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RFQ COPY

TYPE NAME/ADDRESS HERE

State of West Virginia
Department of Administration
Purchasing Division

Request for
Quotation 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130

# **Request for**

RFQ NUMBER BHS12047

ADDRESS CORRESPONDENCE TO ATTENTION OF:

ROBERTA WAGNER 304-558-0067

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HEALTH AND HUMAN RESOURCES BBH/HF **ROOM 350** 350 CAPITOL STREET CHARLESTON, WV

25301-3702

304-558-3672

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- 13. HIPAA BUSINESS ASSOCIATE ADDENDUM: The West Virginia State Government HIPAA Business Associate Addendum (BAA), approved by the Attorney General, is available online at www.state.wv.us/admin/purchase/vrc/hipaa.htm and 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.
- 14. 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. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/noticeConfidentiality.pdf.
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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 material, 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.

#### **INSTRUCTIONS TO BIDDERS**

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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

BHS12047

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BBH/HF
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CHARLESTON, WV
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## ADDENDUM #1 BHS12047

1. Many of the requests for technical assistance under Section 2.2 are vaguely written, so it is difficult to understand the requested level of assistance. Accordingly, would you please provide an actual number of hours for each item listed under Section 2.2 for last year or an anticipated number of hours for each item listed under Section 2.2 for the current year?

Response: We can not provide an "actual number". Based on the current contract the estimated number of hours for each item listed under 2.2 would be 9.5 hours per task.

Please provide an agenda from the training sessions for the last year.

Response: We did not have training last year

3. Please provide the due dates of the cost report for each facility and indicate if extensions were filed for the most current year.

Response: November 30 and there were no extensions for FY2010.

4. Please provide the current Medicaid rates set for each facility detailed in Item E.

Response: Please see the attached – Rate Change Letter 2012

5. Will the letters provided to summarize findings/suggestions be available to the public for review?

Response: No, the information provided to the state owned hospitals will not be shared with the public. However, if a Freedom of Information Act is requested the information will be subject to public review.

6. Please provide copies of the most recent cost reports for Hopemont Hospital, Lakin Hospital, John Manchin, Sr. Health Care Center, and Jackie Withrow Hospital.

Response: Please see attachments.

7. On the bid schedule sheet included on page 14 of the RFQ it has a maximum number of hours by level filled in as 15. Does this mean that out-of-scope billings under the contract are limited to 15 hours or was this just for illustrative purposes?

Response: Yes, the out-of-scope billings are limited to a 15 hour maximum.

8. Are you looking for expertise in both Medicare and Medicaid DSH? If not, which are you looking for?

Response: We are looking for expertise specifically in MEDICAID DSH.

9. Who will be responsible for developing the in-service training courses? Is the vendor only responsible for providing the training, not developing the courses?

Response: The vendor will be responsible for developing and providing in-service training courses.

10. We were told by another party that there is a pre-bid conference for RFQ BHS12047. I do not see any mention of one in the RFQ or on the WV Purchasing site. Is there a prebid conference for this RFQ?

Response: No there will not be a pre bid conference for this RFQ.

11. Who was the previous contractor?

Response: Arnett & Foster.

12. What was the previous contract price? Would you please break down that price by the various tasks?

Response: See attached copy of contract.

13. Did the previous contract require the same services as this RFQ?

Response: The previous contract request similar services but the specifications on BHS12047 do differ. Vendors are responsible for bidding the specifications as they are written for BHS12047.

14. May we have a copy of the previous contractor's contract?

Response: See attached copy of previous contract.

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WORKSHEET S II

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

WORKSHEET S-2

#### HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

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21.05 FOR ST	E COST REPORTING PERIOD. ENTER ( TANDARD GEOGRAPHIC RECLASSIFICAT	ION (NOT WAGE), WHAT IS	S YOUR STATUS AT TI	HE END OF THE	2				21.05
21.06 DOES T	REPORTING PERIOD. ENTER (1) URBAI THIS HOSPITAL QUALITY FOR THE THI RURAL HOSPITAL UNDER THE PROSPE DRA SECTION 5105? ENTER 'Y' FOR	REE-YEAR TRANSITION OF CTIVE PAYMENT SYSTEM FO	HOLD HARMLESS PAYI OR HOSPITAL OUTPAT	MENTS FOR A LENT SERVICES	ИО				21.06
22 PBE VC	OU CLASSIFIED AS A REFERRAL CENT THIS FACILITY OPERATE A TRANSPLA	ER?	ER CERTIFICATION D	ATE(S) BELOW	NO NO				22 23
23.01 IF TH)	IS IS A MEDICARE CERTIFIED KIDNE	Y TRANSPLANT CENTER, E	NTER THE CERTIFICA	TION DATE					23.01
23.02 IF TH	L. 2 AND TERMINATION IN COl. 3. IS IS A MEDICARE CERTIFIED HEART	TRANSPLANT CENTER, EN	TER THE CERTIFICAT	ION DATE					23.02
23.03 IF TH	L. 2 AND TERMINATION IN COL. 3. IS IS A MEDICARE CERTIFIED LIVER	TRANSPLANT CENTER, EN	TER THE CERTIFICAT	ION DATE					23.03
23.04 IF TH	L. 2 AND TERMINATION IN COL. 3. IS IS A MEDICARE CERTIFIED LUNG	TRANSPLANT CENTER, ENT	ER THE CERTIFICATION	ON DATE					23.04
23.05 IF ME	L. 2 AND TERMINATION IN COL. 3. DICARE PANCREAS TRANSPLANTS ARE	PERFORMED SEE INSTRUCT	IONS FOR ENTERING	CERTIFICATION					23.05
23.06 IF TH	ERMINATION DATE. IS IS A MEDICARE CERTIFIED INTES	TINAL TRANSPLANT CENTE	R, ENTER THE CERTI	FICATION					23.06
23.07 IF TH	IN COL. 2 AND TERMINATION IN COL IS IS A MEDICARE CERTIFIED ISLET	3. Transplant center ent	ER THE CERTIFICATI	ON DATE					23.07
24 IF TH	L. 2 AND TERMINATION IN COL. 3. IS AN ORGAN PROCUREMENT ORGANIZA	ATION (OPO), ENTER THE	OPO NUMBER IN COL	2.					24
24 01 TF TH	ERMINATION IN COL. 3. IS A MEDICARE TRANSPLANT CENTER;	ENTER THE CCN (PROVID	ER NUMBER) IN COL	2, THE					24.01
CERTI 25 IS TH	FICATION DATE OR RECERTIFICATION IS A TEACHING HOSPITAL OR AFFILI	DATE LAFTER DECEMBER	26, 2007) IN COL 3	•	NO				25
25.01 IS TH 25.02 IF LI	NTS FOR I & R? IS TEACHING PROGRAM APPROVED IN NE 25.01 IS YES, WAS MEDICARE PA FECT DURING THE FIRST MONTH OF T	ARTICIPATION AND APPROV THE COST REPORTING PERI	OD? IF YES, COMPLE	m SIMIUS	NO				25.01 25.02
WORKS	HEET E-3, PART IV. IF NO, COMPLE	ETE WORKSHEET D-2, PART COST REIMBURSEMENT FO	TII. OR PHYSICIANS' SERV		NO				25.03
DEFIN	ED IN CMS PUB. 15-I, SECTION 214	18? IF YES, COMPLETE WO	ORKSHEET D-9.	D-2	NO				25.04
25.05 HAS Y	OUR FACILITY DIRECT GME FTE CAP R 413.79(c)(3) OR 42 CFR 412.105	(COLUMN 1) OR IME CAP 5(f)(1)(iv)(B)? ENTER ' FIONS)	Y' FOR YES AND 'N'	FOR NO IN					25.05
25.06 HAS Y	OUR FACILITY RECEIVED ADDITIONAL MENT CAP SLOTS UNDER 42 CFR 413.7 MD 'N' FOR NO IN THE APPLICABLE	DIRECT GME FTE RESIDE	105(1)(1)(10)(0)?	IE FTE ENTER 'Y' FOR					25.06

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> WORKSHEET S-2 (CONTINUED)

### HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

				, , ,	
OTI 2	ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR				26
2	NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.  6.01 ENTER THE APPLICABLE SCH DATES:  6.03 IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT				26.01 26.03
2	AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA. 6.04 IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):				26.04
2	BEGINNING: ENDING: BEGINNING: ENDING:	NO			27
2	FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN ALCED CARE				28
0.77.0	OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02. 8.01 IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER				28.01
	THE COLE 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1ST				28.02
2	8.02 ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				
	A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SHE REVENUE FROM WORKSHEET G-2, PART 1, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)				
	8.03 STAFFING	0.00		N	28.03 28.04
	8.09 RECRUITMENT	0.00		N	28.05
	8.06 TRAINING 8.07 OTHER (SPECIFY)	0.00		14	28.07
	TO THE A PHOAT HASPITAL WITH A CERTIFIED SNE WHICH HAS FEWER THAN 50 BEDS IN THE	ИО			29
	AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURGENTS  DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS	по			30
3	HOSPITAL (CAH)? SEE 42 CFR 485.606ff. 80.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH?				30.01
3	SEE 42 CFR 413.70. 80.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF				30.02
	PAYMENT FOR OUTPATIENT SERVICES?  80.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE				30.03
3	ON OR AFTER 12/21/2000) 30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR 16R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE	1			30.04
3	WORKSHEET D-2, PART II.  13 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE?  SEE 42 CFR 412.113(c).	ИО			31
	ISCELLANEOUS COST REPORTING INFORMATION 32 IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY)	NO			32
	IN COLUMN 2.  33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR YES AN	Ю			33
	DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	MO			34
	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(1) TEFRA?  HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(1)?	МО			35
		V 1	XVIII	X1X 3	Κ.
-	ROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	МО	36 36.01
	36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	МО		200	5/5/E/E/E/E
	THE ACCEPTATE OF THE PROPERTY	ИО	NO	МО	37 37.01
-	37.01 IF 100 ARC A BOLD BARTLESS FROTEDRY RING TO TEST				

### HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 (CONTINUED)

38 38. 38.	C XIX INPATIENT HOSPITAL SERVICES  DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?  DI IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN  DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?  ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?  DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	PART? NO NO NO NO		38 38.01 38.02 38.03 38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-1,	YES	3	40
	CHAPTER 107 IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE	00		
	PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.			
40	ol name: FI/Contractor's name:	FI/CONTRAC	CTOR'S NUMBER:	40.01
		P.O.BOX:		40.02
	O3 CITY:	STATE:	ZIP CODE:	40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YE	S	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YE	S	42
	DI ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.01
	D2 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO		43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ON	ILY? NO		44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT	r? NO		45
7.5	SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLU	MN 2.		
45	01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?			45.01
	02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			45.02
	03 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMO DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASE	ED SNF)		46
	DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.			

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

	Ē	PART A	PART B	OUTPATIENT ASC	OUTPATIEN RADIOLOGY		UTPATIENT IAGNOSTIC			
47 48 49 50	HOSPITAL SUBPROVIDER I SKILLED NURSING FACILITY HOME HEALTH AGENCY	1 N N N	2 N N N	и и	4 N N		5 N N			47 48 49 50
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FO	R EXTRAORDII	NARY CIRCUMSTA	NCES IN ACCORDAN	CE WITH	Ю				52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HEXCEPTION PAYMENT PURSUANT TO 42 CFR 412	ARMLESS PRO	VIDER ARE YOU I	LIGIBLE FOR THE	SPECIAL	ИО				52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL EFFECT. ENTER BEGINNING AND ENDING DATES	, (MDH), ENTI OF MDH STA	ER THE NUMBER ( TUS ON LINE 53	OF PERIODS MDH S .01. SUBSCRIPT I	STATUS IN LINE					53
53.01 54	53.01 FOR NUMBER OF PERIODS IN EXCESS OF MDH PERIOD: LIST AMOUNTS OF MALPRACTICE PREMIUMS AND		BEGINNING:	DATES.	ENDING:					53.01 54
	PREMIUMS: PAID LOSSES: ARE MALPRACTICE PREMIUMS AND PAID LOSSES GENERAL COST CENTER? IF YES, SUBMIT SUPP	REPORTED I	AND/OR SELF IN N OTHER THAN T	HE ADMINISTRATIV	/E AND AMOUNTS	МО				54.01
55	CONTAINED THEREIN.  DOES YOUR FACILITY QUALIFY FOR ADDITIONA 42 CFR 412,107. ENTER 'Y' FOR YES AND 'N	AL PROSPECTI	VE PAYMENT IN	ACCORDANCE WITH		Ю				55
	42 CFR 412.107, ENTER 11 FOR 125 AND 1	Y POR BOT			DATE	Y/N 1	LIMIT 2	У/N 3	FEES	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES PROVIDED FROM YOUR FISCAL INTERMEDIARY. NO ENTRY IS REQUIRED IN COL 2. IF COL 1 WHETHER THIS IS YOUR FIRST YEAR OF OPERJENTER IN COL 4, IF APPLICABLE, THE FEE SEGINNING ON OR AFTER 4/1/2002.	IF THIS IS IS 'Y', ENT ATIONS FOR R	FIRST YEAR OF ER 'Y' OR 'N' ENDERING AMBUL	OPERATIONS, IN COL 3 ANCE SERVICES.	1.1	ИО	0.00	NO		56
57 58	ARE YOU CLAIMING NURSING AND ALLIED HEAD ARE YOU AN INPATIENT REHABILITATION FACTOR	ILITY (IRF),	OR DO YOU CON	TAIN AN IRF SUB	PROVIDER?	ио				57 58
	ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FO PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y AVAILABLE FOR COST REPORTING PERIODS BEV	' FOR YES AN SINNING ON O	D 'N' FOR NO. R AFTER 1/1/20	THIS OPTION IS O	ONLY 0/1/2002.					58.01
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACTOR REPORTING PERIOD ENDING ON OR BEFORE OR 'N' FOR NO. IS THE FACTLITY TRAINING WITH FR VOL 70, NO 156 DATED AUGUST 15, 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, IF THE CURRENT COST REPORTING PERIOD COOR IF THE SUBSEQUENT ACADEMIC YEARS OF	RE NOVEMBER RESIDENTS I 2005 PAGE 4 2, OR 3 RESP VERS THE BEG	15, 2004? ENTE N A NEW TEACHI 7929? ENTER IN ECTIVELY IN CO INNING OF THE	R IN COLUMN 1 '' NG PROGRAM IN A COLUMN 2 'Y' FO LUMN 3 (SEE INS' FOURTH ENTER 4	Y' FOR YES CCORDANCE OR YES OR TRUCTIONS) IN COLUMN 3,					VV,V-
59	(SEE INSTRUCTIONS) ARE YOU A LONG TERM CARE HOSPITAL (LTCH ENTER IN COLUMN 1 'Y' FOR YES AND 'N' F PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y	OR NO. IF YE	S HAVE YOU MAD	E THE ELECTION	FOR 100% NS)	NO				59

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 (CONTINUED)

60

60.01

ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A
NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)

60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT
COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N'
FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH
42 CFR SEC. 412.424(d) (1) (111) (2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2
IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST
REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE
SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)

61

DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

FTE/ STATE: ZIP CODE CBSA CAMPUS 5

NO

NO

COUNTY:

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2,01	TITLE V 3	TITLE XVIII	/ O/P VISITS LTCH NONCOVERED DAYS 4.01	/ TRIPS TITLE XIX 5	OBS. BEDS ADMITTED 5.01
1	HOSPITAL ADULTS & PEDS, EXCL								1
_	SWING BED, OBSERV & HOSPICE DAYS								2
2	HMO								2
3	HOSPITAL ADULTS & PEDS -								3
	SWING BED SNF								4
4	HOSPITAL ADULTS & PEDS - SWING BED NF								4
5	TOTAL ADULTS & PEDS								5
•	EXCL OBSERVATION BEDS								
6	INTENSIVE CARE UNIT		2						6
7	CORONARY CARE UNIT								7
8	BURN INTENSIVE CARE UNIT								8
9	SURGICAL INTENSIVE CARE UNIT								. 9
10	OTHER SPECIAL CARE (SPECIFY)								10 11
11	NURSERY								12
12 13	TOTAL HOSPITAL RPCH VISITS								13
14	SUBPROVIDER I								14
15	SKILLED NURSING FACILITY '								15
16	NURSING FACILITY	98	35770					34023	16
17	OTHER LONG TERM CARE								17
18	HOME HEALTH AGENCY								18
20	ASC (DISTINCT PART)								20
21	HOSPICE (DISTINCT PART)								21 23
23	O/P REHAB PROVIDER								24
24 25	RHC I TOTAL	98							25
26	OBSERVATION BED DAYS	90							26
27	AMBULANCE TRIPS								27
28	EMPLOYEE DISCOUNT DAYS								28

WORKSHEET S-3

## HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

----I/P DAYS / O/P VISITS / TRIPS--OBS. OBS. OBS. LESS 16R
BEDS NOT TOTAL ALL BEDS BEDS NOT REPL NON- EMPLOYEES MONDAID
ADMITTED PATIENTS ADMITTED ADMITTED

	COMPONENT		TOTAL ALL PATIENTS 6	BEDS ADMITTED 6.01	BEDS NOT ADMITTED 6.02	TOTAL 7	REPL NON- PHYS ANES 8	NET 9	ON PAYROLL 10	WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL.										1
- 2	SWING BED, OBSERV & HOSPICE DA	YS									2
2	HMO XIX										3
3	HOSPITAL ADULTS & PEDS -										•
	SWING BED SNF										4
4	HOSPITAL ADULTS & PEDS -										
2	SWING BED NF										5
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS										_
6	INTENSIVE CARE UNIT										6
7	CORONARY CARE UNIT										8
8	BURN INTENSIVE CARE UNIT										9
9	SURGICAL INTENSIVE CARE UNIT					9.					10
10	OTHER SPECIAL CARE (SPECIFY)										11
11	NURSERY										12
12	TOTAL HOSPITAL										13
13	RPCH VISITS										14
14	SUBPROVIDER I SKILLED NURSING FACILITY								64696 6866		15
15 16	NURSING FACILITY		34622						167.00		16
17	OTHER LONG TERM CARE										17 18
18	HOME HEALTH AGENCY										20
20	ASC (DISTINCT PART)										21
21	HOSPICE (DISTINCT PART)										23
23	O/P REHAB PROVIDER										24
24	RHC I								167.00		25
25	TOTAL										26
26	OBSERVATION BED DAYS AMBULANCE TRIPS										27
27 28	EMPLOYEE DISCOUNT DAYS										28
20	Diff Doubly Droopout Diffe										

PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

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### HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I (CONTINUED)

						(CONTINUED)
			DISCH/			
	COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
	HOSPITAL ADULTS & PEDS, EXCL.					1
	SWING BED, OBSERV & HOSPICE DAYS HMO XIX					2
3	HOSPITAL ADULTS & PEDS -					3 .
4	SWING BED SNF HOSPITAL ADULTS & PEDS -					4
4	SWING BED NF					5
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT		#8			8
9	SURGICAL INTENSIVE CARE UNIT					10
10	OTHER SPECIAL CARE (SPECIFY)					11
11	NURSERY					12
12	TOTAL HOSPITAL					13
13	RPCH VISITS					14
14	SUBPROVIDER I					15
15	SKILLED NURSING FACILITY					16
16	NURSING FACILITY					17
17	OTHER LONG TERM CARE					18
18	HOME HEALTH AGENCY					20
20	ASC (DISTINCT PART)					21
21	HOSPICE (DISTINCT PART)					23
23	O/P REHAB PROVIDER					24
24	RHC I					25
25	TOTAL					26
26	OBSERVATION BED DAYS					27
27	AMBULANCE TRIPS					28
28	EMPLOYEE DISCOUNT DAYS					20

WORKSHEET S-3

ADJUSTED PAID HOURS AVERAGE RECLASS. HOSPITAL WAGE INDEX INFORMATION HOURLY WAGE PART II OF SALARIES SALARIES RELATED DATA TO SALARY (COL.3 / AMOUNT FROM WKST. (COL.1 + PART II - WAGE DATA COL. 4) SOURCE COL. 2) IN COL. 3 REPORTED A-6 6 SALARIES 1 2 4360870 TOTAL SALARIES NON-PHYSICIAN ANESTHETIST PART A NON-PHYSICIAN ANESTHETIST PART B 2 NON-PHYSICIAN ARESTHETIST PART B
PHYSICIAN - PART A
4.01 TEACHING PHYSICIAN SALARIES
PHYSICIAN - PART B
5.01 NON-PHYSICIAN - PART B
6 INTERNS & RESIDENTS (IN APPR PGM)
6.01 CONTRACT SERVICES, 1&R
7 HOME OFFICE PERSONNEL 4.01 5.01 6.01 8.01 2227271 269592 8.01 EXCLUDED AREA SALARIES OTHER WAGES & RELATED COSTS OTHER WAGES & RELATED COSTS

9 CONTRACT LABOR

9.01 PHARMACY SERVICES UNDER CONTRACT

9.02 LABORATORY SERVICES UNDER CONTRACT

9.03 MANAGEMENT AND ADMINISTRATIVE SERVICES'

10 CONTRACT LABOR: PHYSICIAN PART A

10.01 TEACHING PHYSICIAN UNDER CONTRACT

11 HOME OFFICE SALARIES & WAGE REL COSTS

12 HOME OFFICE: PHYSICIAN PART A

13 ON TEACHING PHYSICIAN SALARIES 9.01 9.02 9.03 10 10.01 11 12.01 TEACHING PHYSICIAN SALARIES WAGE-RELATED COSTS WAGE RELATED COSTS (CORE) 13 CMS 339 14 CMS 339 WAGE RELATED COSTS (OTHER) 14 15 CMS 339 EXCLUDED AREAS NON-PHYSICIAN ANESTHETIST PART A 16 17 CMS 339 16 CMS 339 NON-PHYSICIAN ANESTHETIST PART B 17 CMS 339 18 18 PHYSICIAN PART A 18.01 PART A TEACHING PHYSICIANS 19 PHYSICIAN PART B 18.01 CMS 339 19 CMS 339 19.01 19.01 WAGE RELATED COSTS (RHC/FQHC)
20 INTERNS & RESIDENTS (IN APPR PGM)
OVERHEAD COSTS - DIRECT SALARIES
21 EMPLOYEE BENEFITS CMS 339 20 21 22 22 ADMINISTRATIVE & GENERAL
22.01 ADMINISTRATIVE & GENERAL UNDER CONTACT
23 MAINTENANCE & REPAIRS
24 OPERATION OF PLANT 289922 22.01 23 137712 24 25 LAUNDRY & LINEN SERVICE HOUSEKEEPING 26 298883 26.01 HOUSEKEEPING UNDER CONTRACT 26.01 27 480939 DIETARY 27.01 27.01 DIETARY UNDER CONTRACT 28 CAFETERIA 28 29 29 MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES AND SUPPLY 30 206330 31 77563 31 32 32 33 MEDICAL RECORDS & MEDICAL RECORDS LIBR 63514 34 383929 -269592 SOCIAL SERVICE OTHER GENERAL SERVICE 35 WORKSHEET S-3 HOSPITAL WAGE INDEX INFORMATION PART III

ADJUSTED PAID HOURS AVERAGE RECLASS. HOURLY WAGE SALARIES RELATED TO SALARY OF SALARIES (COL. 3 / THUOMA FROM WKST. (COL.1 + IN COL. 3 COL. 4) COL. 2) PART III - HOSPITAL WAGE INDEX SUMMARY REPORTED A-6 4360870 4360870 NET SALARIES NET SALARIES
EXCLUDED AREA SALARIES
SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)
SUBTOTAL OTHER WAGES & REL COSTS
SUBTOTAL WAGE-RELATED COSTS
TOTAL (SUM OF LINES 3 THRU 5)
NET SALARIES 2496863 269592 2227271 1864007 -269592 2133599 3 1864007 -269592 2133599 SUBTOTAL SALARIES (LINE 7 MINUS LINE 8) SUBTOTAL OTHER WAGES & REL COSTS 10 11 SUBTOTAL WAGE-RELATED COSTS 11 12 TOTAL (SUM OF LINES 9 THRU 11) TOTAL OVERHEAD COSTS 13 1996156 -269592 1726564

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES	OTHER 2	TOTAL	RECLASSI~ FICATIONS	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
2	0100 0200	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-WVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		216296 43405	216296 43405	24116	216296 67521		216296 67521	1 2 3
5 6	0500 0600	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	289922 137712	2040249 475837 107874	2040249 765759 245586	-9176	2040249 756583 245586	-73911 862940	1966338 1619523 245586	4 5 6 7
8 9 10	0800 0900 1000	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING	57364 298883 480939	455347 223337 49068 426729	455347 280701 347951 907668	-14940	440407 280701 347951 907668	-36012 -64660	440407 244689 347951 843008	8 9 10 11
12	1200 1300	DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION	206330	1232	207562		207562	0,000	207562 77563	12 13 14 15
15 16 17 18	1600 1700	CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	77563 63514 114337	-501 1400	77563 -501 63514 115737		77563 -501 63514 115737		-501 63514 115737	16 17 18
18.10 18.20	1950 1951	RECREATION STAFF DEVELOPMENT INPATIENT ROUTINE SERV COST CENTERS	269592	3809 1017 153034	273401 1017 2380305	-273401 -1017 274418	2654723		2654723	18.10 18.20
	5000	NURSING FACILITY ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY	106075	8860	114935	214410	114935 7117	-4800	114935	50 50.10
50.20	3950	DENTAL PSYCHOLOGY OUTPATIENT SERVICE COST CENTERS	31368	7117 19428	7117 50796		50796	-50796	2311	50.20
62 71		OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY								71
95		NONREIMBURSABLE COST CENTERS	4360870	4233538	8594408		8594408	632761	9227169	95 97.10
97.20 98.10 98.20	9702 9801 9802	RENTAL VACANT OUTSIDE MEDICAL CHARGES BARBER AND BEAUTY BARBER AND BEAUTY		2233 5175 20654	2233 5175 20654	1.45	2233 5175 20654		2233 5175 20654	97.20 98.10
99.10 101	9901	MISCELLANEOUS NON-ALLOWABLE TOTAL	4360870	4261600	8622470		8622470	632761		

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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#### RECLASSIFICATIONS

RKSHEET	A-6
PAGE	1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 2	- INCREASE LINE # 3	SALARY 4	OTHER 5
1	CAP. REL MOVABLE EQUIPMENT	A	OLD CAP REL COSTS-MVBLE EQUIP	2		24116 1
2 3 4 5	RECREATION - SALARY AND OTHER STAFF DEVELOPMENT - OTHER	A B C	NURSING FACILITY NURSING FACILITY	35 35	269592	3809 3 1017 4 5
6 7 8 9 10						7 8 9 10 11 12
12 13 14 15 16						13 14 15 16
17 18 19 20					*	17 18 19 20
21 22 23 24						21 22 23 24 25
25 26 27 28						26 27 28 29
29 30 31 32 33						30 31 32 33
34 35 36	TOTAL RECLASSIFICATIONS				269592	34 35 28942 36

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RECLASSIFICATIONS

WORKSHEET A-6 PAGE 1

	EXPLANATION OF	CODE		DECREASE			WKST A-7	į
	RECLASSIFICATION ENTRY	CODE	COST CENTER	LINE #	SALARY	OTHER	REF.	
	RECEMBER TOWN ENTRY	1	6	7	8	9	10	
			•	0.55		5	5350	
1	CAP. REL MOVABLE EQUIPMENT	A	ADMINISTRATIVE & GENERAL	6		9176	9 1	
2	CAE. RED HOVADDE EQUITMENT	A	OPERATION OF PLANT	8		14940	9 2	
3	RECREATION - SALARY AND OTHER	В	RECREATION	18.10	269592	3809	3	
		C	STAFF DEVELOPMENT	18.20	203032	1017	۵	
4	STAFF DEVELOPMENT - OTHER	C	SIMPL DEVELOPMENT	10.20		1017	5	
5							6	
6							7	
7							8	
8							9	
9							10	
10							11	
11							12	
12							13	
13							14	
14							15	
15							16	
16							17	
17							18	
18								
19							19	
20							20	
21	#6						21	
22							22	
23							23	
24							24	
25							25	
26							26	
27							27	
28							28	
29							29	
30							30	
31							31	
32							32	
33							33	
34							34	
35							35	
36	TOTAL RECLASSIFICATIONS				269592	28942	36	

WORKSHEET A-7 PARTS I & II

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

TOTAL	*	3231	DISVIANA	OF	CHANGES	TN	OLD	CAPITAL	ASSET	BALANCES

	1111.7 1 1111.1111	carros consumadado destreiro		ACQUISITIONS		DISPOSALS	ENDING	FULLY DEPRECIATED	
	DESCRIPTION	BEGINNING BALANCES 1	PURCHASE 2	DONATION 3	TOTAL	RETIREMENTS 5	BALANCE 6	ASSETS 7	
1 2 3 4 5 6 7 8 9	LAND LAND IMPROVEMENTS BUILDINGS AND FIXTURES BUILDING IMPROVEMENTS FIXED EQUIPMENT MOVABLE EQUIPMENT SUBTOTAL RECONCILING ITEMS TOTAL	,		•					1 2 3 4 5 6 7 8 9
	PART II - ANALYSIS OF CHANGES IN NEW	CAPITAL ASS	SET BALANCE	s					
	DESCRIPTION	BEGINNING BALANCES 1	PURCHASE 2	ACQUISITIONS DONATION 3	TOTAL	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1 2	LAND LAND IMPROVEMENTS								2

LAND IMPROVEMENTS
BUILDINGS AND FIXTURES
BUILDING IMPROVEMENTS
FIXED EQUIPMENT
MOVABLE EQUIPMENT
SUBTOTAL
RECONCILING ITEMS
TOTAL

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96) VERSION: 2008.05 11/30/2010 12:11

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7 PARTS III & IV

			COMPUTATION	OF RATIOS GROSS		ALLO	CATION OF	OTHER CAPITAL		
	DESCRIPTION	GROSS ASSETS	Capitali2ed Leases	ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
	4	1	2	3	4	5	6	7	8	
1 2 3	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT	216296 67521		216296 67521	.762097 .237903 .000000					1 2 3 4
4 5	NEW CAP REL COSTS-MVBLE EQUIP TOTAL	28381	7	283817	1.000000					5
					SUMMARY OF	OLD AND NEW	CAPITAL	OTHER		
	DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
			9	10	11	12	13	14	15	
1 2 3	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		216296 67521						216296 67521	
4	NEW CAP REL COSTS-MVBLE EQUIP TOTAL		283817			<b>*</b> )			283817	5
	PART IV - RECONCILIATION O	F AMOUNTS F	ROM WORKSHEET	A, COLUMN	2, LINES 1	THRU 4	V CAPITAL			
	DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL	
			9	10	11	12	13	14	1.5	
1 2 3	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		216296 43405						216296 43405	
4 5	NEW CAP REL COSTS-MVBLE EQUIP TOTAL		259701						259701	5

#### ADJUSTMENTS TO EXPENSES

PERIOD	FROM 07/01/2009 TO 06/30/2010		IN LIEU C	)F. FORW CW2-5225-30 (111,30)		
	ADJUSTMENTS TO EXPENSES			EXPENSE CLASSIFICATION ON WORK FROM WHICH THE AMOUNT IS TO BE	SHEET A TO/ ADJUSTED LINE NO.	WORKSHEET A-8 WKST A-7 REF
	DESCRIPTION	BASIS 1	AMOUNT 2	COST CENTER 3	4	5
2 3 4 5 6	INVESTMENT INCOME-OLD BLDGS & FIXTURES INVESTMENT INCOME-OLD MOVABLE EQUIPMENT INVESTMENT INCOME-NEW BLDGS & FIXTURES INVESTMENT INCOME-NEW MOVABLE EQUIPMENT INVESTMENT INCOME-OTHER TRADE, QUANTITY, AND TIME DISCOUNTS REFUNDS AND REBATES OF EXPENSES RENTAL OF PROVIDER SPACE BY SUPPLIERS TELEPHONE SERVICES (PAY STATIONS EXCL) TELEVISION AND RADIO SERVICE PARKING LOT			OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	1 2 3 4	1 2 3 4 5 6 7 8 9 10
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-55596			12 13
13 14 15 16	SALE OF SCRAP, WASTE, ETC. RELATED ORGANIZATION TRANSACTIONS LAUNDRY AND LINEN SERVICE CAFETERIA - EMPLOYEES AND GUESTS	WKST A-8-1 A B	789034 -36012 -64660	LAUNDRY & LINEN SERVICE DIETARY	9 11	14 15 16 17
17 18 19 20 21 22	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS SALE OF DRUGS TO OTHER THAN PATIENTS SALE OF MEDICAL RECORDS AND ABSTRACTS NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					18 19 20 21 22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4 WKST		PHYSICAL THERAPY	50	26
27 28 29 30 31 32 33	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION UTIL REVIEW-PHYSICIANS' COMPENSATION DEPRECIATIONOLD BUILDINGS & FIXTURES DEPRECIATIONNEW BUILDINGS & FIXTURES DEPRECIATIONNEW MOVABLE EQUIPMENT NON-PHYSICIAN ANESTHETIST PHYSICIANS' ASSISTANT	A-8-3		HOME HEALTH AGENCY UTILIZATION REVIEW-SNF OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MYBLE EQUIP NONPHYSICIAN ANESTHETISTS	71 89 1 2 3 4 20	27 28 29 30 31 32 33
34 35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				35
36 37	EXCESS OF LIMITATION - HOSPITAL MISCELLANEOUS-REVENUE	WKST WKST A-8-4 B	-5	ADMINISTRATIVE & GENERAL	6	36 37 38
38 39 40 41 42 43 44 45 46 47 48						39 40 41 42 43 44 45 46 47 48 49
49 50	TOTAL		632761			30

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS: MOUNT OF AMOUNT LINCE. NET ADJ- WKST

LINE NO. 1 1 5 2 6	COST CENTER 2 EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	EXPENSE ITEMS 3 PEIA CENTRAL OFFICE	AMOUNT OF ALLOWABLE COST 4 782571 862945	IN WKST A, COL 5) 5 856482	USTMENTS 6 -73911 862945	A-7 REF 7	1 2 3 4
4 5	TOTALS		1645516	856482	789034		5

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

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

				-	 KPMITCH	) OUGITATION IT	Oli (2) Inibi ou		
SYMBOL	NAME		PERCE OF OWNERS	0.00 0.00	NAME		PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
		VIRGINIA VIRGINIA	3 100.00 100.00	DEPT.	4 HEALTH HEALTH		5 100.00 100.00	6	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.

B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.

C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.

D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.

E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.

F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.

G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

22

PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

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#### WORKSHEET A-8-2

	-		ASED PHYSICIAN	ND HISTMENTS						WORKS	REET A-8-2
	WKST A	COST	CENTER/ IDENTIFIER 2	ADDUSTRIBATO	TOTAL REMUNERA- TION INCL FRINGES 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNAD- JUSTED RCE LIMIT 8	PERCENT OF UNAD- JUSTED RCE LIMIT 9
1 2 101		DENTAL PSYCHOLOG' TOTAL	Υ	DENTAL SERVICES PSYCHOLOGICAL SERVI	4800 50796 55596	4800 50796 55596			8.		

