST REPORTS, FOR DHHR, OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING (OAMR) PER THE ATTACHED SPECIFICATIONS EXHIBIT 3 LIFE OF CONTRACT: THIS CONTRACT BECOMES EFFECTIVE ON UPON AWARD..... AND EXTENDS FOR A PERIOD OF ONE (1) YEAR OR UNTIL SUCH "REASONABLE TIME" THEREAFTER AS IS NECESSARY TO OBTAIN A NEW CONTRACT OR RENEW THE ORIGINAL CONTRACT. THE "REASONABLE TIME" PERIOD SHALL NOT EXCEED TWELVE (12) MONTHS. DURING THIS "REASONABL						

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

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TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

**GENERAL TERMS & CONDITIONS
REQUEST FOR QUOTATION (RFQ) AND REQUEST FOR PROPOSAL (RFP)**

1. Awards will be made in the best interest of the State of West Virginia
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3. All quotations are governed by the *West Virginia Code* and the *Legislative Rules* of the Purchasing Division
4. Prior to any award, the apparent successful vendor must be properly registered with the Purchasing Division and have paid the required \$125 fee.
5. All services performed or goods delivered under State Purchase Order/Contracts are to be continued for the term of the Purchase Order/Contracts, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise available for these services or goods, this Purchase Order/Contract becomes void and of no effect after June 30.
6. Payment may only be made after the delivery and acceptance of goods or services.
7. Interest may be paid for late payment in accordance with the *West Virginia Code*.
8. Vendor preference will be granted upon written request in accordance with the *West Virginia Code*.
9. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes
10. The Director of Purchasing may cancel any Purchase Order/Contract upon 30 days written notice to the seller.
11. The laws of the State of West Virginia and the *Legislative Rules* of the Purchasing Division shall govern all rights and duties under the Contract, including without limitation the validity of this Purchase Order/Contract.
12. Any reference to automatic renewal is hereby deleted. The Contract may be renewed only upon mutual written agreement of the parties.
13. **BANKRUPTCY:** In the event the vendor/contractor files for bankruptcy protection, this Contract may be deemed null and void, and terminated without further order.
14. **HIPAA BUSINESS ASSOCIATE ADDENDUM:** The West Virginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, and available online at the Purchasing Division's web site (<http://www.state.wv.us/admin/purchase/vrc/hipaa.htm>) is hereby made part of the agreement. Provided that, the Agency meets the definition of a Cover Entity (45 CFR §160 103) and will be disclosing Protected Health Information (45 CFR §160 103) to the vendor.
15. **WEST VIRGINIA ALCOHOL & DRUG-FREE WORKPLACE ACT:** If this Contract constitutes a public improvement construction contract as set forth in Article 1D, Chapter 21 of the West Virginia Code ("The West Virginia Alcohol and Drug-Free Workplace Act"), then the following language shall hereby become part of this Contract: "The contractor and its subcontractors shall implement and maintain a written drug-free workplace policy in compliance with the West Virginia Alcohol and Drug-Free Workplace Act, as set forth in Article 1D, Chapter 21 of the West Virginia Code. The contractor and its subcontractors shall provide a sworn statement in writing, under the penalties of perjury, that they maintain a valid drug-free work place policy in compliance with the West Virginia and Drug-Free Workplace Act. It is understood and agreed that this Contract shall be cancelled by the awarding authority if the Contractor: 1) Fails to implement its drug-free workplace policy; 2) Fails to provide information regarding implementation of the contractor's drug-free workplace policy at the request of the public authority; or 3) Provides to the public authority false information regarding the contractor's drug-free workplace policy."

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<p>TIME" THE VENDOR MAY TERMINATE THIS CONTRACT FOR ANY REASON UPON GIVING THE DIRECTOR OF PURCHASING 30 DAYS WRITTEN NOTICE.</p> <p>UNLESS SPECIFIC PROVISIONS ARE STIPULATED ELSEWHERE IN THIS CONTRACT DOCUMENT, THE TERMS, CONDITIONS AND PRICING SET HEREIN ARE FIRM FOR THE LIFE OF THE CONTRACT.</p> <p>RENEWAL: THIS CONTRACT MAY BE RENEWED UPON THE MUTUAL WRITTEN CONSENT OF THE SPENDING UNIT AND VENDOR, SUBMITTED TO THE DIRECTOR OF PURCHASING THIRTY (30) DAYS PRIOR TO THE EXPIRATION DATE. SUCH RENEWAL SHALL BE IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT AND SHALL BE LIMITED TO TWO (2) ONE (1) YEAR PERIODS.</p> <p>CANCELLATION: THE DIRECTOR OF PURCHASING RESERVES THE RIGHT TO CANCEL THIS CONTRACT IMMEDIATELY UPON WRITTEN NOTICE TO THE VENDOR IF THE COMMODITIES AND/OR SERVICES SUPPLIED ARE OF AN INFERIOR QUALITY OR DO NOT CONFORM TO THE SPECIFICATIONS OF THE BID AND CONTRACT HEREIN.</p> <p>OPEN MARKET CLAUSE: THE DIRECTOR OF PURCHASING MAY AUTHORIZE A SPENDING UNIT TO PURCHASE ON THE OPEN MARKET, WITHOUT THE FILING OF A REQUISITION OR COST ESTIMATE, ITEMS SPECIFIED ON THIS CONTRACT FOR IMMEDIATE DELIVERY IN EMERGENCIES DUE TO UNFORESEEN CAUSES (INCLUDING BUT NOT LIMITED TO DELAYS IN TRANSPORTATION OR AN UNANTICIPATED INCREASE IN THE VOLUME OF WORK.)</p> <p>ORDERING PROCEDURE: SPENDING UNIT(S) SHALL ISSUE A WRITTEN STATE CONTRACT ORDER (FORM NUMBER WV-39) TO THE VENDOR FOR COMMODITIES COVERED BY THIS CONTRACT.</p>						

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<p>THE ORIGINAL COPY OF THE WV-39 SHALL BE MAILED TO THE VENDOR AS AUTHORIZATION FOR SHIPMENT, A SECOND COPY MAILED TO THE PURCHASING DIVISION, AND A THIRD COPY RETAINED BY THE SPENDING UNIT.</p> <p>BANKRUPTCY: IN THE EVENT THE VENDOR/CONTRACTOR FILES FOR BANKRUPTCY PROTECTION, THIS CONTRACT IS AUTOMATICALLY NULL AND VOID, AND IS TERMINATED WITHOUT FURTHER ORDER.</p> <p>INQUIRIES: WRITTEN QUESTIONS SHALL BE ACCEPTED THROUGH CLOSE OF BUSINESS ON 9/15/2008. QUESTIONS MAY BE SENT VIA USPS, FAX, COURIER OR E-MAIL. IN ORDER TO ASSURE NO VENDOR RECEIVES AN UNFAIR ADVANTAGE, NO SUBSTANTIVE QUESTIONS WILL BE ANSWERED ORALLY. IF POSSIBLE, E-MAIL QUESTIONS ARE PREFERRED. ADDRESS INQUIRIES TO:</p> <p>ROBERTA WAGNER DEPARTMENT OF ADMINISTRATION PURCHASING DIVISION 2019 WASHINGTON STREET, EAST CHARLESTON, WV 25311</p> <p>FAX: 304-558-4115 E-MAIL: ROBERTA.A.WAGNER@WV.GOV</p> <p>REV. 3/88</p> <p>PURCHASING CARD ACCEPTANCE: THE STATE OF WEST VIRGINIA CURRENTLY UTILIZES A VISA PURCHASING CARD PROGRAM WHICH</p>						

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<p>IS ISSUED THROUGH A BANK. THE SUCCESSFUL VENDOR MUST ACCEPT THE STATE OF WEST VIRGINIA VISA PURCHASING CARD FOR PAYMENT OF ALL ORDERS PLACED BY ANY STATE AGENCY AS A CONDITION OF AWARD.</p> <p>REV 07/16/2007</p> <p>VENDOR PREFERENCE CERTIFICATE</p> <p>CERTIFICATION AND APPLICATION* IS HEREBY MADE FOR PREFERENCE IN ACCORDANCE WITH WEST VIRGINIA CODE, 5A-3-37 (DOES NOT APPLY TO CONSTRUCTION CONTRACTS) .</p> <p>A. APPLICATION IS MADE FOR 2.5% PREFERENCE FOR THE REASON CHECKED:</p> <p>() BIDDER IS AN INDIVIDUAL RESIDENT VENDOR AND HAS RESIDED CONTINUOUSLY IN WEST VIRGINIA FOR FOUR (4) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS CERTIFICATION; OR</p> <p>() BIDDER IS A PARTNERSHIP, ASSOCIATION OR CORPORATION RESIDENT VENDOR AND HAS MAINTAINED ITS HEAD-QUARTERS OR PRINCIPAL PLACE OF BUSINESS CONTINUOUSLY I WEST VIRGINIA FOR FOUR (4) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS CERTIFICATION; OR 80% OF THE OWNERSHIP INTEREST OF BIDDER IS HELD BY ANOTHER INDIVIDUAL, PARTNERSHIP, ASSOCIATION OR CORPORATION RESIDENT VENDOR WHO HAS MAINTAINED ITS HEADQUARTERS OR PRINCIPAL PLACE OF BUSINESS CONTINUOUSLY IN WEST VIRGINIA FOR FOUR (4) YEARS IMMEDIATELY PRECEDING THE DATE OF THIS CERTIFICATION; OR</p> <p>() BIDDER IS A CORPORATION NONRESIDENT VENDOR WHICH HAS AN AFFILIATE OR SUBSIDIARY WHICH EMPLOYS A MINIMUM OF ONE HUNDRED STATE RESIDENTS AND WHICH</p>						

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State of West Virginia
 Department of Administration
 Purchasing Division
 2019 Washington Street East
 Post Office Box 50130
 Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER
HHR90057

PAGE
6

ADDRESS CORRESPONDENCE TO ATTENTION OF
ROBERTA WAGNER
304-558-0067

RFQ COPY
 TYPE NAME/ADDRESS HERE

VENDOR

SHIP TO

HEALTH AND HUMAN RESOURCES
 ACCOUNTABILITY & MGT REPORTING
 STATE CAPITOL COMPLEX
 BUILDING 3 ROOM 550
 CHARLESTON, WV
 25305 304-558-0460

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
08/27/2008				

BID OPENING DATE: 10/02/2008 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
<p>CONTRACT OR PURCHASE ORDER.</p> <p>BY SUBMISSION OF THIS CERTIFICATE, BIDDER AGREES TO DISCLOSE ANY REASONABLY REQUESTED INFORMATION TO THE PURCHASING DIVISION AND AUTHORIZES THE DEPARTMENT OF TAX AND REVENUE TO DISCLOSE TO THE DIRECTOR OF PURCHASING APPROPRIATE INFORMATION VERIFYING THAT BIDDER HAS PAID THE REQUIRED BUSINESS TAXES, PROVIDED THAT SUCH INFORMATION DOES NOT CONTAIN THE AMOUNTS OF TAXES PAID NOR ANY OTHER INFORMATION DEEMED BY THE TAX COMMISSIONER TO BE CONFIDENTIAL.</p> <p>UNDER PENALTY OF LAW FOR FALSE SWEARING (WEST VIRGINIA CODE 61-5-3), BIDDER HEREBY CERTIFIES THAT THIS CERTIFICATE IS TRUE AND ACCURATE IN ALL RESPECTS; AND THAT IF A CONTRACT IS ISSUED TO BIDDER AND IF ANYTHING CONTAINED WITHIN THIS CERTIFICATE CHANGES DURING THE TERM OF THE CONTRACT, BIDDER WILL NOTIFY THE PURCHASING DIVISION IN WRITING IMMEDIATELY.</p> <p>BIDDER: -----</p> <p>DATE: -----</p> <p>SIGNED: -----</p> <p>TITLE: -----</p> <p>* CHECK ANY COMBINATION OF PREFERENCE CONSIDERATION(S) IN EITHER "A" OR "B", OR BOTH "A" AND "B" WHICH YOU ARE ENTITLED TO RECEIVE. YOU MAY REQUEST UP TO THE MAXIMUM 5% PREFERENCE FOR BOTH "A" AND "B".</p>						

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Request for Quotation

RFQ NUMBER
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PAGE
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DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
08/27/2008				

BID OPENING DATE: 10/02/2008 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT
	(REV. 12/00)					
	NOTICE					
	A SIGNED BID MUST BE SUBMITTED TO:					
	DEPARTMENT OF ADMINISTRATION PURCHASING DIVISION BUILDING 15 2019 WASHINGTON STREET, EAST CHARLESTON, WV 25305-0130					
	PLEASE NOTE: 5 CONVENIENCE COPIES WOULD BE APPRECIATED.					
	THE BID SHOULD CONTAIN THIS INFORMATION ON THE FACE OF THE ENVELOPE OR THE BID MAY NOT BE CONSIDERED:					
	SEALED BID					
	BUYER:-----RW/FILE 22-----					
	RFQ NO.:-----HHR90057-----					
	BID OPENING DATE:--10/2/2008-----					
	BID OPENING TIME:-----1:30 PM-----					
	PLEASE PROVIDE A FAX NUMBER IN CASE IT IS NECESSARY TO CONTACT YOU REGARDING YOUR BID:					

	CONTACT PERSON (PLEASE PRINT CLEARLY):					

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08/27/2008				
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LINE	QUANTITY	UOP	CAT NO	ITEM NUMBER	UNIT PRICE	AMOUNT
***** THIS IS THE END OF RFQ HHR90057 ***** TOTAL: _____						

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Inquiries:

Additional information inquiries regarding specifications of this RFQ must be submitted in writing to the State Buyer with the exception of questions regarding the proposal submission which may be oral. The deadline for written inquiries is identified in the Schedule of Events. All inquiries of specification clarification must be addressed to:

Roberta Wagner, Senior Buyer
Purchasing Division
2019 Washington Street, East
P.O. Box 50130
Charleston, WV 25305-0130
Fax: (304) 558-4115
Email: roberta.a.wagner@wv.gov

Schedule of Events

Release of the RFQ.....	08/29/2008
Mandatory Prebid Conference.....	09/11/2008
Final Deadline for Vendor Questions.....	09/15/2008
Bid Opening Date.....	10/02/2008

Mandatory Prebid Conference:

A mandatory prebid conference shall be conducted on the date specified above at 1:30 PM. Said conference will be held at State Capitol Complex, 1900 Kanawha Blvd, East, Charleston, WV 25305, Building 3, Room 522, at 1:30 PM. **All interested bidders are required to be present at this meeting. Failure to attend the mandatory prebid conference shall automatically result in disqualification. No one person can represent more than one vendor.**

Vendors responding to this RFQ should submit:

One original and plus (5) convenience copies to:

Purchasing Division
2019 Washington Street, East
P.O. Box 50130
Charleston, WV 25305-0130

The outside of the envelope or package(s) should be clearly marked:

Buyer: Roberta Wagner
Req#: HHR90057
Opening Date: 10/2/2008
Opening Time: 1:30 pm

Background:

The WVDHHR Office of Accountability and Management Reporting (OAMR) is charged with the task of receiving LTC-FASRs semi-annually from all providers for whom per diem rates are set by WV Medicaid.