23

PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

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17

HORKSHEET A-8-2

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WKST COST CENTER/ PHYSICIAN IDENTIFIER A NO. 11 10

COST OF PROVIDER PHYSICIAN PROVIDER
MEMBERSHIP COMPONENT COST OF COMPONENT
4 CONTIN. SHARE OF MALPRACTICE SHARE OF
EDUCATION COLUMN 12 INSURANCE COLUMN 14
12 13 14 15

ADJUSTED RCE DIS-ALLOWANCE LIMIT 16

18 4800 50796

ADJUST-MENT

1 50.10 DENTAL 2 50.20 PSYCHOLOGY 01 TOTAL 101

DENTAL SERVICES
PSYCHOLOGICAL SERVI

55596

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST		OLD CAP MOVABLE	EMPLOYEE BENEFITS	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		ALLOCATION 0	FIXTURES 1	EQUIPMENT 2	5	5A	6	7	8	
		-								
	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT	216296	216296							1
2	OLD CAP REL COSTS-MVBLE EQUIP	67521		67521						2
	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS	1966338	20.000		1966338	1201460	1791468			6
	ADMINISTRATIVE & GENERAL	1619523 245586	31412 290	9806 91	130727 62095	1791468 308062	73937	381999		Ž
	MAINTENANCE & REPAIRS OPERATION OF PLANT	440407	4512	1408		446327	107121	20201	573649	8
	LAUNDRY & LINEN SERVICE	244689	686	214	25866	271455 484725	65151 116337	3070 6845	3054 6808	9 10
10	HOUSEKEEPING	347951 843008	1529 15206	477 4747	134768 216858	1079819	259163	68088	67715	11
11 12	DIETARY CAFETERIA	043000	1899	593	02000	2492	598	8502	8455	12 13
13	MAINTENANCE OF PERSONNEL			90	93035	300976	72236	1293	1286	
14	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	207562 77563	289 2900	905	34974	116342	27923	12986	12915	15
15 16	PHARMACY	-501			10/4/19/20	-501	00000	3717	3697	16 17
17	MEDICAL RECORDS & LIBRARY	63514	830	259 233	28639 51555	93242 168271	22379 40386	3342	3323	18
18	SOCIAL SERVICE RECREATION	115737	746	233 ,	51333	100271	.0000	**************************************	- P. (B. (B. (B. (B. (B. (B. (B. (B. (B. (B	18.10
	STAFF DEVELOPMENT									18.20
	INPATIENT ROUTINE SERV COST CENTE	ERS	53837	16807	1139991	3865358	927708	241055	239739	35
35	NURSING FACILITY ANCILLARY SERVICE COST CENTERS	2654723	53037	10007	1133331					
50	PHYSICAL THERAPY	114935	2061	643	47830	165469	39714 556	9229	9178	50 50.10
	DENTAL	2317				2317	536			50.20
50.20	PSYCHOLOGY OUTPATIENT SERVICE COST CENTERS									62
62	OBSERVATION BEDS (NON-DISTINCT									02
21	OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY									71
71	SPECIAL PURPOSE COST CENTERS						1750000	378328	356170	95
95	SUBTOTALS	9227169	116197	36273	1966338	9095822	1753209	376326	330170	22
07 10	NONREIMBURSABLE COST CENTERS RENTAL		48018	14990		63008	15122		213828	
	VACANT	2000	51261	16002		67263 2233	16144 536			97.20 98.10
	OUTSIDE MEDICAL CHARGES	2233 5175	820	256		6251	1500	3671	3651	98.20
	BARBER AND BEAUTY MISCELLANEOUS NON-ALLOWABLE	20654	020	230		20654	4957			99.10 101
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER	9255231	216296	67521	1966338	9255231	1791468	381999	573649	
103	TOTAL	7233231	210230	0.001		69 500				

COST ALLOCATION - GENERAL SERVICE COSTS

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WORKSHEET B PART I

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING	DIETARY 11	CAFETERIA	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18 18.10	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION	342730	614715 118944 14852 2258 22686 6493 5838	1593729 232675	267574 30078	378049	192852	-501	129528	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18.10 18.20
	STAFF DEVELOPMENT INPATIENT ROUTINE SERV COST CENTER NURSING FACILITY	RS 342730	421109	1048566	219331	378049	192852		129528	35
50 50.10	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY DENTAL	2.3.21	16122		18165		n <b>é</b> g			50 50.10 50.20
50.20 62	PSYCHOLOGY OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS									62 71
71 95	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS	342730	608302	1281241	267574	378049	192852		129528	95
97.10	NONREIMBURSABLE COST CENTERS RENTAL			312488						97.10 97.20
98.10 98.20 99.10 101	O VACANT O OUTSIDE MEDICAL CHARGES O BARBER AND BEAUTY MISCELLANEOUS NON-ALLOWABLE CROSS FOOT ADJUSTMENTS		6413					-501		98.10 98.20 99.10 101 102
102 103	NEGATIVE COST CENTER TOTAL	342730	614715	1593729	267574	378049	192852	-501	129528	103

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## COST ALLOCATION - GENERAL SERVICE COSTS

		OCIAL ERVICE 18	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18 19 18 19 19 19 19 19 19 19 19 19 19 19 19 19	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION STAFF DEVELOPMENT	251238				1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18.10 18.20
18.20	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	251238	8257263		8257263	35
33	ANCILLARY SERVICE COST CENTERS		257877		257877	50
50	PHYSICAL THERAPY DENTAL		2873		2873	50.10 50.20
	PSYCHOLOGY					
	OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT					62
62	OTHER REIMBURSABLE COST CENTERS	4)				71
71	HOME HEALTH AGENCY					95
95	SPECIAL PURPOSE COST CENTERS SUBTOTALS	251238	8518013		8518013	95
	NONREIMBURSABLE COST CENTERS		604446		604446	97.10
	RENTAL		83407		83407	97.20 98.10
97.20	VACANT OUTSIDE MEDICAL CHARGES		2769		2769	98.10
98.10	BARBER AND BEAUTY		21486		21486	99.10
99.10	MISCELLANEOUS NON-ALLOWABLE		25611		25611	101
101	CROSS FOOT ADJUSTMENTS		-501		-501	102
102	NEGATIVE COST CENTER	251238	9255231		9255231	103
103	TOTAL	201000	*.000.000.00			

> WORKSHEET B PART II

### ALLOCATION OF OLD CAPITAL RELATED COSTS

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	OLD CAP BLDGS & FIXTURES 1	OLD CAP MOVABLE EQUIPMENT 2	CAP REL COST TO BE ALLOC 4A	ADMINIS- TRATIVE & GENERAL 6	MAIN- TENANCE & REPAIRS 7	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE 9	
	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT									1 2
1 2	OLD CAP REL COSTS-MVBLE EQUIP									3
3	NEW CAP REL COSTS-BLDG & FIXT									4
4	NEW CAP REL COSTS-MVBLE EQUIP									5
5	EMPLOYEE BENEFITS		31412	9806	41218	41218				6
	ADMINISTRATIVE & GENERAL		290	91	381	1701	2082	11 10/21		7
	MAINTENANCE & REPAIRS		4512	1408	5920	2465	110	8495	0.461	8
	OPERATION OF PLANT LAUNDRY & LINEN SERVICE		686	214	900	1499	17	45 101	2461	10
	HOUSEKEEPING		1529	477	2006	2677	37 371	1003		11
	DIETARY		15206	4747	19953 2492	5963 14	46	125		12
12	CAFETERIA		1899	593	2492	7.4	,,	£00.80		13
	MAINTENANCE OF PERSONNEL		289	90	379	1662	7	19		14
	NURSING ADMINISTRATION		2900	905	3805	642	71	191		15
	CENTRAL SERVICES & SUPPLY		2500							16 17
16 17	PHARMACY MEDICAL RECORDS & LIBRARY		830	259	1089	515	20	55 49		18
18	SOCIAL SERVICE		746	233	979	929	18	99		18.10
	RECREATION									18.20
	STAFF DEVELOPMENT									
	INPATIENT ROUTINE SERV COST CENT	ERS	53837	16807	70644	21344	1315	3550	2461	35
35	NURSING FACILITY		53637	10001						
	ANCILLARY SERVICE COST CENTERS		2061	643	2704	914	50	136		50 50.10
50	PHYSICAL THERAPY DENTAL					13				50.20
	PSYCHOLOGY									30.20
30.20	OUTPATIENT SERVICE COST CENTERS									62
62	OBSERVATION BEDS (NON-DISTINCT									
	OTHER REIMBURSABLE COST CENTERS									71
71	HOME HEALTH AGENCY									0.5
0.5	SPECIAL PURPOSE COST CENTERS		116197	36273	152470	40338	2062	5274	2461	95
95	SUBTOTALS NONREIMBURSABLE COST CENTERS				15 350			3167		97.10
97 10	RENTAL		48018	14990	63008	348		3101		97.20
	VACANT		51261	16002	67263	371 12				98.10
98.10	OUTSIDE MEDICAL CHARGES		820	256	1076	35	20	54		98.20
98.20	BARBER AND BEAUTY		820	236	1010	114				99.10
	MISCELLANEOUS NON-ALLOWABLE									101
101	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER					_0 8		0.105	2461	102
102	TOTAL		216296	67521	283817	41218	2082	8495	2401	103
103	IVIA									

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KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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## ALLOCATION OF OLD CAPITAL RELATED COSTS

WORKSHEET B

	COST CENTER DESCRIPTION	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		10	11	12	14	15	17	18	25	
1 2 3 4 5 6 7	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	4821 933 116 18 178 51	28223 4120	6913 777	2085	4887	1730	2798		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
18.10	RECREATION STAFF DEVELOPMENT						932		100050	18.20
35	INPATIENT ROUTINE SERV COST CENT NURSING FACILITY	3303	18569	5667	2085	4887	1730	2798	138353	50
50 50.10	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY DENTAL	126		469						50.10 50.20
62	PSYCHOLOGY OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS									62 71
71 95	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS	4771	22689	6913	2085	4887	1730	2798	142765	95
97.10 97.20 98.10	NONREIMBURSABLE COST CENTERS ) RENTAL ) VACANT ) OUTSIDE MEDICAL CHARGES ) BARBER AND BEAUTY ) MISCELLANEOUS NON-ALLOWABLE	50	5534						12 1235 114	97.20 98.10 98.20 99.10
101 102 103	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER TOTAL	4821	28223	6913	2085	4887	1730	2798	283817	102 103

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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> WORKSHEET B PART II

			I&R COST &	
COST	CENTER	DESCRIPTION	POST STEP-	TOTAL
			DOWN ADJS	
			26	27

ALLOCATION OF OLD CAPITAL RELATED COSTS

		26	27		
	GENERAL SERVICE COST CENTERS				1
	OLD CAP REL COSTS-BLDG & FIXT				2
	OLD CAP REL COSTS-MVBLE EQUIP				3
3	NEW CAP REL COSTS-BLDG & FIXT				4
4	NEW CAP REL COSTS-MVBLE EQUIP				5
5	EMPLOYEE BENEFITS				6
6	ADMINISTRATIVE & GENERAL				ž
7	MAINTENANCE & REPAIRS				Ŕ
8	OPERATION OF PLANT				8 9
9	LAUNDRY & LINEN SERVICE				10
10	HOUSEKEEPING				11
11	DIETARY				12
12	CAFETERIA				13
13	MAINTENANCE OF PERSONNEL				14
14	NURSING ADMINISTRATION				15
15	CENTRAL SERVICES & SUPPLY				16
16	PHARMACY				17
17	MEDICAL RECORDS & LIBRARY				18
18	SOCIAL SERVICE				18.10
	RECREATION				18.20
18.20	STAFF DEVELOPMENT				
2020	INPATIENT ROUTINE SERV COST CENTERS		138353		35
35	NURSING FACILITY		130333		
	ANCILLARY SERVICE COST CENTERS		4399		50
50	PHYSICAL THERAPY		13		50.10
	DENTAL		13		50.20
50.20	PSYCHOLOGY OUTPATIENT SERVICE COST CENTERS				
60	OBSERVATION BEDS (NON-DISTINCT				62
62	OTHER REIMBURSABLE COST CENTERS				
71	HOME HEALTH AGENCY				71
11	SPECIAL PURPOSE COST CENTERS				0.5
95	SUBTOTALS		142765		95
90	NONREIMBURSABLE COST CENTERS				97.10
97 10	RENTAL		72057		97.10
	VACANT		67634		98.10
	OUTSIDE MEDICAL CHARGES		12		98.20
	BARBER AND BEAUTY		1235	<b>⊕</b>	99.10
99.10	MISCELLANEOUS NON-ALLOWABLE		114		101
101	CROSS FOOT ADJUSTMENTS				102
102	NEGATIVE COST CENTER				103
103	TOTAL		283817		103
0.75	DEAT ST				

COST ALLOCATION - STATISTICAL BASIS

## KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/97)

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	COST CENTER DESCRIPTION	OLD CAP BLDGS & FIXTURES	OLD CAP MOVABLE EQUIPMENT	employee Benefits	RECON- CILIATION		MAIN- TENANCE & REPAIRS	OPERATION OF PLANT SQUARE	
		SQUARE	SQUARE FEET	SQUARE FEET		ACCUM COST	SQUARE FEET	FEET	
		1	2	5	6A	6	7	8	
1 2 3	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	167800	167800	WO 10 ACCUSED					1 2 3 4
6 7 8	EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE	24369 225 3500 532	225 3500 532	137712 57364	-1791468	7464264 308062 446327 271455 484725	66186 3500 532	99938 532	5 6 7 8 9
10 11 12	HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL	1186 11797 1473	11797	480939		1079819 2492	11797 1473	11797 3 1473	11 12 13
14	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	224 2250	2250	77563	501		2250	2250	14 15 16 17
17 18 18.10	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION STAFF DEVELOPMENT	644 579				93242 168271			
35	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	41766	4176	2528231		3865358	4176	6 41766	35
	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY DENTAL PSYCHOLOGY	1599	1599	106075		165469 231		9 1599	50 50.10 50.20
62	OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS						9		62 71
71 95	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS	9014	4 9014	4 4360870	-179096	7 730485	5 6555	0 62050	95
97.10	NONREIMBURSABLE COST CENTERS RENTAL VACANT	3725 3976				6300 6726	3	37252	97.10 97.20 98.10
98.10 98.20 99.10 101	OUTSIDE MEDICAL CHARGES BARBER AND BEAUTY MISCELLANEOUS NON-ALLOWABLE CROSS FOOT ADJUSTMENTS	63	6 63	6		223 625 2065	1 63	6 636	98.20 99.10 101 102
102 103 104	NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I	21629	6 6752 .40239			179146	5.77159	18	104
104 105	UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT II	1.28901	1	. 450905	í	.24000 4121		57	105 106
106 106 107 108 108	UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT II COST TO BE ALLOC PER B PT III UNIT COST MULT-WS B PT III UNIT COST MULT-WS B PT III					.00552	2	.085003	106 107 108 108

WORKSHEET B-1

### COST ALLOCATION - STATISTICAL BASIS

ži.	COST CENTER DESCRIPTION	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		SERVICE POUNDS OF LAUNDRY 9	SQUARE FEET 10	MEALS SERVED 11	MEALS SERVED 12	DIRECT NRSING HRS 14	COSTED	COSTED REQUIS. 16	TIME SPENT 17	
	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION STAFF DEVELOPMENT		60968 11797 1473 224 2250 644 579	156972 22917		100	) 100	100	100	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18.10 18.20
35	INPATIENT ROUTINE SERV COST ON NURSING FACILITY	CENTERS 100	4176	103277	1185	7 10	0 10	0 100	100	35
	ANCILLARY SERVICE COST CENTED PHYSICAL THERAPY DENTAL PSYCHOLOGY OUTPATIENT SERVICE COST CENT OBSERVATION BEDS (NON-DISTIN-	ERS	159	e	98	2				50 50.10 50.20
71	OTHER REIMBURSABLE COST CENT HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS							. 10	0 100	71. 95
97.20 98.10 98.20	SUBTOTALS NONREIMBURSABLE COST CENTERS RENTAL VACANT OUTSIDE MEDICAL CHARGES BARBER AND BEAUTY MISCELLANEOUS NON-ALLOWABLE	10	63	3077		5 10	0 10	0 100	, 100	97.10 97.20 98.10 98.20 99.10
101 102 103 104 104 105 106 106 107 108	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I	24.61000	0 10.08258 1 482	10.15295 4 1 2822 .17979	1 18.49803 3 693	30 13 208 20.85000	)0 1928.52000 35 486	00 37	129528 1295.280000 1730 17.300000	102 103 104 104 105 106

WORKSHEET B-1

### COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION

SOCIAL SERVICE

TIME SPENT

	18		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
17 18	SOCIAL SERVICE	100	18 18.10
	RECREATION		18.20
18.20	STAFF DEVELOPMENT		
35	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	100	35
33			
	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY DENTAL		50 50.10 50.20
50.20	PSYCHOLOGY OUTPATIENT SERVICE COST CENTERS		62
62	OBSERVATION BEDS (NON-DISTINC		02
~ ~	OTHER REIMBURSABLE COST CENTERS		71
71	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		95
95	SUBTOTALS	100	7,
	NONREIMBURSABLE COST CENTERS		97.10
	RENTAL VACANT		97.20 98.10
98.10	OUTSIDE MEDICAL CHARGES		98.20
	BARBER AND BEAUTY		99.10
99.10 101	MISCELLANEOUS NON-ALLOWABLE CROSS FOOT ADJUSTMENTS		101 102
102	NEGATIVE COST CENTER	n reactions to	103
103	CO31 10 DB 11BB00 1B11 2 11 1	1238	104
104	UNIT COST MULT-WS B PT I 2512.38	0000	104 105
104	COST TO BE ALLOC PER B PT II	2798	105
106	UNIT COST MULT-WS B PT II 27.98	0000	106
106	UNIT COST MULT-WS B PT II		107
107	COST TO BE ALLOC PER B PT III UNIT COST MULT-WS B PT III		108 108
108	UNIT COST MULT-WS B PT III		108

33
PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (5/1999) VERSION: 2008.05 11/30/2010 12:11

> WORKSHEET C PART I

#### COMPUTATION OF RATIO OF COST TO CHARGES

(	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27)	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
35	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	8257263					35
33	ANCILLARY SERVICE COST CENTERS	***					
50	PHYSICAL THERAPY	257877					50 50,10
	DENTAL	2873					50.20
50.20	PSYCHOLOGY						301.60
	OUTPATIENT SERVICE COST CENTERS						62
62	OBSERVATION BEDS (NON-DISTI						
WAY YEAR TO	OTHER REIMBURSABLE COST CENTERS	8518013					101
101	SUBTOTAL	0218012					102
102	LESS OBSERVATION BEDS TOTAL	8518013					103

PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (5/1999)

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I (CONT)

			CHARGES		COST OR OTHER	TEFRA INPATIENT	PPS INPATIENT	
	COST CENTER DESCRIPTION	INPATIENT 6	OUTPATIENT 7	TOTAL 8	RATIO 9	RATIO 10	RATIO 11	
	INPATIENT ROUTINE SERV COST CE	NTERS						35
35	NURSING FACILITY							
	ANCILLARY SERVICE COST CENTERS	0106		9126	28.257396			50
50	PHYSICAL THERAPY	9126		7100				50.10
50.10	DENTAL							50.20
50.20		29						
	OUTPATIENT SERVICE COST CENTER	\$						62
62	OBSERVATION BEDS (NON-DISTI							
	OTHER REIMBURSABLE COST CENTER	\$		9126				101
101	SUBTOTAL	9126		9120				102
102	LESS OBSERVATION BEDS			0106				103
103	TOTAL			9126				