These costs are submitted on the standard LTC-FASR form (Sample 3 attached) semi-annually and are used to calculate the per diem rates participating long term care providers are paid for services rendered to West Virginia Medicaid clients. The examination engagements of the LTC-FASRs are used to determine whether any retroactive rate adjustments are necessary (e.g. based on unallowable or undocumented costs submitted, adjustments in census information, or other matters increasing or decreasing costs as originally reported).

Long term care providers are reimbursed only for allowable costs (as outlined in the rate setting methodology per the West Virginia Medicaid State Plan). Any reimbursement over cost is recovered through recalculation of the rate after the LTC-FASRs have been examined and adjusted for any findings of the examination. The rate is adjusted for any discrepancies noted in the examination; additionally any other payments received by the provider during the period covered by the LTC-FASR under examination (such as payments for bed reservation days or unapplied West Virginia Medicaid payments) that are determined to be in error are recovered through this process as well.

Providers have a right to appeal the findings, recoveries and rate adjustments resulting from examinations and auditors are required to appear in administrative, evidentiary or other hearings to support the findings and conclusions of the examination as well as prepare documents necessary for the attorneys or hearing examiner to sufficiently evaluate the findings or conclusions at issue.

These LTC-FASRs are desk reviewed and used to calculate the prospective per diem rates that will be paid to each provider for the next six-month period. OAMR is also charged with the responsibility of examining LTC-FASRs to determine whether the costs and other data included on the submitted LTC-FASRs are allowable per WV Medicaid rules and regulations, documented, and appropriately classified and accounted for on the LTC-FASR. A typical examination of LTC-FASRs is performed on an individual provider basis (including all facilities or locations owned by the provider), typically incorporating six (6) to ten (10) consecutive semi-annual cost reporting periods per engagement. Any adjustments needed as a result of this process are incorporated into an adjusted rate calculation for each six-month rate period. The adjusted rate is then used to determine whether the provider was over- or under-paid and a recovery or additional payment is processed as needed to ensure that the provider is reimbursed for total allowable costs under the applicable rules and regulations.

Through the course of the contract the vendor is expected to allow OAMR staff to be present during fieldwork (at the discretion of OAMR). The OAMR Division of Audit & Rate Setting staff will be available as a resource for assistance in interpretation of applicable rules and regulations. Additionally, the adjusted rate calculation will be performed by OAMR's Rate Setting staff. The transmittal of the final report; communications with the provider of the recovery; or additional payment due; will be performed by the WVDHHR Bureau for Medical Services. Vendor is expected to appear at any and all hearings resulting from provider appeals of findings, and is expected to provide documentation sufficient to support the conclusions and findings included in the report. Appearance at hearings is expected whether or not the timing of the hearing coincides with the term of the contract.

The vendor's principal contact with OAMR will be Craig Richards, Director, OAMR, or a designated representative, who will coordinate the assistance that OAMR will provide for the LTC-FASR engagements.

GENERAL INFORMATION

Purpose: The Department of Health & Human Resources, Office of Accountability and Management Reporting, hereinafter referred to as "Agency", is requesting bids for a Certified Public Accountant to provide examination engagements of Long Term Care Financial and Statistical Reports (LTC-FASRs) received from West Virginia Medicaid providers.

Project: To obtain the services of a Certified Public Accountant to ensure that the costs submitted by long term care providers participating in the West Virginia Medicaid Program ("Provider") are accurate and allowable in accordance with the West Virginia Medicaid Provider Manuals and all other applicable laws, rules and regulations.

Work Location: Work is to be performed onsite at Provider offices as well as home office locations (for long term care providers that are part of a chain of facilities) or at the vendor's location. Limited space and resources are available at Agency offices to accommodate vendor staff.

Requirements: Failure to meet the requirements of this requisition will result in disqualification.

Mandatory Requirements – Vendor Experience/Capabilities:	
Vendor must provide documentation of experience/capabilities.	
1	Vendor must have been in business at least ten (10) years and have at least five (5) years experience conducting governmental audits.
2	Vendor must be a Certified Public Accounting (CPA) firm and must currently have on staff at least ten (10) accounting professionals with at five (5) of those holding CPA certification valid in the State of West Virginia.

Scope of Work - Mandatory Requirements:	
The vendor must comply with the following specifications in the performance of the services.	
1	The engagements performed under this contract and reports issued upon completion of those engagements are to be in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) as well as Government Auditing Standards issued by the Comptroller General of the United States. All work is to be performed in accordance with the provisions contained herein. Seventeen (17) engagements will be performed under this contract. The information specific to each facility is included in Attachment 1
2	Upon request by OAMR, the vendor is to perform financial and compliance audit engagements of semi-annual LTC-FASRs in accordance with the standards established by the American Institute of Certified Public Accountants and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. The vendor is to issue an opinion on the fair presentation, in conformity with generally accepted accounting principles and the rules and regulations established by the West Virginia Department of Health and Human Resources, of the financial and statistical information submitted in the LTC-FASRs for each facility examined along with a list of findings of non-compliance as described below. Additionally, the vendor is to issue a report on compliance and internal control in accordance with Government Auditing Standards

Scope of Work - Mandatory Requirements: The vendor must comply with the following specifications in the performance of the services.	
3	Each engagement is to incorporate a pre-engagement planning meeting between an authorized representative of the vendor and the Agency to establish the procedures to be performed, whether OAMR staff intends to be present for any portion of the examination fieldwork, the planned timing of fieldwork, and the anticipated timing of draft and final report issuance. This meeting is to include a review of the cost reports to be examined as well as any additional information OAMR is aware of that would impact the examination procedures or engagement.
4	The procedures for each engagement are to include, at a minimum, the procedures outlined in the OAMR Audit Guide (Sample 1 attached). However, this is not an all-inclusive list of procedures and the vendor is responsible for performing any and all procedures necessary to support the opinion and findings included in the examination report as described below. Materiality determination and examination procedures should focus on the schedules within the LTC-FASR that have the most impact upon the rate calculation (i.e. schedules WV-6, WV-7 and WV16 through WV-22). Errors found in items sampled from those schedules should result in an expansion of testing to allow quantification and determination of the pervasiveness of the errors found.
5	Each engagement is to be conducted on an individual facility basis, and shall include between one (1) and ten (10) semi-annual LTC-FASRs. The vendor shall issue a report for each engagement expressing an opinion as to the completeness and accuracy of the information submitted on the LTC-FASRs in accordance with the WV Medicaid Provider Manuals and all applicable laws, rules and regulations. The report shall include the following elements: <ol style="list-style-type: none"> 1 Independent accountants' examination report and report in accordance with <i>Government Auditing Standards</i> 2 A definitive list of findings of non-compliance, numbered sequentially and including the following elements (Sample 2 attached): <ol style="list-style-type: none"> a. Criteria b. Condition (to include cost report period, LTC-FASR cost center charged, page/line mapping to LTC-FASR field(s) affected, account number(s) and description(s) (from West Virginia Long Term Care Medicaid Chart of Accounts), amount originally reported on the LTC-FASR, correct amount, and quantification of increase or decrease necessary to adjust for cost or census error). c. Cause d. Effect or Potential Effect e. Recommendation 3 Status of prior findings (if any) 4 Copies of the LTC-FASRs included in the engagement (Sample 3 attached).
6	Examinations of facilities that share a common ownership or control (Chain Facilities) will generally be performed together as a group and shall include in the examination home office or other costs that have been allocated among the facilities and included in the LTC-FASRs submitted for those facilities.
7	Examinations of facilities that are owned by or located within a hospital (Hospital-Based Facilities) are to include in the examination any hospital costs allocated to the long term care facility and included in the LTC-FASR submitted for those facilities.
8	Vendor is prepared to adequately staff the engagement without reliance on OAMR staff for the performance of any audit related work or clerical support necessary for completion of the engagement.

Scope of Work - Mandatory Requirements: The vendor must comply with the following specifications in the performance of the services.	
9	The vendor shall be responsible for knowledge of the West Virginia Medicaid Provider Manuals, particularly Chapter 500, Volume 15 "Nursing Facility Services" as well as the West Virginia Medicaid Long Term Care Chart of Accounts and all West Virginia Medicaid Program instructions pertinent to nursing facility services. The Staff of OAMR, Division of Audit & Rate Setting, shall be available to the vendor to assist in provision of information and explanations, as well as interpretations of rules and regulations as they pertain to audit findings and results of audit tests. It shall be the vendor's responsibility to contact OAMR with any questions as to interpretation of rules or regulations as needed.
10	Vendor is to immediately notify OAMR in writing in the event that any of the following are noted in the course of performing any engagement under this contract: criminal acts; fraudulent transactions; intentional abuse of WV Medicaid funding; irregularities; misrepresentations by facility management; or any issues that would cause delays in the issuance of the engagement report or an adverse opinion.
11	Vendor is to provide representation and consultation for all levels of provider appeals whether or not scheduling of such proceedings occurs during the term of this contract; this may include administrative hearings, evidentiary hearings, and judicial reviews as well as other legal proceedings not individually listed here. This representation shall be included in the price of the engagements and no additional compensation shall be made whether the timing is within or subsequent to the term of this contract.
12	Vendor is to meet with OAMR representatives upon completion of each engagement and will provide at that meeting a draft copy of the report for the engagement (or engagements if Chain Facilities). Any necessary changes must be discussed and agreed upon before final acceptance. Vendor is to be prepared (with workpapers) to discuss each finding and to perform additional work at the request of OAMR for any areas not sufficiently explained or findings not sufficiently quantified. In the event that changes or additional work are deemed necessary a subsequent draft will be submitted and discussed with OAMR.
13	The final draft of the report is to be submitted to OAMR by the vendor and OAMR will transmit the draft report to the facility. The facility shall have at a minimum ten (10) business days from receipt to provide additional information to the vendor to mitigate or resolve the findings.
14	Vendor is responsible for final report preparation, editing and printing. The vendor is to provide OAMR with three (3) copies of the final report for each engagement as well as one (1) copy of the engagement workpapers resulting from the examination.
15	All workpapers and reports are to be retained, at the vendor's expense, for a minimum of five (5) years. After the five (5) years have elapsed all workpapers and reports are to be delivered and surrendered unto the OAMR.
16	Vendor is to be available to OAMR to assist in adapting the engagement procedures as necessary to accommodate rule and regulation changes as they affect the rate determination and engagement process on an as-needed basis.

Scope of Work - Mandatory Requirements: The vendor must comply with the following specifications in the performance of the services.	
17	The bid must include a firm fixed fee for the performance of each facility engagement for the services discussed above (based on a typical engagement including six (6) LTC-FASRs) as well as an hourly rate schedule to accommodate additional work necessitated by the following: addition of additional LTC-FASR periods to be examined (e.g. ten (10) LTC-FASRs covered in a facility engagement); allocated home office cost for Chain Facilities; allocated hospital costs for Hospital-Based Facilities; or additional procedures resulting from extraordinary circumstances found in the course of performing the engagement. In the event additional work outside the standard (six (6) LTC-FASRs) engagement is needed, vendor is to meet with OAMR prior to commencing additional work and the vendor is to provide OAMR with a written estimate of the hours required to perform the additional work. In the event that less than six (6) LTC-FASRs are to be examined in an engagement, the vendor is to adjust the per engagement fee to accommodate the commensurate reduction in work.
18	Vendor is to commit a cohesive, dedicated, highly skilled core team of key personnel to oversee and conduct the tasks required under this agreement. The vendor is to designate one contact person to report to the Director of OAMR or his designee regarding all matters related to this contract. This individual shall be a Certified Public Accountant in good standing licensed by the West Virginia Board of Accountancy. The designated contact person must be able to act on behalf of the vendor and have appropriate experience and expertise in overseeing similar engagements. The designated contact person must be available for monthly on-site meetings with the OAMR Office Director. Meetings may be conducted on less than a monthly basis, if deemed appropriate by the OAMR, and may be requested more frequently on an as needed basis.

Special Terms and Conditions:

General Terms and Conditions:

By signing and submitting its proposal, the successful Vendor agrees to be bound by all the terms contained in this Request for Quotation.

Conflict of Interest:

Vendor affirms that it, its officers or members or employees presently have no interest and shall not acquire any interest, direct or indirect, which would conflict or compromise in any manner or degree with the performance of its services hereunder. The Vendor further covenants that in the performance of the contract, the Vendor shall periodically inquire of its officers, members and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the Agency.

Prohibition against Gratuities:

Vendor warrants that it has not employed any company or person other than a bona fide employee working solely for the vendor or a company regularly employed as its marketing agent to solicit or secure the contract and that it has not paid or agreed to pay any company or person any fee, commission, percentage, brokerage fee, gifts or any other consideration contingent upon or resulting from the award of the contract.

For breach or violation of this warranty, the Agency shall have the right to annul this contract without liability at its discretion or to pursue any other remedies available under this contract or by law.

Certifications Related to Lobbying:

Vendor certifies that no federal appropriated funds have been paid or will be paid, by or on behalf of

the company or an employee thereof, to any person for purposes of influencing or attempting to influence an officer or employee of any Federal entity, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement.