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## KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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#### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART I

	TITLE V-INPT	1	) TI	TLE	XVIII-PAR	AT		(XX) TIT	LTE XIX-IN	IPT		
			Ø 550									
PAR	T I - ALL PROVIDER COMPONENTS				HOSPITAL (OTHER) (50-05001	SUB	I	SUB II	SUB III		NF (OTHER) (50-05001	
	INPATIENT DAYS				1	1		1	1	1	1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWI	NG-1	BED DA	AYS							34622	1
	EXCLUDING NEWBORN)										34622	2
	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUD BED AND NEWBORN DAYS)	1110	OHZIN	,	52							2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING	RO	OM DAY	YS)							34622	3 4 5
	ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTIN	G P	ERIOD									6
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING	PER	IOD									-
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVAT	E										7
0	ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTIN TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVAT	G P	EKTOD									8
1000	ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING	PER	IOD								34023	9
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICAB	STE	TO TH	ε							34023	,
10	PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS) SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TIT	LE	XVIII									10
10	ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER	31	OF T	HE								
	COST REPORTING PERIOD SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TIT	TE	XVIII									11
11	ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 3	31 C	F THE									
0.020	COST REPORTING PERIOD											12
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITE ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER	31	OFT	HE								
	COST REPORTING PERIOD											13
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITE ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 3	ES	V OR	XIX								
	COST REPORTING PERIOD	,, ,										14
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO	) TI	łΕ									14
16	PROGRAM (EXCLUDING SWING-BED DAYS) TOTAL NURSERY DAYS											15
	TITLE V OR XIX NURSERY DAYS											16

## KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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WORKSHEET D-1 PART I (CONT)

### COMPUTATION OF INPATIENT OPERATING COST

(XX) TITLE XIX-INPT [ ] TITLE XVIII-PART A

( ) TITLE V-INPT	( ) TITE	E XVIII-PAR	TA	(XX) TI	TLE XIX-II	IPT		
PART I - ALL PROVIDER COMPONENTS		HOSPITAL (OTHER) (50-05001				SUB IV	NF (OTHER) (50-05001	
SWING-BED ADJUSTMENT		1	1	1	1			17
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING F	TO							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE	TO							18
SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PER 19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE T	0							19
SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING E	O EKTOD							20
SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PER	100						8257263	21 22
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROU DECEMBER 31 OF THE COST REPORTING PERIOD								23
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	į.							24
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	iH							25
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER								
DECEMBER 31 OF THE COST REPORTING PERIOD 26 TOTAL SWING-BED COST 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING	BED COST						8257263	26 27
PRIVATE ROOM DIFFERENTIAL ADJUSTME	<b>₹</b> T							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES								28
(EXCLUDING SWING-BED CHARGES) 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)								29 30
30 CEMI_DRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHAR	BES)							31
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE								32 33
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE 34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL								34 35
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							8257263	36 37
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING AND PRIVATE ROOM COST DIFFERENTIAL	-BED COST				(30)		0231203	J.

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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#### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART II

	***************************************	3.500				PART II
	[ ] TITLE V-INPT [ ] TITLE XVI	III-PART A	(XX) TITLE	TANI-XIX		
PART	II - HOSPITAL AND SUBPROVIDERS ONLY	HOSPITAL SUB (OTHER)	I SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 1	1	1 .	1	
38 39 40 41	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					38 39 40 41
		TOTAL I/P COST	TOTAL 1/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLES V AND XIX ONLY)					42
43 44 45 46 47	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)					43 44 45 46 47
		HOSPITAL SU (OTHER) (50-05001	B I SUB I	I SUB II	I SUB IV	
			1 1	1	1	
48 49	PROGRAM INPATIENT ANCILLARY SERVICE COST TOTAL PROGRAM INPATIENT COSTS	91				48 49
	PASS THROUGH COST ADJUSTMENTS					
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE					50
51	SERVICES PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT					51
52 53	ANCILLARY SERVICES TOTAL PROGRAM EXCLUDABLE COST TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS					52 53

## KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART II (CONT)

COMPORATION OF THEM SEED OF THE SEED OF TH					PART II	(CONT)
[ ] TITLE V-INPT [ ] TITLE XVIII-PART	A	(XX) TITLE	XIX-INPT			
PART II - HOSPITAL AND SUBPROVIDERS ONLY HOSPITA (OTHER (50-0500		SUB II	SUB III	SUB IV		
All and a property of the second seco	1	1	1	1		
TARGET AMOUNT AND LIMITATION COMPUTATION 1  54 PROGRAM DISCHARGES 55 TARGET AMOUNT PR DISCHARGE 56 TARGET AMOUNT 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND		•	-			54 55 56 57
TARGET AMOUNT 58 BONUS PAYMENT 58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING						58 58.01
PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET 58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST						58.02
REPORT UPDATED BY THE MARKET BASKET						58.03
OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT 58.04 RELIEF PAYMENT 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1 59.03 PROGRAM DISCHARGES AFTER JULY 1 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS) 59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1 59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)  PROGRAM INPATIENT ROUTINE SWING BED COST						58.04 59.01 59.02 59.03 59.04 59.05 59.06 59.07
						60
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						61
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						62
TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH						63
DECEMBER 31 OF THE COST REPORTING PERIOD  TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER		3				64
DECEMBER 31 OF THE COST REPORTING PERIOD  65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III & IV

( ) TITLE V-INPT	[ ] TI	TLE XVIII-	PART A	(XX)	TITLE	XIX-INPT	
PART III - SKILLED NURSING FACILITY, NURSING FACILITY AN	D ICF/M	AR ONLY		NF OTHER) 0-05001			
66 SNF/NF/ICF/MR ROUTINE SERVICE COST 67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER IS 68 PROGRAM ROUTINE SERVICE COST 69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO ITOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COST 72 PER DIEM CAPITAL RELATED COSTS 73 PROGRAM CAPITAL RELATED COSTS 74 INPATIENT ROUTINE SERVICE COST 75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS 76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO CO: 77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION 78 INPATIENT ROUTINE SERVICE COST LIMITATION 79 REASONABLE INPATIENT ROUTINE SERVICES 81 UTILIZATION REVIEW—PHYSICIAN COMPENSATION 82 TOTAL PROGRAM INPATIENT OPERATING COSTS	PROGRAM S SERV COS	STS		1 8257263 238.50 8114486 8114486 138353 4.00 136092 7978394 7978394 300.00 10206900 8114486 257877 8372363			66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82
VE AVAIM CONTRACTOR SUCCESSION VESTICAL							

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PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

## KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III & IV

[ ] TITLE V-INPT

[ ] TITLE XVIII-PART A

(XX) TITLE XIX-INPT

SUB II SUB III SUB IV HOSPITAL SUB I (OTHER) (50-05001 1 1 1

1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 85 OBSERVATION BED COST

84 85

41 PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

INPATIENT ANCILLARY COST APPORTIONMENT

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98) VERSION: 2008.05 11/30/2010 12:11

WORKSHEET D-4

( ) TITLE V ( ) TITLE XVIII-PT A (XX) TITLE XIX	(XX) HOSPITAL (50-05001) ( ) SUB I ( ) SUB II ( ) SUB III ( ) SUB III	[ ] SNF [ ] NF [ ] S/B-SNF [ ] S/B-NF [ ] ICF/MR	[ ) PPS [ ) TEFRA [XX] OTHER
---	---	--	------------------------------------

COST CENTER DESCRIPTION

RATIO OF COST INPATIENT INPATIENT
TO CHARGES PROGRAM CHARGES PROGRAM COSTS

1 2 3

NET CHARGES

## KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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WORKSHEET D-4

INPATIENT ANCILLARY COST APPORTIONMENT

[ ] PPS [ ] TEFRA ( ) SNF (XX) NF (50-05001) [ ) S/B-SNF [ ) S/B-NF HOSPITAL [ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX SUB I SUB II SUB I SUB II SUB III SUB IV (XX) OTHER [ ] ICF/MR INPATIENT PROGRAM COSTS INPATIENT PROGRAM CHARGES 2 RATIO OF COST TO CHARGES COST CENTER DESCRIPTION INPATIENT ROUTINE SERVICE COST CENTERS ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY . 50 PHYSICAL THEO...
50.10 DENTAL
50.20 PSYCHOLOGY
 OUTERTIENT SERVICE COST CENTERS
62 OBSERVATION BEDS (NON-DISTINCT
 OTHER REIMBURSABLE COST CENTERS
 TOTAL 257877 28.257396 9126 50.10 50.20 62 101 9126 257877 TOTAL
LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES 102 102 103 103 9126

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WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	( ) TITLE V	( ) TIT	LE XAIII		(XX) TI	TLE XIX		
	5	HOSPITAL (50-05001) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (50-05001) (OTHER)	
1 2 3 4	COMPUTATION OF NET COST OF COVERED SERVICES INPATIENT HOSPITAL/SNF/NF SERVICES MEDICAL AND OTHER SERVICES INTERNS AND RESIDENTS ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O	1	1	1.	1		1 8372363	1 2 3 4
5 6 7	COST OF TEACHING PHYSICIANS SUBTOTAL INPATIENT PRIMARY PAYER PAYMENTS						8372363	5 6 7 8
9	OUTPATIENT PRIMARY PAYER PAYMENTS SUBTOTAL						8372363	9
10 11 12 13	COMPUTATION OF LESSER OF COST OR CHARGES ROUTINE SERVICE CHARGES ANCILLARY SERVICE CHARGES INTERNS AND RESIDENTS SERVICE CHARGES ORGAN ACQUISITION CHARGES, NET OF REVENUE TEACHING PHYSICIANS						8763774 9126	11 12 13 14
15 16	INCENTIVE FROM TARGET AMOUNT COMPUTATION TOTAL REASONABLE CHARGES						8772900	15 16
17 18	CUSTOMARY CHARGES AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							17
19	RATIO OF LINE 17 TO LINE 18						8772900	
20 21	TOTAL CUSTOMARY CHARGES EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						400537	21
22 23	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES COST OF COVERED SERVICES						8372363	
24 25 26 27	PROSPECTIVE PAYMENT AMOUNT OTHER THAN OUTLIER PAYMENTS OUTLIER PAYMENTS PROGRAM CAPITAL PAYMENTS CAPITAL EXCEPTION PAYMENTS							24 25 26 27 28
28 29	ROUTINE SERVICE OTHER PASS THROUGH COSTS ANCILLARY SERVICE OTHER PASS THROUGH COSTS						8372363	29
30 31	SUBTOTAL CUSTOMARY CHARGES (TITLE XIX PPS COVERED						8372363	31
32 33	LESSER OF LINES 30 OR 31 DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						0372303	33

## KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/1999)

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WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	PART III - IIIID V ON IIID V	( ) TIT	TE XVIII		(XX) TIT	TLE XIX		
	( ) TITLE V	( ) 111	DE KVIII					
		HOSPITAL (50-05001) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (50-05001) (OTHER)	
		1	1	1.	1	1	1	
34 35 36 37 38 38.01	COMPUTATION OF REIMBURSEMENT SETTLEMENT EXCESS OF REASONABLE COST SUBTOTAL COINSURANCE SUM OF AMOUNTS FROM WKST E, PARTS C, D AND E, REIMBURSABLE BAD DEBTS REDUCED REIMBURSABLE BAD DEBTS REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE						8372363	34 35 36 37 38 38.01 38.02
39 40 41 42 43 44	BENEFICIARIES (SEE INSTRUCTIONS) UTILIZATION REVIEW SUBTOTAL INPATIENT ROUTINE SERVICE COST MEDICARE INPATIENT ROUTINE CHARGES AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM						8372363	39 40 41 42 43 44
45 46 47 48 49	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) RATIO OF LINE 43 TO LINE 44 TOTAL CUSTOMARY CHARGES EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION							45 46 47 48 49
50	OTHER ADJUSTMENTS							51
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS						8372363	
52 53	SUBTOTAL INDIRECT MEDICAL EDUCATION ADJUSTMENT						8312363	53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						8372363	54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER						0372303	56
56	SEQUESTRATION ADJUSTMENT						7727000	57
57 57.01 58	INTERIM PAYMENTS TENTATIVE SETTLEMENT (FOR FI USE ONLY) BALANCE DUE PROVIDER/PROGRAM						645363	57.01 58 59
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2							

BALANCE SHEET

WORKSHEET G

	BALANCE SHEET					
	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	endowment Fund	PLANT FUND	
	<u> </u>	1	2	3	4	
1 2	CURRENT ASSETS CASH ON HAND AND IN BANKS TEMPORARY INVESTMENTS	79761				1 2 3
4 5	NOTES RECEIVABLE ACCOUNTS RECEIVABLE OTHER RECEIVABLES ALLOWANCE FOR UNCOLLECTIBLE	490923				5
7 8	NOTES & ACCOUNTS RECEIVABLE INVENTORY PREPAID EXPENSES	98286				6 7 8 9
9 10 11	OTHER CURRENT ASSETS DUE FROM OTHER FUNDS TOTAL CURRENT ASSETS	668970				10 11
13 13.01 14 14.01 15	FIXED ASSETS LAND ACCUMULATED DEPRECIATION LAND IMPROVEMENTS ACCUMULATED DEPRECIATION BUILDINGS ACCUMULATED DEPRECIATION LEASEMOLD IMPROVEMENTS ACCUMULATED AMORTIZATION FIXED EQUIPMENT	365366 -288187 7024498 -5246171 413899			*	12 12.01 13 13.01 14 14.01 15 15.01 16.01
16.01	ACCUMULATED DEPRECIATION	-326355 63064				17
17 17,01	AUTOMOBILES AND TRUCKS ACCUMULATED DEPRECIATION	-48349				17.01 18
18	MAJOR MOVABLE EQUIPMENT ACCUMULATED DEPRECIATION	1563168 -1413406				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19 19.01
19.01 20	ACCUMULATED DEPRECIATION MINOR EQUIPMENT-NONDEPRECIABLE					20 21
21	TOTAL FIXED ASSETS	2107527				
22 23 24 25	OTHER ASSETS INVESTMENTS DEPOSITS ON LEASES DUE FROM ONNERS/OFFICERS OTHER ASSETS					22 23 24 25 26
26	TOTAL OTHER ASSETS					
27	TOTAL ASSETS	2776497				27
	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND 4	
	CURRENT LIABILITIES	1	2	3	1	
28 29 30	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (SHORT TERM)	169642 529516				28 29 30 31
31 32	DEFERRED INCOME					32 33
33 34	ACCELERATED PAYMENTS DUE TO OTHER FUNDS	79761				34 35
35 36	OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES	778919				36
37	LONG-TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE					37 38
38 39 40	UNSECURED LOANS LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					39 40 41
41 42 43	OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LIABILITIES	778919				42
4 4 4 5	CAPITAL ACCOUNTS GENERAL FUND BALANCE SPECIFIC PURPOSE FUND BALANCE	1997578				44 45 46
46 47 48 49	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED GOVERNING BODY CREATED - ENDOWMENT FUND BAL PLANT FUND BALANCE - INVESTED IN PLANT					47 48 49 50
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					51
51	TOTAL FUND BALANCES	1997578				
52	TOTAL LIABILITIES AND FUND BALANCES	2776497				52

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WORKSHEET G-1

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND
				14	1
1	FUND BALANCES AT BEGINNING OF PERIOD	2155586			2
2	NET INCOME (LOSS)	-1606932			
3	TOTAL	548654			3
4	ADDITIONS (CREDIT ADJUSTMENTS)	1448924			4
5					5
6					6
7					7
8					8
9					9
10	TOTAL ADDITIONS	1448924			10
		1997578			11
11	SUBTOTAL	1331310			12
12	DEDUCTIONS (DEBIT ADJUSTMENTS)				13
13					14
14					15
15					
16					16
17					17
18	TOTAL DEDUCTIONS			***	18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	1997578			19

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PROVIDER NO. 5005001 HOPEMONT HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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#### STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2 PARTS I & II

#### PART I - PATIENT REVENUES

			1010 FE 010 100 USB VEST	mama r	
	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 2 4 5	GENERAL INPATIENT ROUTINE CARE SERVICES HOSPITAL SUBPROVIDER I SWING BED - SNF SWING BED - NF				1 2 4 5 6
6	SKILLED NURSING FACILITY NURSING FACILITY	8772900		8772900	7 8
8	OTHER LONG TERM CARE	8772900		8772900	9
9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	TOTAL GENERAL INPATIENT CARE SERVICES INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE TOTAL INPATIENT ROUTINE CARE SERVICES ANCILLARY SERVICES OUTPATIENT SERVICES HOME HEALTH AGENCY AMBULANCE CORF ASC HOSPICE	8772900 8772900		8772900	10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
25	TOTAL PATIENT REVENUES	8772900		8772900	25
	PART II - OPE	RATING EXPENSES			
26 27 28 29 30 31 32 33	OPERATING EXPENSES ADD (SPECIFY)  TOTAL ADDITIONS	)		2 8622470	26 27 28 29 30 31 32 33
34 35 36 37 38 39	DEDUCT (SPECIFY)  TOTAL DEDUCTIONS TOTAL OPERATING EXPENSES			8622470	39 35 36 37 38 39 40

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#### STATEMENT OF REVENUES AND EXPENSES

#### DESCRIPTION

1 2 3 4 5	TOTAL PATIENT REVENUES LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS NET PATIENT REVENUES LESS - TOTAL OPERATING EXPENSES NET INCOME FROM SERVICE TO PATIENTS	8772900 1822027 6950873 8622470 -1671597	1 2 3 4 5
6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. INCOME FROM INVESTMENTS REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE PURCHASE DISCOUNTS REBATES AND REFUNDS OF EXPENSES PARKING LOT RECEIPTS REVENUE FROM LAUNDRY AND LINEN SERVICE REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS REVENUE FROM MEATAL OF LIVING QUARTERS REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS TUTTION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN RENTAL OF VENDING MACHINES RENTAL OF HOSPITAL SPACE	64660	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23
23 24	GOVERNMENTAL APPROPRIATIONS MISCELLAMEOUS-REVENUE 1 UTILITIES-REVENUE TOTAL OTHER INCOME TOTAL	5 64665 -1606932	24 24.01 25 26 27
27 28 29 30 31	TOTAL OTHER EXPENSES NET INÇOME (OR LOSS) FOR THE PERIOD	-1606932	28 29 30 31