If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee or any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the Vendor shall complete and submit a disclosure form to report the lobbying

Vendor agrees that this language of certification shall be included in the award documents for all sub-awards at all tiers, including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements, and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this contract was made and entered into.

Vendor Relationship:

The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by the parties to this contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents.

Vendor shall be responsible for selecting, supervising and compensating any and all individuals employed pursuant to the terms of this RFQ. Neither, the Vendor, nor any employees or contractors of the vendor, shall be deemed to be employees of the State or Agency for any purposes whatsoever.

Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, and licensing fees, etc. and the filing of all necessary documents, forms and returns pertinent to all of the foregoing

Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including but not limited to the foregoing payments, withholdings, contributions, taxes, social security taxes and employer income tax returns.

The Vendor shall not assign, convey, transfer or delegate any of its responsibilities and obligations under this contract to any person, corporation, partnership, association or entity without expressed written consent of the Agency.

Indemnification:

The Vendor agrees to indemnify, defend and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data used under the contract in a manner not authorized by the contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees or subcontractors to observe State and Federal laws, including but not limited to labor and wage laws.

Governing Law:

This contract shall be governed by the laws of the State of West Virginia. The Vendor further agrees to comply with the Civil Rights Act of 1964 and all other applicable laws and regulations, Federal, State and Local Government.

Compliance with Laws and Regulations:

The vendor shall procure all necessary permits and licenses to comply with all applicable laws, Federal, State or municipal, along with all regulations, and ordinances of any regulating body.

Vendor shall pay any applicable sales, use or personal property taxes arising out of this contract and the transactions contemplated thereby. Any other taxes levied upon this contract, the transaction, or the equipment, or services delivered pursuant here to shall be borne by the contractor. It is clearly understood that the State of West Virginia is exempt from any taxes regarding performance of the scope of work of this contract.

Subcontracts/Joint Ventures:

The Vendor is solely responsible for all work performed under the contract and shall assume prime contractor responsibility for all services offered and products to be delivered under the terms of this contract. The Agency will consider the Vendor to be the sole point of contact with regard to all contractual matters. The Vendor may, with the prior written consent of the Agency, enter into written subcontracts for performance of work under this contract; however, the vendor is totally responsible for payment of all subcontractors.

Non-Appropriation of Funds:

If the Agency is not allotted funds in any succeeding fiscal year for the continued use of the service covered by this contract by the West Virginia Legislature, the Agency may terminate the contract at the end of the affected current fiscal period without further charge or penalty. The Agency shall give the vendor written notice of such non-allocation of funds as soon as possible after the Agency receives notice. No penalty shall accrue to the Agency in the event this provision is exercised.

Contract Termination:

The Agency may terminate any contract resulting from this RFQ with 30 days prior notice or immediately at any time the Vendor fails to carry out its responsibilities or to make substantial progress under the terms of this RFQ and resulting contract. The Agency shall provide the Vendor with advance notice of performance conditions which are endangering the contract's continuation. If after such notice the Vendor fails to remedy the conditions contained in the notice, within the time period contained in the notice, the Agency shall issue the Vendor an order to cease and desist any and all work immediately. The Agency shall be obligated only for services rendered and accepted prior to the date of the notice of termination.

Changes:

If changes to the original contract become necessary, a formal contract change order will be negotiated by the State, the Agency and the Vendor, to address changes to the terms and conditions, costs of work included under the contract. An approved contract change order is defined as one approved by the Purchasing Division and approved as to form by the West Virginia Attorney General's Office, encumbered and placed in the U.S. Mail prior to the effective date of such amendment. An approved contract change order is required whenever the change affects the payment provision or the scope of the work. Such changes may be necessitated by new and amended Federal and State regulations and requirements.

As soon as possible after receipt of a written change request from the Agency, but in no event more than thirty (30) days thereafter, the Vendor shall determine if there is an impact on price with the change requested and provide the Agency a written statement to identifying any price impact on the contract or to state that there is no impact. In the event that price will be impacted by the change, the

Vendor shall provide a description of the price increase or decrease involved in implementing the requested change.

Price Quotations:

The bid shall include a price for each engagement based on the facilities to be audited during the term of this contract as listed in Attachment 1. Attachment 1 lists the names and locations of the facilities, chain or hospital affiliation of each facility (if applicable) along with locations of home offices or hospital, and the number of LTC-FASR's to be included in the engagement. The price quotation should be all inclusive to render the product outlined in "**Mandatory Requirements**" above, to include all travel, administrative or other costs as well as any work deemed necessary to include home office costs, management fees, hospital or other similar costs allocated to each facility on the LTC-FASR's. The price shall also include any future representation at administrative hearings or other legal proceedings, and the vendor shall be prepared to explain and defend the findings of the audit engagements. The price quote should be on an individual engagement basis. However the vendor shall be committed to perform all seventeen (17) engagements during the term of this contract.

Rates for Additional Professional Staff:

In the event that OAMR requests additional work beyond the work outlined above, the vendor is requested to supply hourly rates that would apply to any charges for same. The maximum number of additional hours has been included on the Cost Sheet by staff level, and are estimates only to be used for evaluation purposes.

Invoices, Progress Payments:

Vendor shall submit invoices, in arrears, to the Agency at the address on the face of the purchase order labeled "Invoice To" pursuant to the terms of the contract. Progress payments shall be made on the basis of accepted final audit reports at the per engagement prices per the Cost Sheet. Progress reports must be submitted to Agency with the invoice detailing progress completed or any deliverables identified. Payment will be made only upon approval of acceptable progress or deliverables as documented in the Vendor's report. Invoices may not be submitted more than once monthly and State law forbids payment of invoices prior to receipt of services.

Liquidated Damages:

According to West Virginia State Code §5A-3-4(8), Vendor agrees that liquidated damages shall be imposed at the rate of **\$200 per week** for failure to meet deadlines agreed upon for an audit. This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue to any other additional remedy to which the State or Agency may have legal cause for action including further damages against the Vendor.

Record Retention (Access & Confidentiality):

Vendor shall comply with all applicable Federal and State of West Virginia rules and regulations, and requirements governing the maintenance of documentation to verify any cost of services or commodities rendered under this contract by Vendor. The Vendor shall maintain such records a minimum of five (5) years and make available all records to Agency personnel at Vendor's location during normal business hours upon written request by Agency within 10 days after receipt of the request.

Vendor shall have access to private and confidential data maintained by Agency to the extent required for Vendor to carry out the duties and responsibilities defined in this contract. Vendor agrees to maintain confidentiality and security of the data made available and shall indemnify and hold harmless the State and Agency against any and all claims brought by any party attributed to actions of breach of confidentiality by the Vendor, subcontractors or individuals permitted access by Vendor.

Insurance Requirements:

The Vendor, as an independent Vendor, is solely liable for the acts and omissions of its employees and agents. Proof of insurance shall be provided by the successful Vendor at the time the contract is awarded. The Vendor shall maintain and furnish proof of coverage of liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the Vendor, its agents and employees in the following amounts *at a minimum*:

1. For bodily injury (including death): Minimum of \$500,000.00 per person, \$1,000,000.00 per occurrence.
2. For property damage and professional liability: Minimum of \$1,000,000.00 per occurrence.

HIPAA Business Associate Addendum

The West Virginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, and available online at the Purchasing Division's website (<http://www.state.wv.us/admin/purchase/vrc/hipaa.htm>) is hereby made part of the Agreement. Provided that, the Agency meets the definition of a Covered Entity (45 CFR §160.103) and will be disclosing Protected Health Information (45 CFR §160.103) to the Vendor.

Debarment and Suspension:

Successful Vendor must certify that no entity, agency or person associated with firm, is currently debarred or suspended from conducting business with any governmental agency.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING

ALL-INCLUSIVE COST SHEET

COST QUOTE FOR STANDARD FACILITY ENGAGEMENT

	<u>Facility</u>	<u>All-Inclusive Per Engagement Cost</u>
1.	Clarksburg Nursing & Rehabilitation Center	
2.	Fayette Nursing & Rehabilitation Center	
3.	E.A. Hawse Nursing & Rehabilitation Center	
4.	Lincoln Nursing & Rehabilitation Center	
5.	Cameron Nursing & Rehabilitation Center	
6.	McDowell Nursing & Rehabilitation Center	
7.	Summers Nursing & Rehabilitation Center	
8.	Wayne Nursing & Rehabilitation Center	
9.	Webster Nursing & Rehabilitation Center	
10.	Wyoming Nursing & Rehabilitation Center	
11.	Mercer Nursing & Rehabilitation Center	
12.	The Brier	
13.	Valley Haven Geriatric Center	
14.	Valley View Nursing Home	
15.	Hampshire Memorial Hospital	
16.	Grafton City Hospital	
17.	Huntington Health & Rehabilitation Center	
Total Cost for Standard Engagements		

HOURLY RATE FOR ADDITIONAL SERVICES

<u>Classification</u>	<u>Maximum Hours</u>	<u>Hourly Rate</u>	<u>Total</u>
Partner/Member	15		
Manager	30		
Supervisor	75		
Staff	150		
Clerical	50		
Total Cost For Additional Services			

SUMMARY OF ALL COSTS

Total Cost for Standard Engagements	
Total Cost for Additional Services	
Total Contract Cost	

Evaluation of Bids: Cost evaluations will be based on the total contract cost and the vendor's documentation of experience & capabilities. It is preferred that all vendors complete the above pricing page rather than submitting a separate quote.

**ATTACHMENT 1
FACILITY AUDIT LIST**

Each audit will include eight (8) West Virginia Medicaid Long-Term Care Financial and Statistical Reports covering the following six-month periods ending: June 30, 2004; December 31, 2004; June 30, 2005; December 31, 2005; June 30, 2006; December 31, 2006; June 30, 2007; and December 31, 2007.

	Facility Name and City	Chain or Hospital Affiliation and Chain Home Office or Hospital Location
1.	Clarksburg Nursing & Rehabilitation Center, Clarksburg	CHAIN-American Medical Facilities Management Charleston, WV
2.	Fayette Nursing & Rehabilitation Center, Fayetteville	CHAIN-American Medical Facilities Management Charleston, WV
3.	E. A. Hawse Nursing & Rehabilitation Center, Baker	CHAIN-American Medical Facilities Management Charleston, WV
4.	Lincoln Nursing & Rehabilitation Center, Hamlin	CHAIN-American Medical Facilities Management Charleston, WV
5.	Cameron Nursing & Rehabilitation Center, Cameron	CHAIN-American Medical Facilities Management Charleston, WV
6.	McDowell Nursing & Rehabilitation Center, Gary	CHAIN-American Medical Facilities Management Charleston, WV
7.	Summers Nursing & Rehabilitation Center, Hinton	CHAIN-American Medical Facilities Management Charleston, WV
8.	Wayne Nursing & Rehabilitation Center, Wayne	CHAIN-American Medical Facilities Management Charleston, WV
9.	Webster Nursing & Rehabilitation Center, Cowen	CHAIN-American Medical Facilities Management Charleston, WV
10.	Wyoming Nursing & Rehabilitation Center, New Richmond	CHAIN-American Medical Facilities Management Charleston, WV
11.	Mercer Nursing & Rehabilitation Center, Bluefield	CHAIN-American Medical Facilities Management Charleston, WV
12.	The Brier, Ronceverte	CHAIN-National Health Care Fairmont, WV
13.	Valley Haven Geriatric Center, Wellsburg	CHAIN-National Health Care Fairmont, WV
14.	Berkeley Springs Rehabilitation and Nursing, Berkeley Springs	CHAIN-National Health Care Fairmont, WV
15.	Hampshire Memorial Hospital, Romney	HOSPITAL-Hampshire Memorial Hospital Romney, WV and Keyser, WV
16.	Grafton City Hospital, Grafton	HOSPITAL-Grafton City Hospital Grafton WV
17.	Huntington Health & Rehabilitation Center, Huntington	CHAIN-SSC Equity Holdings, LLC Atlanta, GA

SAMPLE 1

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING**

AUDIT GUIDE

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

FACILITY NAME

AUDIT PERIOD

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE INDEX**

- I. ENGAGEMENT PLANNING.....**
- II. ENTRANCE CONFERENCE.....**
- III. PRELIMINARY WORK.....**
- IV. STATISTICS.....**
- V. PAYROLL.....**
- VI. RESTORATIVE.....**
- VII. EXPENSES.....**
- VIII. HOME OFFICE COSTS.....**
- IX. HOSPITAL-BASED COST ALLOCATION.....**
- X. MANAGEMENT FEES.....**
- XI. REVENUES.....**
- XII. PATIENT FUNDS.....**
- XIII. MEDICAID CREDIT BALANCES.....**
- XIV. AUDIT CONCLUSIONS.....**

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

I ENGAGEMENT PLANNING

	Date	Initials	Reference
1 Coordinate with OAMR provider notification of examination			
2 Perform review of submitted cost report and provider submitted workpapers Note any unusual entries adjustments allocations or reclassifications.			
3 Perform review of rate calculations Note any unusual or significant variances in provider's reported allowable costs between periods and compare allowable costs to calculated standards. For any unusual or significant variances noted, determine whether scope of examination should be modified; consider any such issues noted in testing of general ledger to cost report tie-in and suspect account analysis (step 14 below) Document the conclusions and any effect on the examination scope in a narrative memorandum			
4 Perform review of facility appraisal reports and depreciation schedule Note any additions or renovations occurring during the examination periods			
5 Perform review of prior year reports and examinations in OAMR files Note adjustments and appeals			
6 Discuss with OAMR audit and rate setting staff their awareness of any provider issues or complaints that would affect the scope of the engagement			
7 Perform review of cost reports filed during the examination period to determine scope of the examination Identify areas that may represent specific risks by preparing a workpaper comparing reported amounts per cost reports to applicable caps for the examination period			
8 Work with OAMR to determine a preliminary materiality amount. a Request that OAMR rate setting staff prepare electronic adjusted rate worksheets and evaluate tolerable misstatement and materiality by cost reporting period. b Discuss with OAMR evaluation of materiality and document any effect on engagement scope			
9 Make arrangements with provider to begin fieldwork This includes sending a confirmation letter regarding the date and time of the entrance conference and sending the provider a list of information required at the entrance conference			
10 Forward a copy of the Internal Control Questionnaire to provider for completion and return prior to beginning of fieldwork			
11 Forward a copy of Patient Trust Fund Questionnaire to provider for completion			
12 Review the completed Internal Control Questionnaire in order to obtain an understanding of the following a Control Environment b Accounting System c Reporting Process			
13 Using the beginning and ending check numbers from the completed Internal Control Questionnaire select a sample of disbursements from operating (i.e. non-payroll) bank accounts for substantive testing Request that the provider complete and return an electronic (Excel) worksheet containing the following elements for each disbursement selected: check number date amount payee general ledger account posting			
14 Prepare a workpaper to determine 'suspect accounts' to compare amounts reported by cost center for each period examined. Calculate the variance between periods and identify the accounts with significant variances for additional testing			

II ENTRANCE CONFERENCE

1 Provide introductions of engagement team and identify facility personnel that will be available to assist the team			
2 Discussions with provider should include (but not limited to) the following: a Adequacy and access to providers records. b Provider's personnel who will be the contact person providing necessary documentation. c Working area for the engagement team d Changes in the provider's operation. e Changes in accounting methods or principles applied f Changes in key personnel. g Significant accounting or reporting problems h Finding of internal or external audits. i Changes or issues in any facility software or hardware (or other system) conversions/changes occurring during the examination period that could affect j Other issues as necessary			
3 If additional issues are found as a result of the entrance conference that affect the scope of the engagement document in a narrative memorandum; if no such issues are noted mark N/A at right			

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

III PRELIMINARY FIELDWORK

	Date	Initials	Reference
1 Conduct a tour of the provider's facility to become familiar with operations. Using the depreciation schedule and latest appraisal physically observe additions, renovations construction in progress and any major equipment purchases Document items reviewed on appraisal Note any significant equipment or additions not included in the appraisal or depreciation schedule on a separate workpaper			
2 Review the Board of Director's Minutes noting capital expenditures changes in contracts, leasing arrangements management contracts salary and revenue increases			
3 Using the related party detail list requested during engagement planning determine if any related parties exist and if so determine the nature of any such relationships. Judgmentally select individual items from the related party detail list for substantive testing to include examination of the facility's calculation to remove profit and ensure that the transaction is reported at cost If any transactions are noted in the testing that include related party profit expand the testing to quantify the amount of related party profit adjustment needed Document the nature of any related party transactions noted as well as any adjustments needed in a narrative memorandum			
4 Perform a reconciliation of Medicaid Cost Report to the provider's general ledger/trial balance for a sample of the cost report periods under examination a Agree amounts, account titles and account numbers per facility general ledger to WV Medicaid Grouping Report b Review general ledger expense accounts for appropriate classification within the cost report cost centers (i.e. nature of expenses for particular general ledger accounts is appropriately classified to commensurate cost center on cost report) c Agree amounts per WV Medicaid Grouping Report to cost report			
5 If available perform review of annual external audit reports Document any items noted that impact the scope of the engagement or planned procedures			
6 Obtain copies of the Federal corporate or partnership tax returns for years under examination			
7 Ask facility administrator and CFO if they are aware of any instances of fraud or mismanagement that have occurred (not specifically limited to the period of audit)			
8 Expand audit scope and testing as necessary to obtain an understanding and quantify any issues noted in performance of Step 1 above			
9 Document the results of the above testing conclusions and any adjustments to engagement scope in a narrative memorandum			

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

IV. STATISTICS

Date Initials Reference

1 Inquire of facility billing and management whether they are aware of any adjustments to the census statistics as originally reported on the cost report

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2 Select one month for each cost report period included in the engagement and perform the following:

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- a Mathematically test midnight census documentation for accuracy and tie s elected midnight census to patient day summaries
- b Mathematically test patient day summaries and tie to census reported by category on the cost report
- c if errors are noted in the above testing expand testing for cost report periods for which errors are noted by selecting additional months for testing
- d Summarize any adjustments needed to census based on the above testing

3 In examination planning the facility was requested to provide a listing of bed reservation days from one selected month during each cost report period (for months with bed reservation days per the WV Medicaid Paid Days Report) Using the listings provided by the facility, examine supporting documentation to ensure the appropriateness of bed reservation days paid by Medicaid to include the following:

- a Calculate the facility occupancy for the midnight census prior to the individual's departure from the facility to ensure that it was above 95% (in accordance with Volume 15 of Chapter 500 Section 510 of the Medicaid Provider Manuals)
- b Summarize any bed reservation days that were inappropriately billed based on the above testing

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**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

V PAYROLL

Date Initials Reference

- 1 Perform a reasonableness test of total wages per cost report to wages on the provider's IRS Form 941 wage tax return or other payroll tax form based on wages. Document the reasons for any variance noted in which the cost report wages exceed the wages reported on the Form 941 by a significant amount. Expand testing as necessary to verify the reasons for such variances.
- 2 If payroll is allocated to cost centers, determine if the allocation methodology is reasonable.
- 3 Select one payroll period and test for the following:
 - a Gross pay per payroll is mathematically correct
 - b Gross to net pay per payroll is mathematically correct
 - c Time card ties to payroll register
 - d Trace postings from the payroll register to the general ledger
- 4 Review time records for administrative personnel to ensure compliance with Chapter 500, Volume 15 of the WV Medicaid Provider Manuals.
- 5 Confirm the time records, work efforts and classifications for employees related to owners and or management.
- 6 Review any bonuses accrued and/or paid.
- 7 Review documentation of fringe and employee benefits. Document any benefit and/or bonus plans that are not equally applicable to all employee classes.
- 8 Document the results of the above testing, findings and adjustments, and conclusions in a narrative memorandum or summary workpaper.

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VI RESTORATIVE

- 1 Identify the types of therapies being administered at the facility and determine if the therapies are being performed by facility employees or by outside contract. (e.g. Physical Therapy, Speech Therapy, Inhalation Therapy, Occupational Therapy)
- 2 If therapies are being performed by an outside contractor, obtain a copy of the current contract and select a sample of transactions and trace to supporting invoices and cancelled checks. Mathematically test the accuracy of the invoices by recalculating against the contract rate.
- 3 Document the results of the above testing, findings and adjustments, and conclusions in a narrative memorandum or summary workpaper.

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**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

VII EXPENSES

	Date	Initials	Reference
1 Using the worksheet prepared in Section I Step 13, request and review the following for the sampled items: a Original invoice b Canceled check (or electronic image) c General ledger posting (noting appropriateness of general ledger account in relation to type of expense). d Approval by appropriate facility staff	[]	[]	[]
2 Review the general ledger account details supporting the accounts identified in the suspect account analysis in Section I, Step 14. Judgmentally select a sample of postings from these accounts and vouch to appropriate supporting documentation	[]	[]	[]
3 Review for personal expenses of the owner/administrator being paid by the facility and being reported on the cost report	[]	[]	[]
4 Determine whether the results of testing in Step 1 and 2 above indicate cost shifting between cost centers to avoid ceiling limitations or to maximize incentives. If any such shifting is indicated, expand expense testing as necessary to quantify the adjustment needed to remove the effects of shifted costs	[]	[]	[]
5 Determine that related party costs are being properly reported net of profit.	[]	[]	[]
6 Determine whether working capital interest is included in the cost reports and whether it is appropriate per Section 530.6 of Volume 15 of Chapter 500 of the WV Medicaid Provider Manuals	[]	[]	[]
7 Review the provider's mileage log for existence and appropriateness. Review general ledger vehicle expense accounts for insurance or other vehicle expenses and determine whether such expenses have been appropriately reclassified to cost report page WV24-Non-Allowable Vehicle Expenses	[]	[]	[]
8 Document the results of the above testing, findings and adjustments and conclusions in a narrative memorandum or summary workpaper	[]	[]	[]

VIII HOME OFFICE COSTS

1 Document (or obtain documentation of) services provided to the facility by the Home Office. Inquire of facility management how the services provided by the home office benefit patient care as required by Section 560.9, Chapter 500 Volume 15 of the WV Medicaid Provider Manuals. Document the response to this inquiry	[]	[]	[]
2 Review the home office allocation to determine the propriety of the allocation method and for reasonableness and allowability. Determine whether the allocation was based on patient days (in accordance with Section 530.9 of Volume 15 of Chapter 500 of the Medicaid Provider Manuals). If an allocation method other than patient days was used, review approval for change from WVDHHR or Medicare intermediary	[]	[]	[]
3 Perform a reasonableness test of Home Office expenses by comparing amount of Home Office costs per cost reports to amount of Home Office cost reported to Medicare for the commensurate period. Document any variances and determine whether additional testing is warranted	[]	[]	[]
4 Document the results of the above testing, findings and adjustments, and conclusions in a narrative memorandum or summary workpaper	[]	[]	[]

IX HOSPITAL-BASED FACILITY COST ALLOCATION

1 Obtain the allocation workpapers and discuss with appropriate provider personnel the allocation methodologies	[]	[]	[]
2 Vouch amounts per account on the allocation workpapers to general ledger. Document any balances that do not agree	[]	[]	[]
3 Trace amounts per account on the allocation workpapers to the FASR Grouping Report. Document any balances that do not agree	[]	[]	[]
4 Perform a test of the allocation workpapers to determine whether accounts are properly classified to either an allowable cost center or non-allowable costs. Document any exceptions to this analysis	[]	[]	[]
5 Compare the allocation methodologies used on the allocation workpapers to the Medicare cost report allocation methodologies. Discuss any differences between the allocation for Medicare cost reporting and the WV Medicaid cost report with facility management and document the responses	[]	[]	[]
6 Review of square footage changes from prior examination period allocation	[]	[]	[]
7 Review patient meals counts. If an actual meal count was not used meals should equal three times in-patient days	[]	[]	[]
8 Discuss with appropriate provider personnel any issues or exceptions noted in the above testing	[]	[]	[]
9 Document the results of the above testing in a narrative memorandum to indicate any necessary adjustments based on the above testing	[]	[]	[]

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

X. MANAGEMENT FEES

Date Initials Reference

1 Review Management Agreement Contract Obtain a copy for OAMR files and document whether management fees paid to related parties are reported on page WV24, Non-allowable Expenses. (in accordance with Section 530 9 of Volume 15 of Chapter 500 of the Medicaid Provider Manuals)

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2 Determine the basis used to calculate the management fees for the period under audit

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3 Review the transaction register and identify all management fees paid

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4 Ensure that payments are calculated in accordance with the management agreement and that they do not exceed allowable amounts

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5 Document whether duplication of services is noted in above testing

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XI. REVENUES

1 Reconcile facility general ledger revenue to cost report revenue Document the reasons for significant variances noted

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2 Review miscellaneous and other income accounts Determine if these accounts are required to be offset against expenses Examples requiring offset are:
 a Interest Income
 b Sale of Meals
 c Rental of facility space

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**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING
AUDIT GUIDE FOR LONG TERM CARE FACILITIES**

XII PATIENT FUNDS

Date Initials Reference

- | 1 Review the patient fund questionnaire completed by the provider for inclusion with the report | | | |
|--|--|--|--|
| 2 Select one month and test reconciliation process for all Medicaid patients
Reconcile the sum of cash in the bank (general ledger check register) and cash on hand (general ledger) as of the statement date | | | |
| 3 Verify that interest earned is credited to the patient's account | | | |
| 4 Determine whether funds are being held for discharged residents | | | |
| 5 Request that provider complete the patient fund reconciliation report | | | |
| 6 Document the results of the above testing, findings and adjustments, and conclusions in a narrative memorandum or summary workpaper | | | |

XIII. MEDICAID CREDIT BALANCES

- | | | | |
|---|--|--|--|
| 1 Review accounts receivable aging report and/or patient ledger cards as of the last date in the engagement period to identify any credit balances which might indicate duplicate payments (third party payments) or other overpayments | | | |
| 2 Inquire as to whether or not there exist any unapplied credits to patient accounts; if so review and determine whether any are related to periods under examination and if recoupment is appropriate | | | |
| 3 If credit balances are found to exist for Medicaid patients review documentation to determine the amount of recoupment (if any) that is necessary Create a list of credit balances to include account number (if any) name, amount | | | |

SAMPLE 2

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING**

**FORMAT FOR LISTING FINDINGS OF
NON-COMPLIANCE AND ADJUSTMENTS**

The following format shall be used to describe findings noted in the examination of LTC-FASR's resulting in adjustments to the amounts reported:

Finding Number ___:

Criteria: Describe criteria applicable to the finding, including rule citations, etc.

Condition: Summarize the finding noted, including the cost report period, LTC-FASR cost center charged, page/line mapping to LTC-FASR field affected, account description, and quantification of cost or census error (the table below is an example; columns/rows may be added as necessary to sufficiently explain the issue and adjustment needed).

Cost Report Period	FASR Cost Center	Page/Line	Account Number/Title	Amount Reported per FASR	Correct Amount	Adjustment and Amount (dollars, days, etc)

Cause: Describe cause (i.e. reason represented by facility, inadequacy of internal controls, etc).

Effect or Potential Effect: Describe the effect of the finding on the LTC-FASR

Recommendation: Describe any recommendations (i.e improvements or changes to internal control or facility procedures) that would prevent this type of finding from occurring again in a future period

The following provides an example of a census adjustment for an engagement covering cost reports from 1/1/2003 through 12/31/2005:

Finding Number 2005-1-Census Error

Criteria: Per section 528 of the West Virginia Medicaid Provider Manuals Chapter 500, Volume 15 Covered Services, Limitations and Exclusions, for Nursing Facility Services:

"Financial and Statistical records must be maintained by the facility to support and verify the information submitted on the cost reports."

Condition: For the six-month period ended June 30, 2005 the facility reported 1,525 total census days; however the facility's records indicated that the actual census was 1,575 for that period. The difference of 50 days was due to an adjustment of days in the "Private Pay" category that was not included when the census was summarized for the month of May 2005.