PRO TO FROM 07/01/2009 TO 06/30/2010

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WORKSHEET S

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

PARTS I & II

	INTERMEDIARY USE ONLY:	(		AUDITED DESK REVI	EWED		DATE RECEIVED INTERMEDIARY NO.		_	) FINAL		;	MCR COD	
						E	PART I - CERTIFI	CATION						
	CHECK APPLICABLE BOX	х			ELECT	RONICALLY	FILED COST REI	PORT	DATE: _					
AND ADMI		ION, RED T	FINE	E AND/OR I	IMPRISONM AYMENT DI	ENT UNDER	NTAINED IN THIS R FEDERAL LAW, I R INDIRECTLY OF NT MAY RESULT.							
				C	ERTIFICAT	ION BY O	FFICER OR ADMIN	ISTRATOR OF	PROVIDER	(S)				
OR MANUA LAKIN HO BEGINNIN COMPLETE	LLY SUBMITTED SPITAL (51-254 G 07/01/2009 A STATEMENT PRE	COST 01) ND EN PARED	REPO DINO FRO	G 06/30/2 OM THE BO	HE BALANC 010, AND OKS AND R	THAT TO	D THAT I HAVE E AND STATEMENT O (PROVIDER N THE BEST OF MY F THE PROVIDER LAWS AND REGULA EPORT WERE PROV (SIGNE	AME(S) AND N KNOWLEDGE AN IN ACCORDANC TIONS REGARD IDED IN COM	NUMBER(S) NO BELIEF E WITH A DING THE PLYANCE W	FOR THE TIS A PPLICABLE PROVISION	COST RE A TRUE, C INSTRUC OF HEAL LAWS AND	PORTING CORRECT TIONS, TH CARE REGULA	PERIOD AND EXCEPT	- - -
						PART	II - SETTLEMEN	T SUMMARY						
						TITI	E V		LE XVIII			TITLE X	XIX	
						1	i.	PART A 2	ŀ	ART B		4		1
2 S 3 S 4 S 5 S 6 I	HOSPITAL SUBPROVIDER I SWING BED - SNI SWING BED - NF SWILLED NURSING NURSING FACILIT HOME HEALTH AGE OUTPATIENT REH	g fac: Ty Ency			DER							10009	930	1 2 3 4 5 6 7 8
9 1	HEALTH CLINIC											10009	930	100

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

WORKSHEET S-2

HOSPITAL	AND	HEALTH	CARE	COMPLEX	IDENTIFICATION	DATA	
11001111111							

NOSPITAL AND SOSPITAL SALVEY CARE COMPLEX NORMESS:   P.O. DR. 570		SELLING THE HELLEN									
CONTROL   CONT	1 STREE	T: 1 BATEMAN CIRCLE		P.O.BOX: 570 ZIP CODE: 252	50 C	OUNTY: MASO	1			uamen.	
CONFORMERT  O	HOCDITAL AND	MOSPITAL-BASED COMPONENT I	DENTIFICATION:		DROWIDER	ידבת	e.				
SUBSTRAIN   LAKIN NOOPITAL   51-25401   11/15/1993   N   0   2   3   3   3   3   3   3   3   3   3						CERTIF		V	XVIII	XIX	
MORPHTAN	1,950 F 1 F 1 F 1 F 1 F 1 F 1 F 1 F 1 F 1 F				2	3		4	5	О	
SURPROVIDER I  SHIFT EDEC - SHIF  SHIFT EDEC - SHIF  SHIP TAL-ASSED SHIF  INDUSTRAL-ASSED SHIF  NOSPITAL-ASSED SHI			INKIN HOSPITAL		51-25401	11/15/	1983	N	N	0	
### SHINDS BEEDS - SHE			Latitati noor 2 mil								4
NOSPITAL-MARCH SITE	4 SWING	BEDS - SNF									
1					51~25401	11/15/	1983	N		0	7
NOSSITAL-MARCH HIME   SEPARATEN CERTIFIED ASC	7 HOSPI	TAL-BASED NF	LAKIN HOSPITAL		31 23101						
11 SEPARATELY CENTIFIED ASC 12 ROSCITAL—BREED MOSTAL—BREED MOSTAL—BREE											11
15   16   17   17   17   17   17   17   17	11 SEPAR	RATELY CERTIFIED ASC									
16 TYPE OF CONTROL  17 COST REPORTING PERIOD (60/00/1717)  18 TYPE OF CONTROL  19 TYPE OF CONTROL  10 10 10 10 10 10 10 10 10 10 10 10 10 1	14 HOSP	-BASED RHC	_								
TYPE OF CONTROL   TYPE OF CO	15 OUTPA	TIENT REHABILITATION PROVI	D .								10
19			· ·		FROM:				/2010		17
TYPE OF CONTROL	17 COST	REPORTING PERIOD (FM/DD/11					2				18
20   SUBPRIANCE	18 TYPE	OF CONTROL									
19   MOSPITAL   20   SUBPROVIDER   2	TYPE OF HOS	PITAL/SUBPROVIDER				9					
OTHER INFORMATION 21 MINOR DEPTREE IT YOUR MOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE 1 MINOR DEPTREE PRINCIPE FROM IN COLUMN 1. IF YOUR MOSPITAL IS GEOGRAPHICALLY CLASSIFIED OF LOCATED IN A RURAL AREA, IS YOUR SED SIZE IN ACCORDANCE WITH CR 4 412.705  LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "I" FOR 100 BEDS ON "FOR NO.  10. DISPROPORTIONIE SECTIVE QUALITY AND IS COMETINE OF THE PRINCIPLE OF THE STREET IN COLUMN 2 CTR 412.1067  21.00 ENTER IN COLUMN 1 HIDELATE IT FOR RECEIVE DECOGRAPHIC ENCLASSIFICATION? ENTER "I" FOR NO.  12.00 ENTER IN COLUMN 1 HIDELATE IT FOR RECEIVE DATE (mandal PRINCIPLE OF THE PRINCIPLE OF THE STREET	19 HOSP	ITAL									20
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LESS THAN OR EQUAL TO LOVE TABLE 19 COCREMENTLY ENCELVING PAYMENT FOR S  21.00 SONO PACILITY SECRIFICATION TO THE COURSE STATE OF THE S	COST	REPORTING PERIOD IN COLUMN	11. If TOOK HOSTITUD TO US	WITH CFR 42 41	12.105						
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AND 'N' FOR NO. IN JOING EDGORAPHIC DOCATION ETHER (1) URBAN (2) RUBAL. IF YOU ANSWERD  URBAN 11 DIDLORE IF YOU RECEIVED ETHER A WAGE OR STANDARD GEOGRAPHIC  URBAN 11 DIDLORE IF YOU RECEIVED ETHER A WAGE OR STANDARD GEOGRAPHIC  ES YESTICATION TO A RUBAL LOCATION, ENTER IN COLUMN 2 1'Y AND 'N' FOR NO. IF COLUMN 2  ES YESTICATION TO A RUBAL LOCATION, ENTER IN COLUMN 2 1'Y AND 'N' FOR NO. IF COLUMN 3  EACHLITY CONTAIN 100 OR FEMER BEDS IN ACCORDANCE WITH 42 CER 412.1055 ENGLOSY  1'Y FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE REVOLUTERS ACTION  OF THE COST REPORTING PERIOD. ENTER IN COLUMN 5 THE REVOLUTERS ACTION  OF THE COST REPORTING PERIOD. ENTER IN COLUMN 5 THE REVOLUTERS ACTION  21.05 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE  22.05 COST REPORTING PERIOD. ENTER IN COLUMN 5 THE REVOLUTERS ACTION  23.06 ENTIRE HOUSE PERIOD. ENTER IN THE REVOLUTE STATUS AT THE END OF THE  24.05 COST REPORTING PERIOD. ENTER IN THE PERIOD OF THE THERE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A  NO 21.06  25.06 ENT HIS HOUSE PERIOD. HOLLY FOR THE THERE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A  NO 22.  ARE YOU CLASSIFIED AS A REFERRAL CENTER?  15 FOR STANDARD GEOGRAPHIC RECLASSIFIED AS A REFERRAL CENTER? IF YES, ENTER CERTIFICATION DATE (STANDARD CENTER)  16 IT THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (STANDARD CENTER)  23.01 IF THIS IS A MEDICARE CERTIFIED LIVES TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (STANDARD CENTER)  24.01 IT FILLS IS A MEDICARE CERTIFIED LIVES TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (STANDARD CENTER)  25.05 IT HIS IS A MEDICARE CERTIFIED LIVES TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (STANDARD CENTER)  26.06 IT HIS IS A MEDICARE CERTIFIED LIVES TRANSPLANT CENTER ENTER THE CERTIFICATION DATE (STANDARD CENTER)  27.07 IT HIS IS A MEDICARE CERTIFIED LIVES TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (STANDARD CENTER)  28.06 IT HIS IS A MEDICARE CERTIFIED LIVES TRANSPLANT CENTER ENTER T				NTER 'Y' FOR YES	S						
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RECLASSIFICATION TO A ROBAL DOUBLE (ROW/Dd/yyy) (SEE INSTRUCTION). DOES YOUR IS YES, EMER IN COURM 3 PERE BEDS IN A ROCONDANCE WITH 42 CET 412.105? EMERS IN COURM 4 FACILITY CONTAIN 100 ON FREE BEDS IN ACCONDANCE WITH 42 CET 412.105? EMERS IN COURM 4 FACILITY CONTAIN 100 ON FREE BEDS IN ACCONDANCE WITH 42 CET 412.105? EMERS IN COURM 4 21.04 COT THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. 21.05 COT THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. 22.06 DOES THIS HOSTITAL QUALITY FOR THE THREE-YEAR THROUGH, WHAT IS YOUR STATUS AT THE END OF THE 22.10.6 DOES THIS HOSTITAL QUALITY FOR THE THREE-YEAR THROUGH, WHAT IS YOUR STATUS AT THE END OF THE 23.00 IN THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. 24.00 CLASSIFIED AS A REFERRANCE FANTE OF ANY END OF THE COST REPORTING PERIOD. ENTER (1) UNDER THE PROSPECTIVE PAYHENT STEAM FOR HOSPITAL OUTPATIENT SERVICES  SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYHENT STEAM FOR HOSPITAL OUTPATIENT SERVICES  SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYHENT STEAM FOR HOSPITAL OUTPATIENT SERVICES  SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYHENT STEAM FOR HOSPITAL OUTPATIENT SERVICES  SMALL RURAL HOSPITAL UNDER THE RURAL THREE-YEAR THREN THE CERTIFICATION DATE (1) THIS IS A MEDICARE CENTER THE CHTER THE CERTIFICATION DATE (2) AND TERMINATION IN COL. 3.  23.01 IF THIS IS A MEDICARE CENTIFIED KIENCH TERMS FLANT CENTER, ENTER THE CERTIFICATION DATE (2) THIS IS A MEDICARE CENTIFIED AND TERMINATION IN COL. 3.  23.04 IF THIS IS A MEDICARE CENTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (2) THE SILVE AND TERMINATION IN COL. 3.  23.05 IF HEIDICARE PRANCERS TENNISHANT ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION IN COL. 3.  24.10 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (2) THIS IS AND TERMINATION IN COL. 3.  25.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (2) THIS IS AND TERMINATION IN COL. 3.  26.10 IN	URBA	IN IN COLUMN I INDICATE IF	TOU KECETAED BILLIEU 3	VI AND 'N' FOR	NO. IF COL	UMN 2					
PACILITY CONTRIN 100 OR FEWER MEDICAL COLUMN 6 THE PROVIDERS ACTUAL MENA OR CESSA.  1. 'FOR YES AUDITOR OR ONE OF THE COST RECORDS ACTUAL MENA OR CESSA.  21.04 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT MAGE), WHAT IS YOUR STATUS AT THE BEGINNING  21.05 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT MAGE), WHAT IS YOUR STATUS AT THE END OF THE  22.05 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT MAGE), WHAT IS YOUR STATUS AT THE END OF THE  23.06 DOES THIS NOT BELL OWLAITY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A  24.06 DOES THIS NOT BELL OWLAITY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A  25.06 DOES THIS NOT BELL OWLAITY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A  26.07 DOES THIS FACILITY OPERATE A TRANSPELANT CENTER, ENTER THE CERTIFICATION DATE (SINCE AND ADDRESSED AN	RECI	ASSIFICATION TO A RURAL LOVES ENTER IN COLUMN 3 THE	EFFECTIVE DATE (mm/dd/yyyy)	(SEE INSTRUCTION	N). DOES YOU	OUR					
21.04 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (1) RERNA RAND (2) RURAL.  21.05 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOW AGE), WHAT IS YOUR STATUS AT THE END OF THE 22.10.5 FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOW AGE), WHAT IS YOUR STATUS AT THE END OF THE 23.06 DOES THIS HOSPITAL GUNDER THE RESETERS TRANSITION OF HOLD HARMLESS PAYMENTS FOR A 10.00 DOES THIS HOSPITAL GUNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES SHALL RURAL NEWS HOUSE THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES  NO 23.01  1F THIS IS A MEDICARE CERTIFIED LIVER THANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.02  24.01  25.01 IF THIS IS A MEDICARE CERTIFIED LIVER THANSPLANT CENTER, ENTER THE CERTIFICATION DATE  25.02 IF THIS IS A MEDICARE CERTIFIED SILEST TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  26.01 IF THIS IS A MEDICARE CERTIFIED SILEST TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  27.01 IF THIS IS A MEDICARE CERTIFIED SILEST TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  28.01 IF THIS IS A MEDICARE CERTIFIED SILEST TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  29.01 IF THIS IS A MEDICARE CERTIFIED SILEST TRANSPLANT CENT	FACI	LITY CONTAIN 100 OR FEWER	BEDS IN WCCOMPANCE WITH	DC DCTUAL MCA O	R CBSA.						21 04
OF THE COST REPORTING PERCENTIANS SEPTICATION (NOT WASE), WHAT IS YOUR STATUS AT THE END OF THE 2 COST REPORTING PERIOD. ENTER 31) UNBARN AND (2) RURAL.  21.06 DOES THIS HOSTITAL QUALIFF FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SHALL RURAL HOSTITAL QUALIFF FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS SERVICES SHALL RURAL HOSTITAL QUALIFF FOR THE PROSPECTIVE PAYMENT SYSTEM FOR HOSTITAL QUALIFF FOR THE PROSPECTIVE PAYMENT SYSTEM FOR HOSTITAL QUALIFF FOR A SHALL RURAL HOSTITAL QUALIFF FOR THE PROSPECTIVE PAYMENT SYSTEM FOR HOSTITAL QUALIFF FOR A SHALL RURAL HOSTITAL QUALIFF FOR THE PROSPECTIVE PAYMENT SYSTEM FOR HOSTITAL QUALIFF FOR A SHALL RURAL HOSTITAL QUALIFF FOR THE PAYMENT SERVICES SHALL RURAL HOSTITAL TO PER A SHALL RURAL HOSTITAL OPERATE A SHALL RURAL HOSTITAL TO PER A SHALL RURAL HOSTITAL TO PER A SHALL RURAL HOSTITAL THE PAYMENT SERVICES SHALL RURAL HOSTITAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.06 IF THIS IS A REDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.07 IF THIS IS A REDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  24.11 THIS AND ROBRAD PROCUEDMENT ORGANIZATION (DPO), ENTER THE OPD NUMBER IN COL 2. THE THIS AND ROBRAD HOSTITAL HOSTITAL HOSTITAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  25.11 THIS A TRACKING PROGRAM APPROVED IN ACCORDANCE WITH CROPPED AND A SERVICES AS NO 25.02  25.12 THIS A TEACHING HOSTITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING NO 25.02  25.02 THE LIBE 25.01 IS YES, WAS MEDICARE PRATICI					AT THE BE	GINNING	2				
COST REPORTING PERIOD. THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SHALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES  UNDER DRA SCRION 310 EDITER 'Y' FOR YES AND 'N' FOR NO.  22 ARE YOU CLASSIFIED AS A REFERRAL CENTER?  23 DOES THIS FACE REPERAL CENTER?  24 ARE YOU CLASSIFIED AS A REFERRAL CENTER?  25 OLDS THIS FACE CERTIFIED KINNEY TRANSPLANT CENTER, ENTER CERTIFICATION DATE  17 COL. 2 AND TERMINATION IN COL. 3.  28 OLDS THIS FACE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  18 COL. 2 AND TERMINATION IN COL. 3.  29 OLD 18 THE STAN A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  29 OLD 2 AND TERMINATION IN COL. 3.  20 OLD 3 AND TERMINATION IN COL. 3.  20 OLD 4 AND TERMINATION IN COL. 3.  21 OLD 2 AND TERMINATION IN COL. 3.  22 OLD 4 THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23 OLD 4 THIS IS A MEDICARE CERTIFIED LIVE TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  24 OLD 5 THE FORM AND THE TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  25 OLD 6 THE THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  26 OLD 7 THE THIS AS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  27 OLD 7 THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  28 OLD 7 THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  29 OLD 7 THIS IS A MEDICARE CERTIFIED SLEET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  20 OLD 7 THIS IS A MEDICARE CERTIFIED TO SAME THE CENTER THE CERTIFICATION DATE  29 OLD 7 THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CONCERNMENT TO OLD 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER	OF S	THE COST REPORTING PERIOD.	ENTER (1) URBAN AND (2) KUK SIFICATION (NOT WAGE), WHAT	IS YOUR STATUS	AT THE EN	D OF THE	2				21.05
SHALL RURAL HOSPITAL QUALITY FOR THE INTERTINATION STATEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105; EMPTER 'Y' FOR MES AND 'N' FOR NO.  22 ARE YOU CLASSIFIED AS A REFERRAL CENTER. 23 DOES THIS FACILITY OPERATE A TRANSPLANT ENTERS IF YES, ENTER CERTIFICATION DATE  23 DOES THIS FACILITY OPERATE A TRANSPLANT ENTERS IF YES, ENTER CERTIFICATION DATE  23 LI THIS IS A MEDICARE CERTIFIED KINEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  24 LI THIS IS A MEDICARE CERTIFIED HORST TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  25 LI THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  26 LI THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  27 LI THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  28 LI THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  29 LI THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION  20 AND TERMINATION DATE.  20 LI THIS IS A MEDICARE TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERLING CERTIFICATION  20 AND TERMINATION DATE.  21 LI THIS AN ORGAN PROCURENENT ORGANIZATION (OPO), ENTER THE CERTIFICATION DATE  22 LI THIS AN ORGAN PROCURENENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL. 2.  24 LI THIS AN ORGAN PROCURENENT ORGANIZATION COPPOLATE NUMBER, IN COL. 2.  25 LI THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  26 LI THIS SA REDICARE TRANSPLANT CENTER; ENTER THE CON (PROVIDER NUMBER) IN COL. 2.  27 LI THIS EN REDICARE TRANSPLANT CENTER; ENTER THE CON (PROVIDER NUMBER) IN COL. 2.  28 LI THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  29 LI THIS EN REDICARE TRANSPLANT CENTER; ENTER THE CON (PROVIDER NUMBER) IN COL. 2.  21 LI THIS EN REDICARE TRANSPLANT CENTER; ENTER THE CON (PROVIDER NUMBER) IN COL. 2.  25 LIS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  20 LIS THIS TEACHING HOSPITAL OR AFFILIATED WITH A T	COS	r reporting period, enter t	I) ONDING THE MANUATORON	AR UATA HARMIES	S PAYMENTS	FOR A	10				21.06
UNDER DRA SECTION 5105; PIER I T. CO. 22  22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? IF YES, ENTER CERTIFICATION DATE (S) BELOW NO 23  23 ODES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE (S) BELOW NO 23  23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (S) 23.01  23.02 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (S) 23.03  23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (S) 23.04  23.04 IF THIS IS A MEDICARE CERTIFIED LONG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (S) 23.05  23.05 IF MEDICARE PANCRESS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION (S) 23.06  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION (S) 23.06  23.07 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION (S) 23.07  23.07 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (S) 23.07  24.07 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (S) 23.07  25.07 IF THIS IS A MEDICARE CERTIFIED SUBSTITUTION (S) (S) ENTER THE OPO NUMBER IN COL 2. (A) ADD TERMINATION IN COL. 3. (A	21.06 DOE:	S THIS HOSPITAL QUALIFY FOR	PROSPECTIVE PAYMENT SYSTEM	FOR HOSPITAL C	UTPATIENT	SERVICES					
DOES THIS FACILITY OPERATE A TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  1N COL. 2 AND TERMINATION IN COL. 3.  23.01 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  1N COL. 2 AND TERMINATION IN COL. 3.  10 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.04 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.05 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.06 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION  23.07 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION  23.08 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION  23.09 AND TERMINATION DATE.  23.00 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  24.10 IF THIS AND ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL. 2.  25.11 IF THIS AND ORGAN PROCUREMENT CENTER, ENTER THE CON (PROVIDER NUMBER) IN COL. 2.  26.12 IF THIS AND ORGAN PROCUREMENT CENTER, ENTER THE CON (PROVIDER NUMBER) IN COL. 2.  27.18 IF THIS AND ORGAN PROCUREMENT CENTER, ENTER THE CON (PROVIDER NUMBER) IN COL. 2.  28.19 IF THIS AND ORGAN PROCUREMENT CENTER, ENTER THE CON TRANSPLANT ON COL. 3.  29.10 IF THIS AND ORGAN APPROVED IN ACCORDANCE WITH CMS PUBLICATION PROPERED TO THE COL. 3.  20.10 IS THIS TERCHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUBLICATION PROBLEM TO THE COL. 3.  29.10 IS THIS TERCHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUBLICATION PROBLEM TO THE COL. 3.  29.10 IS THIS TERCHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUBLICATION PROBLEM TO THE COL. 3.  29.10 IS THIS TERCHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUBLICATION PROBLEM TO THE COL. 3.  29.10 IS THIS TERCHING PROGR	UND	ER DRA SECTION 5105? ENTER	I TOK IES AND W TOWN								0.70
23.01 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  1N COL. 2 AND TERMINATION IN COL. 3.  23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.04 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  1N COL. 2 AND TERMINATION IN COL. 3.  23.05 IF MEDICARE PARCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION  AND TERMINATION DATE.  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION  AND TERMINATION DATE.  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION  DATE IN COL. 2 AND TERMINATION IN COL. 3.  24. IF THIS A MEDICARE TRANSPLANT CONTER ENTER THE CERTIFICATION DATE  10. COL. 2 AND TERMINATION IN COL. 3.  24. IF THIS A MEDICARE TRANSPLANT CONTER, ENTER THE OPO NUMBER IN COL 2.  25. AND TERMINATION IN COL. 3.  26. CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  27. IT THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE  28. CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  29. OF THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  20. OF THIS A TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CHAPTER 4?  20. OF THIS COL. 2 AND TERMINATION OF THE COST REPORTING PERIOD IT PYES, COMPLETE  NO MORKSHEET C-3, PART IV. IF NO, COMPLETE WORKSHEET D-2. PART II.  21. OF THIS IS A MEDICARE TRANSPLANT OF THE MORKSHEET D-2. PART II.  22. OF THIS A TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CHAPTER 4?  23. OF THE COLUMN OF THE COLUMN OF THE COST REPORTING PERIOD IT PYES, COMPLETE  NO MORKSHEET C-3, PART IV. IF NO, COMPLETE WORKSHEET D-2. PART II.  23. OF THE PROCREMENT OF THE PROBLEM OF THE PERIOD OF THE PROCREMENT OF THE PERIOD OF THE PERIOD OF THE PERIOD OF THE	22 ARE	YOU CLASSIFIED AS A REFERR THIS FACILITY OPERATE A T	RANSPLANT CENTER? IF YES, E	ENTER CERTIFICAT	TION DATE (S	DATE	Ю				
23.02 IF THIS IS A MEDICARE CERTIFIED HARK TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  10 COL. 2 AND TERMINATION IN COL. 3.  23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  10 COL. 2 AND TERMINATION IN COL. 3.  23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  11 N COL. 2 AND TERMINATION IN COL. 3.  23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION  AND TERMINATION DATE.  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION  AND TERMINATION DATE.  23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  10 COL. 2 AND TERMINATION IN COL. 3.  24 IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2.  25 AND TERMINATION IN COL. 3.  26 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL. 2, THE  27 CERTIFICATION DATE OR RECERTIFICATION DATE (RETER DECEMBER 26, 2007) IN COL 3.  28 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  29 PAYMENTS FOR I 4 R?  20 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  20 NO MORSHEET B-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  21 NO MORSHEET B-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TRANSPLANT FOR NO 10 PARTICIPATION AND APPROVED TO REVISICIANS' SERVICES AS NO 25.03  25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS NO 25.04  26.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  27 DEFINED IN CMS PUBL 15-1, SECTION 21499 IF YES, COMPLETE WORKSHEET D-2  28.06 ARS YOUR FACILITY DIRECT GME FTE CAP (COLUMN I) OR IME CAP IV. FOR NO IN THE APPELICABLE COLUMNS. (SEE INSTRUCTIONS)  29 DEFINED IN CASE PUBL 15-1, SECTION 2149 IF YES, COMPLETE WORKSHEET D-3 NO 25.04  29 DEFINED IN CASE PUBL 15	23.01 IF	THIS IS A MEDICARE CERTIFIE	D KIDNET INMSTERMIT CONTENT								23.02
IN COL. 2 AND TERMINATION IN COL. 3.  33.04 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  IN COL. 2 AND TERMINATION IN COL. 3.  23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION  23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE  23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE COL. 2.  24 IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL. 2.  25 IS THIS AN AREDICARE TRANSPLANT CENTER THE CCN (PROVIDER NUMBER) IN COL. 2.  26 IS THIS A TEACHING HOSE OF A RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL. 3.  27 IS THIS A TEACHING HOSEITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  28 IS THIS A TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CRAPTER 4?  29 IN LINE 25-01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  10 IN COL. 2. AND TERMING THE FIRST MONTH OF THE COST REPORTING PERIODY IF YES, COMPLETE  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  25-03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS  10 IN COL. 2.  25-04 ARE YOU CLAIMING COSTS ON LINE 70 OF MORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  25-05 AND YOUR FACILITY DIRECT GIVE FITE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER  42 CER 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  10 HE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  11 HE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  12 HAS POUR FACILITY RECEIVED ADDITIONAL DIRECT GME FITE RESIDENT CAP SLOTS OR IME FTE  25-06 HAS YOUR FACILITY RECEIVED ADD	22 02 TE	THIS IS A MEDICARE CERTIFIE	D HEART INMISERMAT COULDNY	ENTER THE CERTI	IFICATION L	DATE					
IN COL. 2 AND TERMINATION IN COL. 3.  23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.  23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.  23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.  24 IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL. 2, THE AND TERMINATION IN COL. 3.  25 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL. 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL. 3.  25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  26 IF THIS A A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  27 IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  28 OBJETINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  29 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  20 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  20 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  20 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  20 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  21 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  22 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  23 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  25 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  26 DEFINED IN CMS PUBB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  27 DEFINED IN CMS PUBB. 15-1, SECTION 2148	IN	COL. 2 AND TERMINATION IN C	CD LIVER TRANSPLANT CENTER,	ENTER THE CERT	IFICATION D	DATE					23.03
IN COL. 2 AND TERMINATION HOLD.  23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.  23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE  DATE IN COL. 2 AND TERMINATION IN COL. 3.  23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.  24 IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.  25 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  25 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?  NO 25.01  25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  NO 25.02  25 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?  NO 25.03  25 IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? If YES, COMPLETE WORKSHEET D-3.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUBLICATION OF THE COLUMN 21	23.03 II	COL. 2 AND TERMINATION IN C	COL. 3.	ENTER THE CERTII	FICATION DA	ATE					23.04
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IN COL. 2 AND TERMINATION IN COL. 3.  1F THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2.  AND TERMINATION IN COL. 3.  24.01 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  1S THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  PAYMENTS FOR I 6 R?  25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?  NO 25.02  25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  NO 25.02  25.03 IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 21487 IF YES, COMPLETE WORKSHEET D-9.  25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER  42 CFR 413.79(c) (3) OR 42 CFR 412.105(f) (1) (iv) (B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  25.06  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06	DAT	THE IN COL. 2 AND TERMINATION	ED ISLET TRANSPLANT CENTER	ENTER THE CERTI	FICATION D	ATE					
AND TERMINATION IN COL. 3.  24.01 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  PAYMENTS FOR I 4 R?  25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?  25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  NO  25.02  25.03 IS THIS TEACHING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER  42 CFR 413.79(c) (3) OR 42 CFR 412.105(f) (1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  25.06	23.07 II	COL. 2 AND TERMINATION IN	COL. 3.	HE OPO NUMBER I	N COL 2.						24
24.01 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER INCOMPLETE CAPTER DECEMBER 26, 2007) IN COL 3.  CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.  25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING  PAYMENTS FOR I 6 R?  25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?  NO 25.02  25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  NO 25.02  IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER  42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  25.06  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06	24 IF ANI	THIS AN ORGAN PROCURENTALLY TERMINATION IN COL. 3.	ONGINE DIE CON (PRO	ALLOCO MUMBER! I	N COL 2. T	HE					24.01
IS THIS A TEACHING HOSPITAL OR AFFIRMED WITH CMS PUB. 15-I, CHAPTER 4?  PRYMENTS FOR I 6 R?  25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?  NO 25.02  25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-9, PART III.  DEFINED IN CMS PUB. 15-I, SECTION 21487 IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 21487 IF YES, COMPLETE WORKSHEET D-2  25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUNN 1) OR IME CAP (COLUNN 2) BEEN REDUCED UNDER  42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUNNS. (SEE INSTRUCTIONS)  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06	24.01 IF	THIS A MEDICARE TRANSPLANT	FICATION DATE (AFTER DECEMB	ER 26, 2007) IN	COL 3.	VINC	NO				25
25.02 25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? 25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS  IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE  WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.  25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-2  25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER  42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  25.06  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06	25 IS	THIS A TEACHING HOSPITAL O	K WILLPINIED MILL II YELLOWE			KING					25 01
25.02 IF LINE 25.01 IS YES, WAS MEDICARD FAMILIAND FAMIL	PA:	YMENTS FOR I & R?	THE PARCENTAGE WITH CMG	DIIR 15-T. CHA	PTER 4?						
WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET FOR PHYSICIANS' SERVICES AS  25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS  DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.  NO  25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  NO  25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER  42 CFR 413.79(c) (3) OR 42 CFR 412.105(f) (1) (iv) (B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06	25.02 IF	LINE 25.01 IS YES, WAS MED	NTU OF THE COST REPORTING E	ERIOD? IF YES,	COMPLETE		1500000				
25.03 AS A TEACHING HOSPITAL, DID 100 ELECT COST KENTINGENEET D-9.  DEFINED IN CMS PUB. 15-1, SECTION 21487 IF YES, COMPLETE WORKSHEET D-9.  25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2  NO  25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUNN 1) OR IME CAP (COLUNN 2) BEEN REDUCED UNDER  42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUNNS. (SEE INSTRUCTIONS)  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE	IN	EFFECT DURING THE FIRST INC	WIN OF THE COOK HOPENERS OF T	NDT II			NO				25.03
25.04 ARE YOU CLAIMING COSTS ON DING 1/0 OF MARK 2001 ARE YOU CLAIMING COSTS ON DING 1/0 OF MARK 2001 ARE YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER  42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.07 (A) OR 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR	25.03 AS	A TEACHING HOSPITAL, DID I	OU ELECT COST KETTBOROSIET	WORKSHEET D-9.		n 1953	NO				25.04
25.05 HAS YOUR FACILITY DIRECT GME FIE CAP (12.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN  THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE	25 NA AR	E YOU CLAIMING COSTS ON DIE	E 10 Of HOMIONDER	onn (cottinue 2) I	BEEN REDUCE	ED UNDER	NO				
THE APPLICABLE COLUMNS. (SEE INSTANCE) THE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE	25.05 HA	S YOUR FACILITY DIRECT GIVE	412.105(f)(1)(iv)(B)? ENT	ER 'Y' FOR YES	AND 'N' FOR	R NO IN					
25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT ON 42 CFR 412.105(f) (1) (iv) (C)? ENTER 'Y' FOR	TH	E APPLICABLE COLUMNS, (SEE	INSTRUCTIONS!	CYDENT CAR SLOTS	S OR IME E	ΓE					25.06
YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)					v)(C)? ENT	ER 'Y' FOR					
*** Commence of the tention of the t	YE	S AND 'N' FOR NO IN THE API	PLICABLE COLUMNS. (SEE INST	KOCTIONS)							

#### HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

PERIOD FROM 07/01/2009 TO 06/30/2010 IN LIEU OF FORM CMS-2352-90 (03/20	3071	11/5	47 2424	
HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA			WORKSHEI (CONTI)	
OTHER INFORMATION 26 IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR				26
NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.  26.01 ENTER THE APPLICABLE SCH DATES:  26.03 IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT				26.01 26.03
AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA. 26.04 IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):				26.04
BEGINNING: ENDING: BEGINNING: ENDING: ENDING: ENDING: 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913	Ю			27
FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.				28
OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 20.02.				28.01
IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OK AFTER OCTOBER 1ST				28.02
If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SHE REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED				
EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS) 28.03 STAFFING	0.00	N		28.03 28.04
28.04 RECRUITMENT 28.05 RETENTION OF EMPLOYEES	0.00	13		28.05 28.06
28.06 TRAINING 28.07 OTHER (SPECIFY)	0100	2.0		28.07
29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE	ИО			29
AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?  DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS	МО			30
HOSPITAL (CAH)? SEE 42 CFR 485.606ff. 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH?				30.01
SEE 42 CFR 413.70. 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF				30.02
PAYMENT FOR OUTPATIENT SERVICES?				30.03
SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE HOST DE				22 24
30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR 16K TRAININ PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE	G			30.04
WORKSHEET D-2, PART II.  31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE?  SEE 42 CFR 412.113(c).	NO			31
MISCELLANEOUS COST REPORTING INFORMATION 32 IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY)	NO			32
IN COLUMN 2.  33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N'	NO			33
FOR NO IN COLUMN 2.  34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?  35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO NO			34 35
	V	XVIII	XIX 3	
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL  36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO 1	NO	00	36
36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONALE SHAKE IN ACCOMMENDED		120		36.01
DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?  37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	МО	ИО	ИО	37 37.01
51.01 It 100 ARD A ROLD BARGEDOO FRONTING TO THE TOTAL T				

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 (CONTINUED)

				### N=1 N = 1 N   N
38 38.01 38.02	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	PART?	NO NO NO NO NO	38 38.01 38.02 38.03 36.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION,		YES	40
40.02 40.03 41 42 42.01 42.02 43 44	EMTER THE NAME AND ADDRESS OF THE HOME OFFICE.  NAME:  FI/CONTRACTOR'S NAME:  STREET:  CITY:  ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?  ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?  ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?  ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?  ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?  ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?  IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ON	P.O.BOX STATE: NLY? I?	ZIP CODE: YES YES YES YES NO NO NO	40.01 40.02 40.03 41 42 42.01 42.02 43 44
	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY TROUBLE (mm/dd/yyyy) IN COLUME SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMES THERE A CHANGE IN THE STATISTICAL BASIS?  WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASE DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.			45.01 45.02 45.03 46

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

ENTE	A . I. FOR EACH COMPONENT WAS LIFE OF OR		CONTRACTOR DE SACROCACIONOS				0.00				
					OUTPATIENT	OUTPATIENT		UTPATIENT DIAGNOSTIC			
		PART	A PA	RT B		RADIOLOGY	L	5 5			
	HOSPITAL SUBPROVIDER I SKILLED NURSING FACILITY	. 1		2	3	4 N		ท			47
47	UNCETTAL.	N		H	N	N		N			48
48	SUBPROVIDER I	14		31	N			3.5			49
49	SKILLED NURSING FACILITY	11		11							50
50	HOME HEALTH AGENCY	N		N	<b>2</b> 3)						
50				n cint	TANCES IN ACCORDANCE	HTTH	NO				52
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FO	R EXTR	AORDINARY CI	KCOM	STANCES IN ACCOMPTANCE						10107-1210
	42 CFR 412.348(e)? IF YOU ARE A FULLY PROSPECTIVE OR HOLD H						NO				52.01
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD IN EXCEPTION PAYMENT PURSUANT TO 42 CFR 412	348 (4)	12 IF YES. C	OMPLE	ETE L, PART IV.						53
1020						atus in					53
53						ЭИ					
	53.01 FOR NUMBER OF PERIODS IN EXCESS OF	ONE A	ND ENTER SUE	SEQUI	ENT DATES.						53.01
C2 01	WOULD DEDICE.		DEGI	NNING	G: E	NDING:					54
53.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND	PAID	LOSSES:								177
	PREMIUMS: PAID LOSSES:		AND/OR	SELF	INSURANCE:	MID	NO				54.01
54.01	PREMIUMS: PAID LOSSES: ARE MALPRACTICE PREMIUMS AND PAID LOSSES	REPOR	TED IN OTHER	THA	N THE AUMINISTRATIVE	MOUNTS	110				
01.02	GENERAL COST CENTER? IF YES, SUBMIT SUPE	ORTING	SCHEDULE LI	STIN	G COST CENTERS AND A	11001110					
							МО				55
55	CONTAINED THEREIN. DOES YOUR FACILITY QUALIFY FOR ADDITIONA	L PROS	PECTIVE PAIR	ICM1	IN ACCOMPAND WITH						
	42 CFR 412.107. ENTER 'Y' FOR YES AND 'N	I. FOR	NO.			DATE	Y/N	LIMIT	Y/N	FEES	
						0	1	2	3	4	
	ARE YOU CLAIMING AMBULANCE COSTS? IF YES	ENTE	R IN COL 2	THE P	AYMENT LIMIT	/ /	110	0.00	NO		56
56											
	ENTER IN COL 4, IF APPLICABLE, THE FEE 3	SCHEDUL	LES AMOUNTS	FOR T	HE PERIOD						
	DECTANTAC ON OR DETER 4/1/2002.						NO				. 57
57		LTH COS	STS?	VAII	CONTAIN AN IRE SHEP	OVIDER?	NO				58
58	ARE YOU CLAIMING NURSING AND ALLIED HEAR	ILITY (	(IRE), OR DO	VOII	MADE THE ELECTION FO	R 100%					
	ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FO	I FOD \	TE THO THI	FOR N	O THIS OPTION IS O	VJ.Y					
	PPS REIMBURSEMENT? ENTER IN COLUMN Z 1 AVAILABLE FOR COST REPORTING PERIODS BE	CIMMIN	ON OR AFTE	R 1/1	/2002 AND BEFORE 10.	/1/2002.					FO 01
	AVAILABLE FOR COST REPORTING PERIODS BE IF LINE 58 COLUMN 1 IS Y, DOES THE FACI	LITY H	AVE A TEACHI	NG PE	ROGRAM IN THE MOST R	ECENT					58.01
58.0	COST REPORTING PERIOD ENDING ON OR BEFO	RE NOVE	EMBER 15, 20	04? E	ENTER IN COLUMN 1 'Y	FOR YES					
	OR 'N' FOR NO. IS THE FACILITY TRAINING	RESID	ENTS IN A NE	W TE	ACHING PROGRAM IN AC	CORDANCE					
	OR 'N' FOR NO. IS THE FACILITY TRAINING WITH FR VOL 70, NO 156 DATED AUGUST 15,	2005	PAGE 47929?	ENTE	R IN COLUMN 2 'Y' FO	R YES OR					
	WITH FR VOL 70, NO 156 DATED AUGUST 15, 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1,	2, OR 3	3 RESPECTIVE	LY II	N COLUMN 3 (SEE INST	RUCTIONS)					
	'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, IF THE CURRENT COST REPORTING PERIOD CO	VERS T	HE BEGINNING	OF '	THE FOURTH ENTER 4 I	M COTOWN 2					
	OR IF THE SUBSEQUENT ACADEMIC YEARS OF	THE NE	w teaching f	ROGRA	AM IN EXISTENCE, ENI	EN J.					
							ИО				59
59	(SEE INSTRUCTIONS) ARE YOU A LONG TERM CARE HOSPITAL (LTCH	), OR	DO YOU CONTA	TN W	MADE THE ELECTION F	OR 100%	1500000				
55.5						S)					
	PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y	FOR	TES WAD IA	COR							

53 KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (05/2007) VERSION: 2008.05 11/30/2010 12:13 PROVIDER NO. 5125401 LAKIN HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010 WORKSHEET S-2 (CONTINUED) HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A
NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)

60.01 IF LIME 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT
COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N'
FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH
42 CFR SEC. 412.424(d) (1) (111) (2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2
IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST
REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE
SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.) 60 NO 60.01 MULTICAMPUS AMPUS
DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO.
IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2,
ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.
COUNTY: 61 NQ FTE/

STATE: ZIP CODE

CBSA

CAMPUS 5

PROVIDER NO. 5125401 LAKIN HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

### HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	TITLE V 3	TITLE XVIII	/ O/P VISITS LTCH NONCOVERED DAYS 4.01	/ TRIPS TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL								1	
	SWING BED, OBSERV & HOSPICE DAYS								2	
2	HMO								3	
3	HOSPITAL ADULTS & PEDS -									
4	SWING BED SNF HOSPITAL ADULTS & PEDS -								4	
4	SWING BED NF								5	
5	TOTAL ADULTS & PEDS								•	
	EXCL OBSERVATION BEDS								6	
6	INTENSIVE CARE UNIT								7	
7	CORONARY CARE UNIT								8	
8	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT								9	
9	OTHER SPECIAL CARE (SPECIFY)								10	
10 11	NURSERY								11 12	
12	TOTAL HOSPITAL								13	
13	RPCH VISITS								14	
14	SUBPROVIDER I								15	
15	SKILLED NURSING FACILITY							31978	16	
16	NURSING FACILITY	114	41610					022.0	17	
17	OTHER LONG TERM CARE								18	
18	HOME HEALTH AGENCY								20	
20	ASC (DISTINCT PART)								21	
21	HOSPICE (DISTINCT PART)								23	
23	O/P REHAB PROVIDER RHC I								24	
24 25	TOTAL	114							25 26	
26	OBSERVATION BED DAYS								27	
27	AMBULANCE TRIPS								28	
28	EMPLOYEE DISCOUNT DAYS								20	
575250	CONTRACTOR SECRETARION D									

PROVIDER NO. 5125401 LAKIN HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/2000) VERSION: 2008.05 11/30/2010 12:13

### HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

OBS. OBS. OBS. LESS I&R
BEDS NOT TOTAL ALL
ADMITTED PATIENTS ADMITTED ADMITTED ADMITTED ADMITTED TOTAL PHYS ANES NET ON PAYROLL WORKERS

5.02 6 6.01 6.02 7 8 9 10 11

	COMPONENT	ADMITTED 5.02	PATIENTS 6	ADMITTED 6.01	ADMITTED 6.02	TOTAL 7	PHYS ANES	NET 9	ON PAYROLL 10	WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL.	V0									1
-	SWING BED, OBSERV & HOSPICE DA	113									2
2	HMO XIX										3
3	HOSPITAL ADULTS & PEDS - SWING BED SNF										4
4	HOSPITAL ADULTS & PEDS - SWING BED NF										-
5	TOTAL ADULTS & PEDS										5.
72	EXCL OBSERVATION BEDS										6
6	INTENSIVE CARE UNIT										7
1	CORONARY CARE UNIT										8
8	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT										9
9											10
10	OTHER SPECIAL CARE (SPECIFY)										11
11	NURSERY TOTAL HOSPITAL										12
12	RPCH VISITS										13
13	SUBPROVIDER I										14
14	SKILLED NURSING FACILITY								10 610 6100		15
15 16	NURSING FACILITY		32587						165.08		16
17	OTHER LONG TERM CARE		TO TOTAL TO SE								17
18	HOME HEALTH AGENCY										18
20	ASC (DISTINCT PART)										20
21	HOSPICE (DISTINCT PART)										21
23	O/P REHAB PROVIDER										23 24
24	RHC I								165.00		25
25	TOTAL								165.08		26
26	OBSERVATION BED DAYS										27
27	AMBULANCE TRIPS										28
28	EMPLOYEE DISCOUNT DAYS										20
	The second secon										

### HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

VERSION: 2008.05 11/30/2010 12:13 WORKSHEET S-3
PART I
(CONTINUED)

COMPONENT  TITLE V XVIII XIX PATIENTS 12 13 14 15  1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS 2 HMO XIX	
SWING BED, OBSERV & HOSPICE DAYS 2 HMO XIX	
SWING BED, OBSERV & HOSPICE DAYS 2 HMO XIX	
2 HMO XIX	
3 HOSPITAL ADULTS & PEDS - SWING BED SNF	
MIND DEL ME	
SWING BED NF	
5 TOTAL ADULTS & PEDS	
EXCL OBSERVATION BEDS	
6 INTENSIVE CARE UNIT 7 CORONARY CARE UNIT	
8 BURN INTENSIVE CARE UNIT	
9 SURGICAL INTENSIVE CARE UNIT	
10 OTHER SPECIAL CARE (SPECIFY)	
11 NURSERY	
12 TOTAL HOSPITAL	
13 RPCH VISITS	
14 SUBPROVIDER I 15 SKILLED NURSING FACILITY	
15 SKILLED NURSING FACILITY 16 NURSING FACILITY	
17 OTHER LONG TERM CARE	
18 HOME HEALTH AGENCY	
20 ASC (DISTINCT PART)	
21 HOSPICE (DISTINCT PART)	
23 O/P REHAB PROVIDER	
24 RHC I 25 TOTAL	
25 TOTAL 26 OBSERVATION BED DAYS	
27 AMBULANCE TRIPS	
28 EMPLOYEE DISCOUNT DAYS	

### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/2000)

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PERIOD FROM 07/01/2009 TO 06/30/2010				NM CMS-2332-3			
HOSPITAL WAGE INDEX INFORMATION	9	RECLASS. OF SALARIES	ADJUSTED SALARIES	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE	משמח	WORKSHEET S-3 PART II
PART II - WAGE DATA	AMOUNT REPORTED	FROM WKST.	(COL.1 +	IN COL.3	COL. 4)	SOURCE	
NON-PHYSICIAN ANESTHETIST PART A NON-PHYSICIAN ANESTHETIST PART B PHYSICIAN - PART A 4.01 TEACHING PHYSICIAN SALARIES PHYSICIAN - PART B NON-PHYSICIAN - PART B INTERNS & RESIDENTS (IN APPR PGM) CONTRACT SERVICES, I&R HOME OFFICE PERSONNEL	4399100	2	3	,	·		1 2 3 4 4.01 5 5.01 6 6.01
8 SNF 8.01 EXCLUDED AREA SALARIES OTHER WAGES & RELATED COSTS 9 CONTRACT LABOR 9.01 PHARMACY SERVICES UNDER CONTRACT 9.02 LABORATORY SERVICES UNDER CONTRACT 9.03 MANAGEMENT AND ADMINISTRATIVE SERVICES' 10 CONTRACT LABOR: PHYSICIAN PART A 10.01 TEACHING PHYSICIAN UNDER CONTRACT 11 HOME OFFICE SALARIES & WAGE REL COSTS 12 HOME OFFICE: PHYSICIAN PART A 12.01 TEACHING PHYSICIAN SALARIES	2616782	173531					9 9.01 9.02 9.03 10 10.01 11 12
WAGE-RELATED COSTS  13 WAGE RELATED COSTS (CORE)  14 WAGE RELATED COSTS (GYHER)  15 EXCLUDED AREAS  16 NON-PHYSICIAN ANESTHETIST PART A  17 NON-PHYSICIAN ANESTHETIST PART B  18 PHYSICIAN PART A  18.01 PART A TEACHING PHYSICIANS  19 PHYSICIAN PART B  19.01 WAGE RELATED COSTS (RHC/FQHC)  20 INTERNS & RESIDENTS (IN APPR PGM)						MS 339 MS 339 MS 339 MS 339 MS 339 MS 339 MS 339 MS 339	13 14 15 16 17 18 18.01 19 19.01
OVERHEAD COSTS - DIRECT SALARIES 21 EMPLOYEE BENEFITS 22 ADMINISTRATIVE & GENERAL 22.01 ADMINISTRATIVE & GENERAL UNDER CONTACT	331930 197155						21 22 22.01 23
23 MAINTENANCE & REPAIRS 24 OPERATION OF PLANT 25 LAUNDRY & LINEN SERVICE 26 HOUSEKEEPING	73786 335275						24 25 26 26.01
26.01 HOUSEKEEPING UNDER CONTRACT 27 DIETARY 27.01 DIETARY UNDER CONTRACT 28 CAFETERIA 29 MAINTENANCE OF PERSONNEL 30 NURSING ADMINISTRATION 31 CENTRAL SERVICES AND SUPPLY 32 PHARMACY	331259 51494						27 27.01 28 29 30 31 32 33
33 MEDICAL RECORDS & MEDICAL RECORDS LIBR 34 SOCIAL SERVICE 35 OTHER GENERAL SERVICE	87063 255632						34 35 WORKSHEET S-3
HOSPITAL WAGE INDEX INFORMATION							PART III
	AMOUNT	RECLASS. OF SALARIES FROM WKST	ADJUSTE SALARIE (COL.1	S RELATED	HOURLY WA Y (COL.3 /	GE	

PART	III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6 2	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4) 5	*	
		4399100		4399100				1
1	NET SALARIES	2616782		2790313				2
2	EXCLUDED AREA SALARIES			1608787				3
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	1782318	-1/3331	1000707				4
4	SUBTOTAL OTHER WAGES & REL COSTS		39					5
5	SUBTOTAL WAGE-RELATED COSTS	UW 192		* * * * * * * * * * * * * * * * * * * *				6
6	TOTAL (SUM OF LINES 3 THRU 5)	1782318	-173531	1608787				7
7	NET SALARIES							8
8	EXCLUDED AREA SALARIES							g
ő	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)							10
10	SUBTOTAL OTHER WAGES & REL COSTS							11
	SUBTOTAL WAGE-RELATED COSTS							12
11	TOTAL (SUM OF LINES 9 THRU 11)							
12		1663594	-173531	1490063				13
13	TOTAL OVERHEAD COSTS	1003334	2.004.					

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## RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

		COST CENTER	SALARIES	OTHER 2	TOTAL	RECLASSI- FICATIONS	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
2	0100 0	SENERAL SERVICE COST CENTERS DLD CAP REL COSTS-BLDG & FIXT DLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		66799 53158	66799 53158	27261	66799 80419		66799 80419	1 2 3 4
4 5 6 7	0400 1 0500 1 0600 7	NEH CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	331930 197155	1901279 470626 48741 215171	1901279 802556 245896 215171	-27261	1901279 775295 245896 215171	417520 880651	2318799 1655946 245896 215171 260385	5 6 7 8 9
8 9 10 11	0900 1000 1100	DEERATION OF FEMALE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	73786 335275 331259	186599 43092 404164	260385 378367 735423	8	260385 378367 735423	-5121	378367 730302	10 11 12 13
13 14 15	1400	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	51494	1174	52668		52668 92022		3 - 3 - 3	14 15 16 17
17 18 18.10	1700 1800 1950	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF DEVELOPMENT	87063 82101 43702	4959 980 1508 35700	92022 83081 45210 35700	-45210	83081 35700	-35700	83081	18 18.10 18.20 18.30
18.20	1952	PSYCHOLOGY RECREATION INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	129829 2616782	4419 231702	134248 2848484	-134248 179458	3027942		3027942	35
50 51 52	5000	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY	118724	4626 8970 5745 250	123350 8970 5745 250		123350 8970 5745 250	-250	123350 8970 5745	51
52.10 60 62	3250	DENTAL OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTINCT		87500	87500		87500	-87500		60 62
71		OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	4399100	3777162	8176262		8176262	1169600	9345862	71 95
95 96 96.10	9601	SUBTOTALS NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CAN BARBER AND BEAUTY		310	310		310		-	96 96.10 96.20
96 20	9602	RELIGION MISCELLANEOUS NON-ALLOWABLE TOTAL	4399100	47770 3825242	47770 8224342		47770 8224342			96.30 101

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RECLASSIFICATIONS

WORKSHEET A-6 PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER 2	INCREASE LINE #	SALARY 4	OTHER 5
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 22 23 24 25 27 28 29 30 31 31 31 31 31 31 31 31 31 31 31 31 31	STAFF DEVELOPMENT RECREATION CAP. REL MOVABLE EQUIPMENT	A B D	NURSING FACILITY NURSING FACILITY OLD CAP REL COSTS-MVBLE EQUIP	35 35 2	43702	1508 1 4419 2 27261 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 334 35
36	TOTAL RECLASSIFICATIONS				173531	33188 36

RECLASSIFICATIONS

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	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	LINE #	SALARY 8	OTHER 9		A-7
1 2 3 4 4 5 6 6 7 7 8 9 100 111 12 133 144 155 166 177 188 199 200 221 225 267 288 29 300 312 333 344 35		A B D	STAFF DEVELOPMENT RECREATION ADMINISTRATIVE & GENERAL	18.10 18.30 6	43702 129829	1508 4419 27261	9	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 27 28 29 29 20 31 31 31 31 31 31 31 31 31 31 31 31 31
36					1,0001	00200		

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WORKSHEET A-7 PARTS I & II

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

PART I -	ANALYSTS	OF	CHANGES	IN	OLD	CAPITAL	ASSET	BALANCES
----------	----------	----	---------	----	-----	---------	-------	----------