Cost Report Period	FASR Cost Center	Page/Line	Account Number and Title	Days per FASR	Days Per Facility Records	Adjustment and Amount
6/30/2005	Census	Page WV6, "Private" Line	N/A	1,525	1,575	Increase Census by 50 days

Cause: Per discussion with facility billing staff, the difference of 50 days was due to an adjustment of days in the "Private Pay" category that was not included when the census was summarized for the month of May 2005.

Effect or Potential Effect: Census days are misstated on the 6/30/2005 Financial and Statistical Report

Recommendation: It was noted during the engagement that the facility's procedure for summarizing census for inclusion in the Financial and Statistical Report does not include a review. We recommend that the facility perform a review of all data to be included on the Financial and Statistical report to ensure that it reconciles to appropriate source records and includes all necessary adjustments.

The following provides an example of a non-allowable cost adjustment for an engagement covering cost reports from 1/1/2003 through 12/31/2005:

Finding Number 2005-2-Non-Allowable Costs

Criteria: Per section 530 7 of the West Virginia Medicaid Provider Manuals Chapter 500, Volume 15 Covered Services, Limitations and Exclusions, for Nursing Facility Services:
"The cost of operating all licenses vehicles will be limited to the per mile rate approved by the West Virginia Travel Management Office "

Condition: For the six-month period ended December 31, 2004 the facility included \$1,500 in vehicle insurance costs in Schedule WV20A, Travel. These costs should have been reported on Schedule WV24, Vehicle.

Cost Report Period	FASR Cost Center	Page and Line	Account Number and Title	Amount Reported per FASR	Correct Amount	Adjustment and Amount
12/31/2004	Administration	Page WV20A, Line 38	Account 8760, Travel	\$8,000	\$6,500	Decrease \$1,500
12/31/2004	Non-Allowable	Page WV24, Line 10	Account 9810, Vehicle	\$1,750	\$3,250	Increase \$1,500

Cause: The amount of insurance expense reclassified to non-allowable in the preparation of the Financial and Statistical Report was miscalculated, omitting the above amount from the reclassification.

Effect or Potential Effect: Allowable expenses on the Financial and Statistical Report are overstated.

Recommendation: Management should ensure that all non-allowable expenses are reclassified prior to submission of the Financial and Statistical report.

SAMPLE 3

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORTING**

SAMPLE LONG TERM CARE FINANCIAL AND STATISTICAL REPORT

FINANCIAL AND STATISTICAL REPORT

FACILITY NAME: Anytown Nursing Home **MEDICAID #** 0001234000
PERIOD BEGINNING: 1/1/2007 **ENDING:** 6/30/2007

RELATED HEALTH FACILITIES (DETAIL BELOW)

NAME OF FACILITY	LOCATION		OWNER, ADMINISTRATOR, EMPLOYEE, STOCKHOLDER
	CITY	STATE	
Pleasant Retirement Village	Logan	WV	Stockholder

TRANSACTIONS WITH RELATED ORGANIZATIONS

EXPENSES (SUPPLIES, RENT, MANAGEMENT FEES, ETC)

NAME OF RELATED ORGANIZATION	DESCRIPTION OF ITEM	COST PER BOOK	COST TO RELATED PARTY
None		0	0
		0	0
		0	0
		0	0
		0	0

REVENUES

NAMES OF RELATED ORGANIZATION	DESCRIPTION OF ITEM	REVENUE OF BOOK	ACTUAL COST
None		0	0
		0	0
		0	0
		0	0
		0	0

OWNER OF FACILITY (LAND & BUILDING)

NAME: ABC Company
ADDRESS: 246 Main Street
CITY: Morgantown
STATE: WV **ZIP:** 26501 **PHONE:** (304) 555-9876

ADMINISTRATOR DATA

NAME: Robert Jones
ADDRESS: 123 First Avenue
CITY: Fairmont **LICENSE:** 1231
STATE: WV **ZIP:** 26555 **PHONE:** (304) 555-3579

ASSISTANT ADMINISTRATOR DATA

NAME: Mary Smith
ADDRESS: 765 Smith Street
CITY: Clarksburg **PHONE:** (304) 123-4567
STATE: WV **ZIP:** 26301

ACCOUNTING FIRM DATA

NAME: Good & Good, P L L C
ADDRESS: P O Box 4791
CITY: Charleston **PHONE:** (304) 987-6543
STATE: WV **ZIP:** 25301

BUREAU FOR MEDICAL SERVICES

CENSUS REPORT

FACILITY NAME: Anytown Nursing Home

MEDICAID # 0001234000

PERIOD BEGINNING: 1/1/2007

ENDING: 6/30/2007

PATIENT CLASSIFICATION	MONTHLY TOTALS						TOTAL
	MONTH 1	2	3	4	5	6	
PRIVATE	340	340	310	308	275	186	1,759
MEDICARE	164	186	243	134	80	138	945
MEDICAID-INTERMEDIATE	2,066	2,107	2,022	2,241	2,199	2,389	13,024
MEDICAID SKILLED	681	673	857	690	610	513	3,804
VETERANS	0	0	0	0	0	0	0
RESPIRE	0	0	0	0	0	0	0
OTHER (DESCRIBE)	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	3,231	3,306	3,232	3,373	3,164	3,226	19,532
LICENSED BEDS							
BEGINNING	113	113	113	113	113	113	
ENDING	113	113	113	113	113	113	

NOTE: PLEASE SUPPLY THE DATE THE CHANGES WERE APPROVED:

BEHOLDS (Included in above totals)							
MEDICAL	2	21	29	42	5	0	99
THERAPEUTIC	0	0	0	0	0	0	0
AVAILABLE BEDS							
BEGINNING	113	113	113	113	113	113	
ENDING	113	113	113	113	113	113	

CLASSIFICATION	BEGINNING CENSUS	ADMISSIONS +	DISCHARGE & DEATH	TRANSFERS		ENDING CENSUS
				TO +	FROM -	
PRIVATE	13	3	6	1	5	6
MEDICARE	6	25	11	2	19	3
MEDICAID-SKILLED	65	25	37	28	5	76
MEDICAID INTERMEDIATE	21	18	20	9	11	17
VETERANS ADMIN	0	0	0	0	0	0
RESPIRE	0	0	0	0	0	0
OTHER (DESCRIBE):	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0
TOTAL	105	71	74	40	40	102

BUREAU FOR MEDICAL SERVICES

**FINANCIAL AND STATISTICAL REPORT
PAYROLL REPORT**

FACILITY NAME: Anytown Nursing Home
PERIOD ENDING: 6/30/2007

MEDICAID # 0001234000
PATIENT DAYS: 19,532

DEPARTMENT	LABOR HOURS			SALARIES AND WAGES			INDIRECT BENEFITS	ADJUSTED TOTAL
	DIRECT	V S N	TOTAL	DIRECT	DIRECT BENEFITS	TOTAL		
NURSING: Director	888	112	798	15,994	0	15,994	4,443	20,437
NURSING: R N 's	2,584	367	2,951	41,289	0	41,289	11,470	52,759
NURSING: L P N 's	16,322	2,732	19,054	170,131	0	170,131	47,262	217,393
NURSING:Aides	35,567	4,387	39,954	241,733	0	241,733	67,153	308,886
RESTORATIVE	3,487	567	4,054	31,638	0	31,638	8,789	40,427
ACTIVITIES	3,457	455	3,912	32,867	0	32,867	9,130	41,997
MEDICAL REC & SERV	3,663	453	4,116	31,000	0	31,000	8,612	39,612
DIETARY	12,571	1,182	13,753	86,137	0	86,137	23,929	110,066
LAUNDRY/HOUSEK'PING	8,227	705	8,932	57,114	0	57,114	15,866	72,980
MAINTENANCE	3,461	395	3,856	32,326	0	32,326	8,980	41,306
ADMINISTRATOR	1,040	0	1,040	49,367	0	49,367	13,714	63,081
ASST ADMINISTRATOR	0	0	0	0	0	0	0	0
ADMIN IN TRAINING	0	0	0	0	0	0	0	0
BOOKEEPER/RECEPT	5,919	718	6,637	68,106	0	68,106	18,920	87,026
NONALLOWABLE SALARY	0	0	0	0	0	0	0	0
TOTALS	96,984	12,073	109,057	857,702	0	857,702	238,268	1,095,970

Contracted Nursing Hours

RN: 0
LPN: 0
AIDE: 0

Contracted Nursing Wages

RN:
LPN:
AIDE:

BUREAU FOR MEDICAL SERVICES

MILEAGE LOG

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID # 0001234000
ENDING: 6/30/2007

NUMBER OF VEHICLES: 1

MONTH	MILEAGE
MONTH #1	800
MONTH #2	0
MONTH #3	0
MONTH #4	0
MONTH #5	0
MONTH #6	104
	<hr/>
TOTAL MILEAGE	904
MILEAGE RATE	X 0 325
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TOTAL REIMBURSEMENT	294
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NOTE: A detailed mileage log must be provided during an audit or upon request

BUREAU FOR MEDICAL SERVICES

BALANCE SHEET - CURRENT ASSETS

FACILITY NAME: Anytown Nursing Home
 PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
 ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
CASH	98,537	0	0	98,537
RESTRICTED CASH	10,526	0	0	10,526
ACCOUNTS RECEIVABLE	816,086	0	0	816,086
PATIENT TRUST FUND	547,086	0	0	547,086
ALLOWANCE	-31,874	0	0	-31,874
INVENTORY	0	0	0	0
NURSING SUPPLIS	19,279	0	0	19,279
FOOD	0	0	0	0
DIETARY SUPPLIS	7,371	0	0	7,371
LINEN	0	0	0	0
HOUSEKEEPING	2,188	0	0	2,188
MAINTENANCE	0	0	0	0
BUSINESS OFFICE	0	0	0	0
PREPAID INSURANCE	8,719	0	0	8,719
PREPAID REAL ESTATE TAXES	0	0	0	0
PREPAID PERSONAL PROPERTY TAXES	0	0	0	0
PREPAID INTEREST	0	0	0	0
PREPAID RENT	0	0	0	0
OTHER PREPAID	0	0	0	0
LICENSES	0	0	0	0
DUES & SUBSCRIPTIONS	0	0	0	0
MAINTENANCE CONTRACTS	0	0	0	0
OTHER	0	0	0	0
TOTAL CURRENT ASSETS	<u>1,477,918</u>	<u>0</u>	<u>0</u>	<u>1,477,918</u>

BALANCE SHEET - FIXED OTHER ASSETS

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
LAND	82,156	0	0	82,156
LAND IMPROVEMENTS	20,682	0	0	20,682
BUILDING	2,117,581	0	0	2,117,581
BUILDING IMPROVEMENTS	0	0	0	0
EQUIPMENT	709,392	0	0	709,392
VEHICLES	0	0	0	0
LEASEHOLD IMPROVEMENTS	0	0	0	0
CAPITALIZED LEASES	0	0	0	0
CONSTRUCTION IN PROGRESS	0	0	0	0
TOTAL FIXED ASSETS	<u>2,929,811</u>	<u>0</u>	<u>0</u>	<u>2,929,811</u>
ACCUMULATED DEPRECIATION	0	0	0	0
LAND DEPRECIATION	-11,377	0	0	-11,377
BUILDING	-868,525	0	0	-868,525
BUILDING IMPROVEMENTS	0	0	0	0
EQUIPMENT	-471,022	0	0	-471,022
VEHICLES	0	0	0	0
LEASEHOLD IMPROVEMENTS	0	0	0	0
ACCUMULATED DEPRECIATION	<u>-1,350,924</u>	<u>0</u>	<u>0</u>	<u>-1,350,924</u>
NET FIXED ASSETS	<u>1,578,887</u>	<u>0</u>	<u>0</u>	<u>1,578,887</u>
DEPOSITS	35,211	0	0	35,211
ORGANIZATION COSTS	0	0	0	0
START UP COSTS	0	0	0	0
GOODWILL	0	0	0	0
OTHER	0	0	0	0
FINANCING COSTS, NET OF AMORT	0	0	0	0
DEBT SERVICE RESERVE	0	0	0	0
OTHER ASSETS	<u>35,211</u>	<u>0</u>	<u>0</u>	<u>35,211</u>
TOTAL ASSETS	<u>3,092,016</u>	<u>0</u>	<u>0</u>	<u>3,092,016</u>

BALANCE SHEET - CURRENT LIABILITIES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
ACCOUNTS PAYABLE	-191,132	0	0	-191,132
SALARIES PAYABLE	5,196	0	0	5,196
PAYROLL TAXES WITHHELD	-35,420	0	0	-35,420
FICA (SOCIAL SECURITY)	-8,692	0	0	-8,692
FEDERAL INCOME TAX	-4,956	0	0	-4,956
STATE INCOME TAX	-4,268	0	0	-4,268
UNION DUES	0	0	0	0
INSURANCE	0	0	0	0
STATE UNEMPLOYMENT TAX	0	0	0	0
OTHER	-110	0	0	-110
ACCRUED	0	0	0	0
FICA	0	0	0	0
STATE UNEMPLOYMENT	-10,575	0	0	-10,575
FEDERAL UNEMPLOYMENT	-3,669	0	0	-3,669
DISABILITY	0	0	0	0
BENEFITS	-79,836	0	0	-79,836
OTHER TAXES	-33,580	0	0	-33,580
REAL PROPERTY	0	0	0	0
PERSONAL PROPERTY	0	0	0	0
FEDERAL INCOME TAX	0	0	0	0
STATE INCOME TAX	0	0	0	0
SALES TAX OR USE	0	0	0	0
PATIENT DEPOSITS	-85,459	0	0	-85,459
MEDICARE SETTLEMENT	0	0	0	0
MEDICAID SETTLEMENT	0	0	0	0
TOTAL CURRENT LIABILITIES	<u>-452,501</u>	<u>0</u>	<u>0</u>	<u>-452,501</u>

BALANCE SHEET - LONG TERM DEBT AND EQUITY

FACILITY NAME: Anytown Nursing Home
 PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
 ENDING: 6/30/2007

ACCOUNT DESCRIPTION	PER BOOKS	ADJ DR	ADJ CR	ADJUSTED
LONG TERM DEBT	0	0	0	0
BONDS	-350,505	0	0	-350,505
TOTAL LONG - TERM LIABILITIES	-350,505	0	0	-350,505
CAPITAL	-818,212	0	0	-818,212
RETAINED EARNINGS	-1,544,264	0	0	-1,544,264
OTHER	0	0	0	0
DIVIDENDS/DRAWINGS	0	0	0	0
TOTAL EQUITY	-2,362,476	0	0	-2,362,476
NET (INCOME) LOSS	-11,993	0	0	-11,993
TOTAL EQUITY / LIABILITIES	-3,177,475	0	0	-3,177,475

SUMMARY OF REVENUE & EXPENSE

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
REVENUE				
PRIVATE	-202,972	0	0	202,972
MEDICARE	-326,429	0	0	-326,429
MEDICAID	-1,864,395	0	0	-1,864,395
VA	0	0	0	0
RESPITE	0	0	0	0
OTHER	-142,847	0	0	-142,847
ANCILLARY	-905	0	0	-905
MISCELLANEOUS	-14,916	0	0	-14,916
DEDUCTIONS	450,063	0	0	450,063
NET REVENUE	-2,102,401	0	0	-2,102,401
EXPENSES				
NURSING	713,214	0	0	713,214
MEDICAL REC & SERV	56,211	0	0	56,211
RESTORATIVE	148,080	0	0	148,080
ACTIVITIES / SOCIAL SERV	49,215	0	0	49,215
DIETARY	219,041	0	0	219,041
LAUNDRY / HOUSEKEEPING	123,860	0	0	123,860
ADMINISTRATION	223,118	0	0	223,118
UTILITIES	44,311	0	0	44,311
TAXES & INSURANCE	162,611	0	0	162,611
MAINTENANCE	54,120	0	0	54,120
COST OF CAPITAL	74,724	0	0	74,724
ANCILLARY	120,002	0	0	120,002
NONALLOWABLE	101,901	0	0	101,901
TOTAL EXPENSES	2,090,408	0	0	2,090,408
NET (INCOME) LOSS	-11,993	0	0	-11,993

ROUTINE & ANCILLARY REVENUE

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
ROUTINE REVENUE	-202,972	0	0	-202,972
PRIVATE ROOM & BOARD	0	0	0	0
PRIVATE NURSING SUPPLIES	0	0	0	0
PRIVATE OXYGEN	0	0	0	0
MEDICARE	-326,429	0	0	-326,429
MEDICAID	-1,864,395	0	0	-1,864,395
VA	0	0	0	0
RESPITE	0	0	0	0
OTHER	-142,847	0	0	-142,847
TOTAL ROUTINE REVENUE	-2,536,643	0	0	-2,536,643
ANCILLIARY REVENUES	-905	0	0	-905
DRUGS	0	0	0	0
PHYSICAL THERAPY	0	0	0	0
OTHER	0	0	0	0
TOTAL ANCILLARY REVENUE	-905	0	0	-905

MISCELLANEOUS INCOME & DEDUCTIONS

FACILITY NAME: Anytown Nursing Home
 PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
 ENDING: 6/30/2007

ACCOUNT DESCRIPTION	PER BOOKS	ADJ DR	ADJ CR	ADJUSTED
MISCELLANEOUS INCOME	-221	0	0	-221
TELEVISION	0	0	0	0
BEAUTY AND BARBER	0	0	0	0
PERSONAL ITEMS	0	0	0	0
VENDING MACHINE	-1,017	0	0	-1,017
RENTAL INCOME	-327	0	0	-327
INTEREST - RESTRICTED	0	0	0	0
INTEREST - UNSRESTRICTED	-13,351	0	0	-13,351
REVENUE FROM BEDHOLDS	0	0	0	0
GIFT SHOP	0	0	0	0
TRAINING REIMBURSEMENTS	0	0	0	0
TOTAL MISCELLANEOUS INCOME	-14,916	0	0	-14,916
CONTRACT ADJUSTMENTS	905	0	0	905
MEDICARE	144,221	0	0	144,221
MEDICAID	-20,669	0	0	-20,669
OTHER	325,606	0	0	325,606
ALLOWANCES	0	0	0	0
PRIVATE	0	0	0	0
MEDICARE	0	0	0	0
MEDICAID	0	0	0	0
VA	0	0	0	0
RESPIRE	0	0	0	0
TOTAL DEDUCTIONS FROM REVENUE	450,063	0	0	450,063

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
NURSING				
DIRECTOR	15,994	0	0	15,994
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	4,443	0	0	4,443
RN'S	41,289	0	0	41,289
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	11,470	0	0	11,470
LPN'S	170,131	0	0	170,131
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	47,262	0	0	47,262
AIDES	241,733	0	0	241,733
DIRECT BENEFITS & TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	67,153	0	0	67,153
SUB-TOTAL	599,475	0	0	599,475
OTHER NURSING				
SUPPLIES	108,607	0	0	108,607
NONPRESCRIPTION DRUGS	4,144	0	0	4,144
OXYGEN	988	0	0	988
CONTRACT NURSING SERVICES	0	0	0	0
OTHER	0	0	0	0
TOTAL NURSING	713,214	0	0	713,214

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
RESTORATIVE				
SALARIES	31,638	0	0	31,638
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	8,789	0	0	8,789
SUB TOTAL	<u>40,427</u>	<u>0</u>	<u>0</u>	<u>40,427</u>
CONSULTANTS				
PHYSICAL THERAPY	44,526	0	0	44,526
SPEECH THERAPY	10,074	0	0	10,074
INHAL THERAPY	0	0	0	0
OCCUP THERAPY	46,476	0	0	46,476
SUPPLIES	6,577	0	0	6,577
EQUIPMENT RENTAL	0	0	0	0
OTHER	0	0	0	0
TOTAL RESTORATIVE	<u>148,080</u>	<u>0</u>	<u>0</u>	<u>148,080</u>
ACTIVITIES / SOCIAL SERVICES				
SALARIES	32,867	0	0	32,867
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	9,130	0	0	9,130
SUB-TOTAL	<u>41,997</u>	<u>0</u>	<u>0</u>	<u>41,997</u>
SUPPLIES	1,172	0	0	1,172
EQUIPMENT RENTAL	0	0	0	0
PURCHASED SERVICES	6,046	0	0	6,046
INCOME	0	0	0	0
ALLOC /CONT ACT/SOC SERV	0	0	0	0
TOTAL ACT / SOCIAL SERVICES	<u>49,215</u>	<u>0</u>	<u>0</u>	<u>49,215</u>

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
MEDICAL RECORDS & SERVICES				
SALARIES	31,000	0	0	31,000
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	8,612	0	0	8,612
SUB-TOTAL	39,612	0	0	39,612
CONSULTANTS				
MEDICAL DIRECTOR	13,200	0	0	13,200
MEDICAL RECORDS	1,854	0	0	1,854
UTILIZATION REVIEW	0	0	0	0
PHARMACY	900	0	0	900
SUPPLIES	645	0	0	645
OTHER	0	0	0	0
ALLOCATED / CONTRACT MED REC	0	0	0	0
EQUIPMENT RENTAL	0	0	0	0
TOTAL MEDICAL REC. & SERVICES	56,211	0	0	56,211
DIETARY				
SALARIES	86,137	0	0	86,137
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	23,929	0	0	23,929
SUB-TOTAL	110,066	0	0	110,066
SUPPLIES	10,341	0	0	10,341
DISHES AND UTENSILS	486	0	0	486
CONSULTANTS	3,361	0	0	3,361
PURCHASED SERVICES	0	0	0	0
OTHER	0	0	0	0
FOOD	98,165	0	0	98,165
MEAL INCOME	-3,378	0	0	-3,378
ALLOCATED / CONTRACTED DIETARY	0	0	0	0
TOTAL DIETARY	219,041	0	0	219,041

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
LAUNDRY & HOUSEKEEPING				
SALARIES	57,114	0	0	57,114
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	15,866	0	0	15,866
SUB-TOTAL	<u>72,980</u>	<u>0</u>	<u>0</u>	<u>72,980</u>
LINEN	112	0	0	112
SUPPLIES	12,090	0	0	12,090
PURCHASED SERVICES	38,678	0	0	38,678
OTHER	0	0	0	0
INCOME	0	0	0	0
ALLOCATED / CONTRACTED LAUN	0	0	0	0
TOTAL LAUNDRY & HOUSEKEEPING	<u>123,860</u>	<u>0</u>	<u>0</u>	<u>123,860</u>
MAINTENANCE				
SALARIES	32,326	0	0	32,326
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	8,980	0	0	8,980
SUB-TOTAL	<u>41,306</u>	<u>0</u>	<u>0</u>	<u>41,306</u>
SUPPLIES	6,262	0	0	6,262
PAINTING	0	0	0	0
GARDENING	0	0	0	0
PURCHASED SERVICES	5,231	0	0	5,231
REPAIRS	1,321	0	0	1,321
ALLOCATED / CONTRACT MAINTENANCE	0	0	0	0
PREVENTIVE MAIN CONTRACTS	0	0	0	0
TOTAL MAINTENANCE	<u>54,120</u>	<u>0</u>	<u>0</u>	<u>54,120</u>

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
ADMINISTRATION				
ADMINISTRATOR	49,367	0	0	49,367
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	13,714	0	0	13,714
ASSIST. ADMINSTRATOR	0	0	0	0
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	0	0	0	0
ADMIN. IN TRAINING	0	0	0	0
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	0	0	0	0
BOOKKEEPING / RECPT.	68,106	0	0	68,106
DIRECT BENEFITS AND TAXES	0	0	0	0
INDIRECT BENEFITS AND TAXES	18,920	0	0	18,920
SUB-TOTAL	150,107	0	0	150,107
WANT ADS	309	0	0	309
OTHER ADVERTISING	946	0	0	946
TELEPHONE	5,901	0	0	5,901
DUES AND SUBSCRIPTION	6,655	0	0	6,655
EQUIPMENT RENTAL	401	0	0	401
SUPPLIES	4,135	0	0	4,135
PRINTING	0	0	0	0
POSTAGE AND FREIGHT	518	0	0	518
INTEREST	0	0	0	0
BANK CHARGES	-1,185	0	0	-1,185
LICENSES	2,269	0	0	2,269
ACCOUNTING	27,512	0	0	27,512
LEGAL	0	0	0	0
OTHER	0	0	0	0
DATA PROCESSING	1,002	0	0	1,002
MILEAGE	294	0	0	294
TRAVEL	409	0	0	409
SEMINARS AND TRAINING	435	0	0	435
INSERVICE - EDUCATION	0	0	0	0
PUBLIC RELATIONS	1,082	0	0	1,082
OTHER	0	0	0	0
ALLOC ADMINISTRATION	0	0	0	0
SUB - TOTAL	200,790	0	0	200,790
CENTRAL OFFICE ALLOCATION FROM WV20				22,328
TOTAL ADMINISTRATIVE COSTS				223,118

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
CENTRAL OFFICE ADMINISTRATION				
ADMINISTRATION	0	0	0	0
OTHER ADMINISTRATION	14,145	0	0	14,145
ACCOUNTING	0	0	0	0
CLERICAL	0	0	0	0
SUB - TOTAL	<u>14,145</u>	<u>0</u>	<u>0</u>	<u>14,145</u>
ADVERTISING	0	0	0	0
WANT ADS	0	0	0	0
TELEPHONE	0	0	0	0
DUES & SUBSCRIPTIONS	0	0	0	0
INSURANCE	0	0	0	0
EQUIPMENT RENTAL	0	0	0	0
SUPPLIES	365	0	0	365
PRINTING	0	0	0	0
POSTAGE & FREIGHT	46	0	0	46
BANK CHARGES	0	0	0	0
LICENSES	0	0	0	0
ACCOUNTING	0	0	0	0
LEGAL	3,165	0	0	3,165
OTHER	747	0	0	747
DATA PROCESSING	0	0	0	0
DEPRECIATION	0	0	0	0
OTHER	0	0	0	0
TRAVEL	0	0	0	0
SEMINARS & TRAINING	0	0	0	0
PUBLIC RELATIONS	0	0	0	0
PAGE TOTAL	<u>18,468</u>	<u>0</u>	<u>0</u>	<u>18,468</u>

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
CENTRAL OFFICE (CONT'D)				
NON-ADMINISTRATIVE SALARIES	0	0	0	0
SUB - TOTAL	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
PAYROLL TAXES & BENEFITS				
FICA	1,082	0	0	1,082
STATE UNEMPLOYMENT	0	0	0	0
FEDERAL UNEMPLOYMENT	0	0	0	0
WORKER'S COMPENSATION	0	0	0	0
GROUP HEALTH	0	0	0	0
GROUP LIFE	0	0	0	0
SUB - TOTAL	<u>1,082</u>	<u>0</u>	<u>0</u>	<u>1,082</u>
UTILITIES				
HEATING	0	0	0	0
ELECTRICITY	0	0	0	0
WATER & SEWER	0	0	0	0
GARBAGE & FIRE	0	0	0	0
SUB - TOTAL	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
TAXES & INSURANCE	1,414	0	0	1,414
COST OF CAPITAL	1,364	0	0	1,364
TOTAL CENTRAL OFFICE EXPENSES	<u>22,328</u>	<u>0</u>	<u>0</u>	<u>22,328</u>

	Allocation To	Number of Facilities
Non-Nursing Facilities	0	0
Other Nursing Facilities	0	0
Anytown Nursing Home	22,328	

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
PAYROLL TAXES				
FICA	62,151	0	0	62,151
STATE UNEMPLOYMENT	14,652	0	0	14,652
FEDERAL UNEMPLOYMENT	5,103	0	0	5,103
WORKERS COMP	42,517	0	0	42,517
SUB - TOTAL	124,423	0	0	124,423
EMPLOYEE BENEFITS				
GROUP HEALTH	111,458	0	0	111,458
GROUP LIFE	0	0	0	0
PENSION	0	0	0	0
DISABILITY	0	0	0	0
OTHER	2,387	0	0	2,387
temp	0	0	0	0
SUB - TOTAL	113,845	0	0	113,845
TOTAL TAXES AND BENEFITS	238,268	0	0	238,268

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
 PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
 ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
UTILITIES				
HEATING	2,727	0	0	2,727
ELECTRICITY	18,018	0	0	18,018
WATER	7,891	0	0	7,891
SEWER	9,346	0	0	9,346
GARBAGE	6,329	0	0	6,329
FIRE SERVICE	0	0	0	0
OTHER	0	0	0	0
SUB - TOTAL	44,311	0	0	44,311
TAXES AND INSURANCES				
REAL PROP. TAX	11,907	0	0	11,907
PERSONAL PROP TAX	0	0	0	0
BUSINESS TAX	142,735	0	0	142,735
INSURANCE - PROPERTY	0	0	0	0
INSURANCE - LIABILITY	7,969	0	0	7,969
INSURANCE - MALPRACTICE	0	0	0	0
INSURANCE - OTHER	0	0	0	0
TOTAL TAXES AND INSURANCE	162,611	0	0	162,611

SCHEDULE OF EXPENSES

FACILITY NAME: Anytown Nursing Home
PERIOD BEGINNING: 1/1/2007

MEDICAID #: 0001234000
ENDING: 6/30/2007

<u>ACCOUNT DESCRIPTION</u>	<u>PER BOOKS</u>	<u>ADJ DR</u>	<u>ADJ CR</u>	<u>ADJUSTED</u>
COST OF CAPITAL				
DEPRECIATION - LAND IMPROVEMENTS	0	0	0	0
DEPRECIATION - BUILDINGS	58,304	0	0	58,304
DEPRECIATION - BLDG IMPROVEMENTS	0	0	0	0
DEPRECIATION - EQUIPMENT	0	0	0	0
DEPRECIATION - LEASEHOLD IMPROVEMENT	0	0	0	0
RENT - BUILDING	0	0	0	0
RENT - EQUIPMENT	0	0	0	0
INTEREST - BUILDING	16,182	0	0	16,182
INTEREST - EQUIPMENT	0	0	0	0
AMORTIZED FINANCING COST	238	0	0	238
AMORTIZED ORGANIZATIONAL COST	0	0	0	0
AMORTIZED START - UP COST	0	0	0	0
OTHER	0	0	0	0
TOTAL CAPITAL COSTS	<u>74,724</u>	<u>0</u>	<u>0</u>	<u>74,724</u>

MEDICAID GROUPING REPORT

Anytown Nursing Home

PERIOD ENDING 6/30/2007

MEDICAID NUMBER 0001234000

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF- M'CAID COA	FACILITY'S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
901						
CASH - PAYROLL CHECKING	1020	1010002	5,000	1,000	6,000	
CASH - EMPLOYEE	1030	1010003	7,728	3,000	10,728	
CASH - POPCORN & BENEFIT	1030	1010004	1,070	-3,000	-1,930	
INVESTMENTS - CD'S & REPO	1031	1010015	79,191	0	79,191	
CASH - EMPLOYEE HEALTH IN	1041	1010008	3,848	0	3,848	
PETTY CASH	1041	1010019	700	0	700	
						98,537
902						
CASH - PATIENT FUND - NOW	1051	1010007	0	-1,000	-1,000	
CASH - INTEREST ON CONST	1060	1010009	11,528	0	11,528	
						10,528
905						
PATIENT RECEIVABLE'S	1070	1050001	632,890	0	632,890	
PART B RECEIVABLE	1081	1050004	46,361	0	46,361	
COST REPORT RECEIVABLE	1100	1050010	-22,807	0	-22,807	
INTEREST RECEIVABLE	1100	1050008	185	0	185	
INCONTENENTS RECEIVABLE-U	1100	1050007	4,853	0	4,853	
PT OT ST RECEIVABLE	1100	1050005	30,115	0	30,115	
OTHER RECEIVABLES	1100	1050006	124,489	0	124,489	
						816,086
906						
CASH - MONEY MARKET	1111	1010010	547,086	0	547,086	
						547,086
907						
ALLOWANCE FOR DOUBTFUL AC	1120	1050002	-31,874	0	-31,874	
						-31,874
911						
NURSING INVENTORY	1131	1100003	19,279	0	19,279	
						19,279
913						
DIETARY INVENTORY	1133	1100001	7,371	0	7,371	
						7,371
915						
HOUSEKEEPING INVENTORY	1135	1100002	2,188	0	2,188	
						2,188
921						
PREPAID INSURANCE	1140	1200002	8,719	0	8,719	
						8,719
1002						
LAND	1200	1510000	82,156	0	82,156	
						82,156

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF- M'CAID COA	FACILITY' S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
1003 LAND IMPROVEMENTS	1210	1520000	20 682	0	20 682	20 682
1004 CUTLIP BUILDING	1220	1560000	28,792	0	28 792	
BUILDING	1220	1530000	2,069,099	0	2,069,099	
Building Improvements	1220	1550000	19 690	0	19 690	2,117,581
1008 EQUIPMENT AND FURNITURE	1240	1580000	709,392	0	709,392	709,392
1016 ACCUM DEPREC LAND IMPROV	1291	1520001	-11,377	0	-11,377	-11 377
1017 Acc Dep -- Building Impro	1292	1550001	-1,231	0	-1,231	
ACCUM DEPREC CUTLIP BLDG	1292	1560001	-21,020	0	-21,020	
ACCUM DEPREC BUILDINGS	1292	1530001	-846,274	0	-846,274	-868 525
1019 ACCUM DEPREC EQMT & FURN	1294	1580001	-471 022	0	-471 022	-471,022
1029 OTHER DEPOSITS & PPD EXPE	1300	1200003	10,578	0	10 576	
WORKER'S COMPENSATION DEP	1303	1200001	24 835	0	24,835	35 211
1030 ORGANIZATION COSTS	1310	1700000	47,799	0	47,799	
ACCUM AMORT ORGANIZATION	1310	1700001	-47,799	0	-47,799	0
1034 BOND ISSUE COSTS	1341	1710000	73,448	0	73,448	
ACCUM AMORT BOND ISSUE CO	1341	1710001	-73,448	0	-73,448	0
1101 PT OT ST PAYABLE	3010	2060000	-28,227	0	-28,227	
ACCOUNTS PAYABLE	3010	2010000	-55,250	0	-55,250	
ACCRUED PROFESSIONAL SERV	3011	2010005	-2,958	0	-2,958	
ADVANCE BILLING	3024	2160003	-74,742	0	-74,742	
DUE TO BLFD HEALTH SYSTEM	3024	2050000	-29,955	0	-29,955	-191,132
1103 SALARIES PAYABLE	3030	2020000	-21,013	0	-21,013	
CASH - GENERAL CHECKING	3030	1010001	26,209	0	26,209	5,186
1105 EMPLOYEE NEW YORK LIFE	3080	2130005	-161	0	-161	
EMPLOYEE DENTAL FUND	3080	2130010	394	0	394	

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF- M'CAID COA	FACILITY' S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
PAUL REVERE DIABILITY W/H	3080	2130004	61	0	61	
EMPLOYEE HEALTH FUND PAYA	3080	2130001	-35,714	0	-35,714	-35,420
1106 FICA WITHHELD	3051	2110001	-8,692	0	-8,692	-8,692
1107 FEDERAL WITHHELD	3052	2110002	-4,956	0	-4,956	-4,956
1108 WV STATE TAX WITHHELD	3053	2110004	-4,268	0	-4,268	-4,268
1112 GARNISHEES WITHHELD	3063	2130008	-110	0	-110	-110
1117 ACCRUED STATE UNEMPL TAX	3073	2140003	-10,575	0	-10,575	-10,575
1118 ACCRUED FED'L UNEMPL TAX	3072	2140004	-3,669	0	-3,669	-3,669
1120 ACCRUED VACATION COSTS	3041	2160001	-61,954	0	-61,954	
ACCRUED WORKERS COMPENSAT	3043	2140005	-17,882	0	-17,882	-79,836
1123 ACCRUED PROVIDER TAX	3080	2150003	-19,083	0	-19,083	
ACCRUED LOCAL B & O	3080	2150009	-14,497	0	-14,497	-33,580
1132 PATIENT PERSONAL FUND PAY	3090	2030000	-85,459	0	-85,459	-85,459
1203 BONDS PAYABLE	3200	2500001	-350,505	0	-350,505	-350,505
1209 COMMON STOCK	5012	2700000	-800,000	0	-800,000	
ADDITIONAL PAID IN CAPITA	5014	2750000	-18,212	0	-18,212	-818,212
1212 RETAINED EARNINGS	5020	2900000	-1,544,264	0	-1,544,264	-1,544,264
1401 ROOM & BOARD PRIVATE	6010	3010008	-202,972	0	-202,972	-202,972
1408 OT - MEDICARE PART A	6050	3010015	-84,525	0	-84,525	
ST - MEDICARE PART A	6050	3010020	-9,925	0	-9,925	

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF- M'CAID COA	FACILITY' S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
PT - MEDICARE PART A	6050	3010010	-84,150	0	-84,150	
MEDICARE PART B	6050	3010007	-73,892	0	-73,892	
ROOM & BOARD MEDICARE	6050	3010002	-93,937	0	-93,937	-328 429
1409						
ROOM & BOARD MEDICAID	6060	3010003	-1,751,270	0	-1,751,270	
OT - MEDICAID	6060	3010045	-6,350	0	-6,350	
PT - MEDICAID PART B	6060	3010055	-58,975	0	-58,975	
OT - MEDICAID PART B	6060	3010060	-31 100	0	-31 100	
ST - MEDICAID PART B	6060	3010065	-13,825	0	-13,825	
PT - MEDICAID	6060	3010040	-2,875	0	-2,875	-1 864 395
1412						
INCONTENENT-UMWA	6070	3010145	-6,783	0	-6,783	
MEDICARE- A SUPPLIES INCO	6070	3010125	-38 736	0	-38,736	
MEDICARE- A PHARMACY INCO	6070	3010130	-32,952	0	-32,952	
PRIVATE SUPPLIES INCOME	6070	3010140	-937	0	-937	
OT - PRIVATE PT B	6070	3010090	-7,655	0	-7,655	
PT - PRIVATE B	6070	3010085	27 725	0	-27,725	
ST - PRIVATE PT B	6070	3010095	-15,325	0	-15,325	
MEDICAID SUPPLIES INCOME	6070	3010135	-12 734	0	-12,734	-142 847
1417						
MEDICARE-A TRANSPORT	6080	3010165	-905	0	-905	-905
1420						
MEDICARE-A LAB	6151	3010155	-5,686	0	-5,686	
CONTRACTUALS MA LAB	6152	3099165	5,686	0	5,686	
MEDICARE-A XRAY	6161	3010160	-178	0	-178	
CONTRACTUALS MA XRAY	6162	3099160	178	0	178	0
1501						
CASH RECEIPTS - OTHER	6170	3100006	-221	0	-221	-221
1505						
VENDING MACHINE INCOME	6176	3100004	-1 017	0	-1,017	-1,017
1506						
RENTAL INCOME	6177	3100005	-327	0	-327	-327
1508						
INTEREST INCOME	6180	3100003	-13,351	0	-13,351	-13,351
1517						
CONTRACTUALS MA TRANSPORT	6190	3099165	905	0	905	905
1518						
CONTRACTUALS-PT MEDICAR A	6191	3099010	84,150	0	84,150	
CONTRACTUALS-OT MEDICAR A	6191	3099015	64 525	0	64 525	

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF- M'CAID COA	FACILITY' S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
CONTRACTUALS-ST MEDICAR A	0191	3099020	9,925	0	9,925	
CONTRACTUALS MEDICARE	0191	3099002	-14,379	0	-14,379	144,221
1519						
CONTRACTUALS-ST MEDICAD B	0192	3099065	4,839	0	4,839	
CONTRACTUALS-PT MEDICAID	0192	3099040	2,875	0	2,875	
CONTRACTUALS-OT MEDICAID	0192	3099045	6,350	0	6,350	
CONTRACTUALS-PT MEDICAD B	0192	3099055	20,641	0	20,641	
CONTRACTUALS-OT MEDICAD B	0192	3099080	10,885	0	10,885	
CONTRACTUALS, MEDICAID	0192	3099003	-68,259	0	-68,259	-20,669
1620						
CONTRACTUALS, UMWA	0193	3099005	-5,348	0	-5,348	
COST REPORT SETTLEMENT AC	0193	3099150	205,140	0	205,140	
CONTRACTUALS, PART B	0193	3099007	20,124	0	20,124	
CONTRACTUALS INCONTINENT	0193	3099145	2,584	0	2,584	
CONTRACTUALS PRIVATE SUPP	0193	3099140	937	0	937	
CONTRACTUALS MEDICAID SUP	0193	3099135	12,734	0	12,734	
CONTRACTUALS CARE A PHARM	0193	3099130	32,952	0	32,952	
CONTRACTUALS CARE A SUPPL	0193	3099125	38,736	0	38,736	
CONTRACTUALS-ST PRIVATE B	0193	3099095	5,364	0	5,364	
CONTRACTUALS-OT PRIVATE B	0193	3099090	2,679	0	2,679	
CONTRACTUALS-PT PRIVATE B	0193	3099085	9,704	0	9,704	325,806
1603						
SALARY DON & ADON	7010	4000001	14,979	0	14,979	
NURSING CONSULTANT	7013	4000006	1,015	0	1,015	15,994
1606						
SALARY RN'S	7020	4000002	41,289	0	41,289	41,289
1609						
SALARY LPN'S	7030	4000003	170,131	0	170,131	170,131
1612						
SALARY NURSING ASSTS	7040	4000004	241,733	0	241,733	241,733
1616						
NURSING SUPPLIES - PERSON	7050	4000018	6,346	0	6,346	
MEDICARE A BILLABLE SUPPL	7050	4000050	265	0	265	
NURSING SUPPLIES	7050	4000020	42,177	0	42,177	
LAUNDRY - SNF	7050	4000088	1,353	0	1,353	
INFECTIOUS WASTE - SNF	7050	4000087	477	0	477	
Incontinent UMWA supplies	7051	4000028	790	0	790	
MEDICARE A NON-BILL SUPPL	7051	4000060	1,683	0	1,683	
PRIVATE NON-BILLABLE SUPP	7051	4000080	2,345	0	2,345	
MEDICAID NON-BILLABLE SUP	7051	4000067	20,432	0	20,432	
EDUCATION INSERVICE	7053	4800068	2,700	0	2,700	
UNACCOUNTED SUPPLIES	7054	4000040	6	0	6	

<u>PAGE LINE</u> <u>REFERENCE/FACILITY</u> <u>ACCOUNT</u> <u>DESCRIPTION</u>	<u>CROSS REF-</u> <u>M'CAID COA</u>	<u>FACILITY'</u> <u>S COA</u> <u>NUMBER</u>	<u>PER</u> <u>BOOKS</u>	<u>NET</u> <u>ADJUSTMENTS</u>	<u>ADJUSTED</u> <u>BALANCE</u>	<u>M'CAID</u> <u>(SUB-TOTAL)</u>
NURSING SUPPLIES - INCONT	7058	4000019	30,053	0	30,053	108,807
1617						
NON PRESCRIPTION DRUGS	7060	4000021	3,648	0	3,648	
PRESCRIPTION DRUGS	7060	4000027	496	0	496	4,144
1618						
OXYGEN	7070	4010020	988	0	988	988
1702						
SALARY RESTORATIVE	7210	4100004	31,638	0	31,638	31,638
1707						
PT CONSULTANTS - MEDICAID	7230	4020070	1,442	0	1,442	
PT CONSULTANTS - PART A	7230	4020060	43,084	0	43,084	44,526
1708						
ST CONSULTANTS - MEDICAID	7240	4020090	707	0	707	
ST CONSULTANTS - PART A	7240	4020080	9,367	0	9,367	10,074
1710						
OT CONSULTANTS - MEDICAID	7250	4020110	3,090	0	3,090	
OT CONSULTANTS - PART A	7250	4020100	43,386	0	43,386	46,476
1711						
OT SUPPLIES	7272	4020115	457	0	457	
SUPPLIES RESTORATIVE	7273	4100008	87	0	87	
ST SUPPLIES	7273	4020095	31	0	31	
PT SUPPLIES	7273	4020075	358	0	358	
PT OT ST EXPENSES	7273	4020050	5,646	0	5,646	8,577
1716						
SALARIES ACTIVITIES	7410	4200005	22,027	0	22,027	
SALARY SOCIAL SERVICES	7415	4250001	10,840	0	10,840	32,867
1720						
SUPPLIES ACTIVITIES	7420	4200029	572	0	572	
SUPPLIES SOCIAL SERVICES	7420	4250067	600	0	600	1,172
1722						
TRAINING & EDUCATION-S S	7430	4250084	80	0	80	
FOOD ACCOUNT ACTIVITIES	7433	4200028	5,088	0	5,088	
CONSULTANT SOCIAL SERVICE	7434	4250009	900	0	900	6,046
1802						
SALARY MED REC CLERK	7612	4300002	31,000	0	31,000	31,000
1807						

<u>PAGE LINE</u> <u>REFERENCE/FACILITY</u> <u>ACCOUNT</u> <u>DESCRIPTION</u>	<u>CROSS REF-</u> <u>M'CAID COA</u>	<u>FACILITY'</u> <u>S COA</u> <u>NUMBER</u>	<u>PER</u> <u>BOOKS</u>	<u>NET</u> <u>ADJUSTMENTS</u>	<u>ADJUSTED</u> <u>BALANCE</u>	<u>M'CAID</u> <u>(SUB-TOTAL)</u>
CONSULTANT - MEDICAL DIRE	7821	4300008	13,200	0	13,200	13,200
1808						
CONSULTANT - MEDICAL RECO	7822	4300010	1,854	0	1,854	1,854
1810						
CONSULTANT - PHARMACY	7824	4300009	900	0	900	900
1811						
MEDICAL RECORDS SUPPLIES	7830	4300030	268	0	268	
SUPPLIES MEDICAL RECORDS	7830	4300029	379	0	379	645
1819						
SALARY DIETARY	7810	4400005	86,137	0	86,137	86,137
1824						
SUPPLIES DIETARY	7820	4400028	10,341	0	10,341	10,341
1825						
DISHES & UTENSILS	7830	4400033	488	0	488	488
1826						
CONSULTANT - DIETARY	7840	4400006	3,381	0	3,381	3,381
1831						
FOOD	7860	4400025	98,165	0	98,165	98,165
1832						
MEAL SALES	7870	3100011	-3,378	0	3,378	-3,378
1902						
SALARIES LAUNDRY	8010	4600005	7,503	0	7,503	
SALARIES HOUSEKEEPING	8210	4600005	49,611	0	49,611	57,114
1906						
OT LAUNDRY EXPENSE	8020	4020117	12	0	12	
ST LAUNDRY EXPENSE	8020	4020097	30	0	30	
PT LAUNDRY EXPENSE	8020	4020077	70	0	70	112
1907						
SUPPLIES LAUNDRY	8030	4500029	120	0	120	
SUPPLIES HOUSEKEEPING	8220	4600029	11,970	0	11,970	12,090
1908						
PURCHASED SERVICES LAUNDR	8040	4500027	38,678	0	38,678	38,678
1918						
SALARIES MAINTENANCE	8410	4700005	32,328	0	32,328	

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF- M'CAID COA	FACILITY' S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
						32,328
1920 SUPPLIES MAINTENANCE	8420	4700029	6,282	0	6,282	6,282
1923 PURCHASED SERVICE MAINTEN	8450	4700027	5,231	0	5,231	5,231
1924 REPAIRS	8480	4700053	1,321	0	1,321	1,321
2003 SALARY ADMINISTRATOR	8611	4800001	49,387	0	49,387	49,387
2012 SALARY BOOKKEEPER	8617	4800003	15,942	0	15,942	
SALARY ADMIN ASSISTANT	8617	4800002	21,825	0	21,825	
SALARY DATA PROCESSING	8617	4800005	2,631	0	2,631	
SALARY - INV CONTROL CLK	8617	4800006	20,959	0	20,959	
SALARY RECEPTIONIST	8620	4800004	6,749	0	6,749	68,106
2020 ADVERTISING WANT ADS	8631	4800054	309	0	309	309
2021 ADVERTISING OTHER	8632	4800055	946	0	946	946
2022 TELEPHONE	8640	4800071	5,901	0	5,901	5,901
2023 DUES & SUBSCRIPTIONS	8650	4800062	6,655	0	6,655	6,655
2024 RENTAL EQUIPMENT	8660	4800031	401	0	401	401
2025 TRACKING SUPPLIES	8670	4800015	94	0	94	
SUPPLIES	8670	4800046	90	0	90	
SUPPLIES	8670	4800029	3,951	0	3,951	4,135
2027 POSTAGE	8690	4800063	518	0	518	518
2029 BANK CHARGES	8710	4800065	15	0	15	
TRUSTEES FEES	8712	4900094	-1,200	0	-1,200	-1,185
2030						

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF. M'CAID COA	FACILITY' S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
LICENSES	8720	4800081	2,289	0	2,289	2,289
2032						
PROFESSIONAL SERVICES OTH	8731	4800049	27,512	0	27,512	27,512
2036						
DATA PROCESSING CONSULTAN	8740	4800042	1,002	0	1,002	1,002
2037						
temporary mileage account number	999998	Mileage2	0	294	294	294
2038						
TRAVEL & ENTERTAINMENT	8760	4800060	409	0	409	409
2039						
EDUCATION SEMINARS	8772	4800067	435	0	435	435
2041						
PUBLIC RELATIONS	8790	4800010	1,082	0	1,082	1,082
2102						
FICA EXPENSE	9011	4810011	62,151	0	62,151	62,151
2103						
STATE UNEMPLOY TAX EXPENS	9012	4810013	14,652	0	14,652	14,652
2104						
FEDERAL UNEMPLOY TAX EXPE	9013	4810012	5,103	0	5,103	5,103
2105						
WORKERS COMPENSATION EXPE	9014	4810016	42,517	0	42,517	42,517
2112						
GROUP HEALTH INSURANCE EX	9020	4810017	111,458	0	111,458	111,458
2116						
OTHER EMPLOYEE BENEFITS	9080	4810019	3,119	0	3,119	
VACCINES	9110	4810020	-732	0	-732	2,387
2202						
GAS	9210	4820076	2,727	0	2,727	2,727
2203						
ELECTRICITY	9220	4820072	18,018	0	18,018	18,018
2204						
WATER	9230	4820073	7,891	0	7,891	

PAGE LINE REFERENCE/FACILITY ACCOUNT DESCRIPTION	CROSS REF- M'CAID COA	FACILITY' S COA NUMBER	PER BOOKS	NET ADJUSTMENTS	ADJUSTED BALANCE	M'CAID (SUB-TOTAL)
						7,891
2205						
SEWER	9240	4820074	9,346	0	9,346	9,346
2206						
INFECTIOUS WASTE	9250	4820077	490	0	490	
GARBAGE	9250	4820075	5,839	0	5,839	6,329
2215						
REAL PROPERTY TAX	9411	4830082	11,907	0	11,907	11,907
2217						
B & O TAX LOCAL EXPENSE	9421	4830086	26,501	0	26,501	
PROVIDER TAX EXPENSE	9421	4830084	116,234	0	116,234	142,735
2222						
INSURANCE LIABILITY EXPEN	9432	4830087	7,669	0	7,669	7,669
2304						
DEPRECIATION	9512	4900093	58,304	0	58,304	58,304
2315						
INTEREST EXPENSE	9531	4900091	16,182	0	16,182	16,182
2319						
AMORTIZATION BOND ISSUE C	9541	4900098	238	0	238	238
2402						
PART A MEDICARE PHARMACY	9710	4000025	14,140	0	14,140	14,140
2403						
MEDICARE-A LAB	9720	4015015	5,378	0	5,378	5,378
2404						
ST CONSULTANTS - MCR PT B	9730	4020085	6,060	0	6,060	
OT CONSULTANTS - MCD PT B	9730	4020104	14,724	0	14,724	
ST CONSULTANTS - MCD PT B	9730	4020084	7,573	0	7,573	
MEDICARE-A XRAY	9730	4015020	415	0	415	
MEDICARE-A TRANSPORT	9730	4015010	725	0	725	
PT CONSULTANTS - MCR PT B	9730	4020065	22,786	0	22,786	
OT CONSULTANTS - MCR PT B	9730	4020105	17,361	0	17,361	
MEDICARE B BILLABLE SUPPL	9730	4000055	9,682	0	9,682	
MEDICAID BILLABLE SUPPLIE	9730	4000065	1,325	0	1,325	
PRIVATE BILLABLE SUPPLIES	9730	4000075	116	0	116	
PT CONSULTANTS - MCD PT B	9730	4020064	19,717	0	19,717	100,484
2410						
MILEAGE	8750	4800030	164	0	164	

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

VENDOR OWING A DEBT TO THE STATE:

West Virginia Code §5A-3-10a provides that: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owed is an amount greater than one thousand dollars in the aggregate.

PUBLIC IMPROVEMENT CONTRACTS & DRUG-FREE WORKPLACE ACT:

West Virginia Code §21-1D-5 provides that: Any solicitation for a public improvement construction contract shall require each vendor that submits a bid for the work to submit at the same time an affidavit that the vendor has a written plan for a drug-free workplace policy in compliance with Article 1D, Chapter 21 of the West Virginia Code. A public improvement construction contract may not be awarded to a vendor who does not have a written plan for a drug-free workplace policy in compliance with Article 1D, Chapter 21 of the West Virginia Code and who has not submitted that plan to the appropriate contracting authority in timely fashion. For a vendor who is a subcontractor, compliance with Section 5, Article 1D, Chapter 21 of the West Virginia Code may take place before their work on the public improvement is begun.

ANTITRUST:

In submitting a bid to any agency for the state of West Virginia, the bidder offers and agrees that if the bid is accepted the bidder will convey, sell, assign or transfer to the state of West Virginia all rights, title and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the state of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the state of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to the bidder.

I certify that this bid is made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership or person or entity submitting a bid for the same materials, supplies, equipment or services and is in all respects fair and without collusion or fraud. I further certify that I am authorized to sign the certification on behalf of the bidder or this bid.

LICENSING:

Vendors must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agencies or political subdivision. Furthermore, the vendor must provide all necessary releases to obtain information to enable the Director or spending unit to verify that the vendor is licensed and in good standing with the above entities.

CONFIDENTIALITY:

The vendor agrees that he or she will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the agency's policies, procedures and rules. Vendors should visit www.state.wv.us/admin/purchase/privacy for the Notice of Agency Confidentiality Policies.

Under penalty of law for false swearing (West Virginia Code §61-5-3), it is hereby certified that the vendor acknowledges the information in this said affidavit and is in compliance with the requirements as stated.

Vendor's Name: _____

Authorized Signature: _____ Date: _____

West Virginia Department of Health & Human Resources FEDERAL PROGRAM PARTICIPATION ACKNOWLEDGMENT, AUTHORIZATION, CONSENT, AND RELEASE

No person who is currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs shall be hired by the West Virginia Department of Health and Human Resources.

I am am not currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs.

Signature *Date*

I authorize and consent to a background check by the West Virginia Department of Health and Human Resources specifically to determine whether I am currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs. If hired, I also agree to periodic conduct of additional such background checks during the course of employment by the West Virginia Department of Health and Human Resources.

I release any persons and the West Virginia Department of Health and Human Resources and its agents, officials, representatives, employees, officers, or related personnel both individually and collectively, from any and all liability for damages of any kind that may result because of compliance with this acknowledgment and authorization.

For positive identification purposes, the following information is required when conducting a background check. This information is confidential and will not be used for any other purposes (please print):

Name _____
last name *first name* *middle initial*

Maiden/Other Names _____
(This should include other married names by which you have been known.)

Current Address _____
street/box# *city* *state*

NOTE: Your social security card must be presented for verification purposes.

Social Security # _____ - - _____ **Date of Birth** _____
month/day/year

Driver's License Number _____ **State of Issue** _____

Signature *Date*

EMPLOYING UNIT INFORMATION

Office/Facility/Region/District _____ Contact Person _____
 Fax Number _____ Phone Number _____

FOR OPS USE ONLY

HHS Match Outcome Positive Negative
 GSA Match Outcome Positive Negative Initial _____ Date _____