	BULL 1 - WIUDIOID OF CHARGOS III								
	Company of the Co	anarimitha.		ACQUISITIONS		DISPOSALS AND	ENDING	FULLY DEPRECIATED	
	DESCRIPTION	BEGINNING BALANCES 1	PURCHASE 2	DONATION 3	TOTAL	RETIREMENTS 5	BALANCE 6	ASSETS 7	
1 2 3 4 5 6 7 8 9	LAND LAND IMPROVEMENTS BUILDINGS AND FIXTURES BUILDING IMPROVEMENTS FIXED EQUIPMENT MOVABLE EQUIPMENT SUBTOTAL RECONCILING ITEMS TOTAL								1 2 3 4 5 6 7 8 9
	The state of the s	CADITAL ACC	OUT BALANCE	9		8			
	PART II - ANALYSIS OF CHANGES IN NEW	CAPITAD HS:				mronoon#0		FULLY	
		55571117116		ACQUISITIONS		DISPOSALS	ENDING	DEPRECIATED	
	DESCRIPTION	BEGINNING BALANCES 1	PURCHASE 2	DONATION 3	TOTAL	RETIREMENTS 5	BALANCE 6	ASSETS 7	
	YAND								1
1	LAND								4

LAND
LAND IMPROVEMENTS
BUILDINGS AND FIXTURES
BUILDING IMPROVEMENTS
FIXED EQUIPMENT
MOVABLE EQUIPMENT
SUBTOTAL
RECONCILING ITEMS
TOTAL

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### PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7 PARTS III & IV

			- COMPUTATION	OF RATIOS GROSS		ALLO	CATION OF	OTHER CAPITAL		
	DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
		1	2	3	4	5	6	7	8	
1 2 3 4	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MYBLE EQUIP	6679 8041	9	66799 80419 147218	.453742 .546258 .000000 .000000					1 2 3 4 5
5	TOTAL	14721	0	14,510	2,00000					
					- SUMMARY OF	OLD AND NEW	CAPITAL	OTHER		
	DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
			9	10	11	12	13	14	15	
1 2 3	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		66799 80419						66799 80419	
4 5	NEW CAP REL COSTS-MVBLE EQUIP TOTAL		147218						147218	5
	PART IV - RECONCILIATION O	F AMOUNTS I	FROM WORKSHEE	T A, COLUMN	2, LINES 1 - SUMMARY O	THRU 4 F OLD AND NE	W CAPITAL	OTHER		
	DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
			9	10	11	12	13	14	15	
1 2	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		66799 53158						66799 53158	
3 4 5	NEW CAP REL COSTS-MYBLE EQUIP TOTAL		119957						119957	5

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#### ADJUSTMENTS TO EXPENSES

1311200						WORKSHEET A-8
	ADJUSTMENTS TO EXPENSES			EXPENSE CLASSIFICATION ON WOR	KSHEET A TO/ E ADJUSTED LINE NO.	WKST A-7
	DESCRIPTION	BASIS 1	AMOUNT 2	COST CENTER 3	4	5
1 2 3 4 5 6 7 8 9 10	INVESTMENT INCOME-OLD BLDGS & FIXTURES INVESTMENT INCOME-OLD MOVABLE EQUIPMENT INVESTMENT INCOME-NEW BLDGS & FIXTURES INVESTMENT INCOME-NEW MOVABLE EQUIPMENT INVESTMENT INCOME-OTHER TRADE, QUANTITY, AND TIME DISCOUNTS REFUNDS AND REBATES OF EXPENSES RENTAL OF PROVIDER SPACE BY SUPPLIERS TELEPHONE SERVICES (PAY STATIONS EXCL) TELEVISION AND RADIO SERVICE PARKING LOT			OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	1 2 3 4	1 2 3 4 5 6 7 8 9 10
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT SALE OF SCRAP, WASTE, ETC.	WKST A-8-2	-123450			12 13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1	1298171		B	14 15
15 16 17	LAUNDRY AND LINEN SERVICE CAFETERIA - EMPLOYEES AND GUESTS RENTAL OF QUARTERS TO EMPLOYEES & OTHERS	В	-5121	DIETARY	11	16 17
19 20 21 22	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS SALE OF DRUGS TO OTHER THAN PATIENTS SALE OF MEDICAL RECORDS AND ABSTRACTS NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.) VENDING MACHINES					18 19 20 21 22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT	WKST				24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL ADJ FOR PHYSICAL THERAPY COSTS IN	A-8-4 WKST		RESPIRATORY THERAPY	49	25
26	EXCESS OF LIMITATION - HOSPITAL ADJ FOR HHA PHYSICAL THERAPY COSTS IN	A-8-4 WKST		PHYSICAL THERAPY	50	26
27 28 29 30 31 32 33 34	EXCESS OF LIMITATION  UTIL REVIEW-PHYSICIANS' COMPENSATION DEPRECIATIONOLD MOVABLE EQUIPMENT DEPRECIATIONNEW BUILDINGS & FIXTURES DEPRECIATIONNEW BOUNDED EQUIPMENT NON-PHYSICIAN ANESTHETIST PHYSICIANS' ASSISTANT	A-8-3		HOME HEALTH AGENCY UTILIZATION REVIEW-SNF OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP NONPHYSICIAN ANESTHETISTS	71 89 1 2 3 4 20	27 28 29 30 31 32 33 34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		OCCUPATIONAL THERAPY	51	35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		SPEECH PATHOLOGY	52	36 37
37 38 39 40 41 42 43 44 45 46 47 48						38 39 40 41 42 43 44 45 46 47 48
50	TOTAL		1169600			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

VERSION: 2008.05 11/30/2010 12:13 WORKSHEET A-8-1

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

HOME OFFI	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL 5) 5	NET ADJ- USTMENTS 6	WKST A-7 REF 7	
1 5	EMPLOYEE BENEFITS	PEIA	1134034	716514	417520 880651		2
2 6	ADMINISTRATIVE & GENERAL	CENTRAL OFFICE	880651		000051		3
3							4
4	TOTALS		2014685	716514	1298171		5

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

THE RESERVE WITH THE PARTY OF T	RELATED ORG	ANICATION(S) MID ON HOLD STATE	
SYMBOL NAME	PERCENT OF NAME OWNERSHIP	PERCENT OF TYPE OF OWNERSHIP BUSINESS	
1 2 1 B STATE OF WV 2 B STATE OF WV 3	3 100.00 DEPT. OF HEALTH 100.00 DEPT. OF HEALTH	5 100.00 100.00	

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

  A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.

  B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.

  C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.

  D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.

  E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.

  F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.

  G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

65 PROVIDER NO. 5125401 LAKIN HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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PROVIDER-BASED	DUVCTCTAN	AUJUSTMENTS

	WKST A LINE NO. 1		CENTER/ IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNAD- JUSTED RCE LIMIT 8	PERCENT OF UNAD- JUSTED RCE LIMIT 9
1 2 3 4 101	60 60	DENTAL CLINIC CLINIC PSYCHOLOG TOTAL	Y	DENTAL SERVICES PHYSICIAN SERVICES PSYCHIATRIC SERVICE PSYCHOLOGICAL SERVI	250 41250 46250 35700 123450	250 41250 46250 35700 123450					

PROVIDER NO. 5125401 LAKIN HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

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#### PROVIDER-BASED PHYSICIAN ADJUSTMENTS

į	NKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	MALPRACTICE	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUST- MENT 18
1 2 3 4 101	60 60	DENTAL CLINIC PSYCHOLOGY TOTAL	DENTAL SERVICES PHYSICIAN SERVICES PSYCHIATRIC SERVICE PSYCHOLOGICAL SERVI							250 41250 46250 35700 123450

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> WORKSHEET B PART I

#### COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTION	NET EXP	OLD CAP BLDGS &	OLD CAP MOVABLE	EMPLOYEE BENEFITS	SUBTOTAL		MAIN- TENANCE &	OPERATION OF PLANT	
	COST CENTER DESCRIPTION	ALLOCATION 0	FIXTURES 1	EQUIPMENT 2	5	5A	GENERAL 6	REPAIRS 7	8	
2	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT	66799 80419	66799	80419						1 2 3 4
4 5	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS	2318799 1655946	2947	3548	2318799 174963	1837404	1837404			5 6
6	ADMINISTRATIVE & GENERAL	245896	7474	8998	103922	366290	89065	455355	2001202	7
7	MAINTENANCE & REPAIRS	215171	820	987		216978	52759	6620	276357	8
8	OPERATION OF PLANT	260385	1872	2254	38893	303404	73774	15121	9312	9
9	LAUNDRY & LINEN SERVICE	378367	287	346	176726	555726	135127	2322		10
10	HOUSEKEEPING	730302	2839	3418	174609	911168	221554	22931	14122	11
11	DIETARY	130002	1833	2207		4040	982	14805	9118	12
12	CAFETERIA MAINTENANCE OF PERSONNEL						2000		2001	13
13	NURSING ADMINISTRATION		443	533		976	237	3578	2204	14 15
14	CENTRAL SERVICES & SUPPLY	52668	11028	13277	27143	104116	25316	89073	54856	16
15	PHARMACY	(18,57) 537, 53						00644	14561	17
16 17	MEDICAL RECORDS & LIBRARY	92022	2927	3524	45892	144365	35103	23644	3072	18
18	SOCIAL SERVICE	83081	618	744	43276	127719	31055	4989	3072	18.10
	STAFF DEVELOPMENT									18.20
	PSYCHOLOGY									18.30
	RECREATION									10,00
10.50	INPATIENT ROUTINE SERV COST CENTI	ERS		0.0001.2		4570220	1111299	262404	161606	35
35	NURSING FACILITY	3027942	32488	39113	1470795	4570338	1111533	202404	101000	
30	ANCILLARY SERVICE COST CENTERS				60600	188085	45734	7898	4864	50
50	PHYSICAL THERAPY	123350	978	1177	62580	9020	2193	184	113	51
51	OCCUPATIONAL THERAPY	8970	23	27		5795	1409	184	113	52
52	SPEECH PATHOLOGY	5745	23	27		3195	1.100			52.10
52.10	DENTAL									
	OUTPATIENT SERVICE COST CENTERS									60
60	CLINIC									62
62	OBSERVATION BEDS (NON-DISTINCT									
	OTHER REIMBURSABLE COST CENTERS									71
71	HOME HEALTH AGENCY									101111111111111111111111111111111111111
	SPECIAL PURPOSE COST CENTERS	02/5052	66600	80180	2318799	9345424	1825607	453753	275371	95
95	SUBTOTALS	9345862	00000	00100	2020.77					
	NONREIMBURSABLE COST CENTERS		85	102		187	45	683	421	
96	GIFT, FLOWER, COFFEE SHOP & CAN	310	91	110		511	124	735	452	96.10
96.10	BARBER AND BEAUTY	310	71	120				0200	222	96.20
96.20	RELIGION	47770	23	27		47820	11628	184	113	96.30
	MISCELLANEOUS NON-ALLOWABLE	47770	2.5							101
101	CROSS FOOT ADJUSTMENTS								00000	102
. 102	NEGATIVE COST CENTER	9393942	66799	80419	2318799	9393942	1837404	455355	276357	103
103	TOTAL	3333712		8 396 T N						

COST ALLOCATION - GENERAL SERVICE COSTS

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	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES & SUPPLY 15	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	
18.20	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF DEVELOPMENT PSYCHOLOGY RECREATION	401611 113151 49126	807756 42947 27728 6701 166822 44282 9344	1261848 16031	72704 4748 1632 1039	13696	444931	263587	177218	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18.10 18.20 18.30
35 50 51 52	INPATIENT ROUTINE SERV COST CENTE NURSING FACILITY ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DENTAL	239334	491451 14793 344 344	1245817	62911 2374	13696	444931	263587	177218	35 50 51 52 52.10
60 62	OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS							ě.		60 62 71
96 2	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CAN D BARBER AND BEAUTY O RELIGION MISCELLANEOUS NON-ALLOWABLE	401611	804756 1280 1376 344	1261848	72704	13696	444931	263587	177218	95 96 96.10 96.20 96.30
101 102 103	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER TOTAL	401611	807756	1261848	72704	13696	444931	263587	177218	102

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## COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTION	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 17 18 18 19 18 19 19 19 19 19 19 19 19 19 19 19 19 19	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF DEVELOPMENT PSYCHOLOGY RECREATION			4		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18.10 18.20 18.30
35	INPATIENT ROUTINE SERV COST CENTE NURSING FACILITY	RS 9044592		9044592		35
50	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY	263748		263748		50 51
51	OCCUPATIONAL THERAPY	11854		11854 7845	2	52
52 52 10	SPEECH PATHOLOGY DENTAL	7845		1015		52.10
	OUTPATIENT SERVICE COST CENTERS					60
60 62	OBSERVATION BEDS (NON-DISTINCT					62
72	OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY					71
71	SPECIAL PURPOSE COST CENTERS			9328039		95
95	SUBTOTALS NONREIMBURSABLE COST CENTERS	9328039		9328039		96
96	GIFT, FLOWER, COFFEE SHOP & CAN	2616		2616		96.10
	BARBER AND BEAUTY	3198		3198		96.20
	RELIGION MISCELLANEOUS NON-ALLOWABLE	60089		60089		96.30 101
101	CROSS FOOT ADJUSTMENTS					102
102 103	NEGATIVE COST CENTER TOTAL	9393942		9393942		103
100	10110					

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## ALLOCATION OF OLD CAPITAL RELATED COSTS

	100000000000000000000000000000000000000			OLD CAP	CAP REL	ADMINIS-	MAIN-	OPERATION	LAUNDRY	
		DIR ASSGND CAP-REL	BLDGS &	MOVABLE	COST TO	TRATIVE &	TENANCE &	OF PLANT	& LINEN SERVICE	
	COST CENTER DESCRIPTION	COSTS	FIXTURES	EQUIPMENT	BE ALLOC	GENERAL	REPAIRS 7	8	9	
		0	1	2	4 A	6		v	170	
	GENERAL SERVICE COST CENTERS									1
1	OLD CAP REL COSTS-BLDG & FIXT									2
2	OLD CAP REL COSTS-MVBLE EQUIP									3
3 1	NEW CAP REL COSTS-BLDG & FIXT									4
	NEW CAP REL COSTS-MVBLE EQUIP									5
	EMPLOYEE BENEFITS		2947	3548	6495	6495				7
	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS		7474	8998	16472	315	16787 244	2238		В
7	OPERATION OF PLANT		820	987	1807	187 261	557	75	5019	9
9	LAUNDRY & LINEN SERVICE		1872	2254	4126 633	478	86	12	1414	10
10	HOUSEKEEPING		287	346 3418	6257	784	845	114	614	11
	DIETARY		2839 1833	2207	4040	3	546	74		12
12	CAFETERIA		1633	1023						13 14
13	MAINTENANCE OF PERSONNEL		443	533	976	1	132	18		15
	NURSING ADMINISTRATION		11028	13277	24305	90	3284	444		16
7.00	CENTRAL SERVICES & SUPPLY				2.122	104	872	118		17
16 17	PHARMACY MEDICAL RECORDS & LIBRARY		2927	3524	6451	124 110	184	25		18
18	SOCIAL SERVICE		618	744	1362	110				18.10
18.10	STAFF DEVELOPMENT									18.20
18,20	PSYCHOLOGY									18.30
18.30	RECREATION COM CENTER	· p.c						1309	2991	35
920	INPATIENT ROUTINE SERV COST CENTE	200	32488	39113	71601	3926	9673	1309	2991	33
35	NURSING FACILITY ANCILLARY SERVICE COST CENTERS				1	1.62	291	39		50
50	PHYSICAL THERAPY		978	1177	2155 50	162 8	7	1		51
51	OCCUPATIONAL THERAPY		23	27 27	50	5	7	1		52
52	SPEECH PATHOLOGY		23	2.1	50					52.10
	DENTAL									60
	OUTPATIENT SERVICE COST CENTERS									62
60	OBSERVATION BEDS (NON-DISTINCT									02
62	OTHER REIMBURSABLE COST CENTERS									71
71	HOME HEALTH AGENCY									
11	SPECIAL PURPOSE COST CENTERS			80180	146780	6454	16728	2230	5019	95
95	SUBTOTALS		66600	80100	140700					96
5,650	NONREIMBURSABLE COST CENTERS		85	102	187		25			96,10
96	GIFT, FLOWER, COFFEE SHOP & CAN		91		201		27	4		96.20
96.10	BARBER AND BEAUTY						7	1		96.30
96.20	RELIGION MISCELLANEOUS NON-ALLOWABLE		23	27	50	41		· ·	2	101
101	CROSS FOOT ADJUSTMENTS									102
102	NEGATIVE COST CENTER		66700	80419	147218	6495	1.6787	2238	5019	103
103	TOTAL		66799	00413	11,210					

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### ALLOCATION OF OLD CAPITAL RELATED COSTS

**	COST CENTER DESCRIPTION	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		10	11	12	14	15	17	18	25	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 18 19 18 19 19 19 19 19 19 19 19 19 19 19 19 19	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF DEVELOPMENT PSYCHOLOGY	2623 139 90 22 542 144 30	8753 111	4864 318 109 69	1149	28983	7818	1780		1 2 3 4 5 6 7 8 9 10 11 11 12 13 14 15 16 17 18 18.10 18.20 18.30
18.30 35	RECREATION INPATIENT ROUTINE SERV COST CENTINURSING FACILITY	ERS 1597	8642	4209	1149	28983	7818	1780	143678	35
1703	ANCILLARY SERVICE COST CENTERS	48		159					2854	50
50 51	PHYSICAL THERAPY OCCUPATIONAL THERAPY	1							67 64	51 52
52	SPEECH PATHOLOGY DENTAL	1								52.10
52.10	OUTPATIENT SERVICE COST CENTERS									60
60 62	CLINIC OBSERVATION BEDS (NON-DISTINCT									62
	OTHER REIMBURSABLE COST CENTERS									71
71	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS				1000 A100			1700	146663	95
95	SUBTOTALS	2614	8753	4864	1149	28983	7818	1780	140003	20.00
96	NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CAN	4							219	96 96.10
96.10	BARBER AND BEAUTY	4								96.20
	RELIGION MISCELLANEOUS NON-ALLOWABLE	1							100	96.30 101
101	CROSS FOOT ADJUSTMENTS									102
102 103	NEGATIVE COST CENTER TOTAL	2623	8753	4864	1149	28983	7818	1780	147218	103

35

96.10 96.20 96.30 101 102 103

COST CENTER DESCRIPTION

## ALLOCATION OF OLD CAPITAL RELATED COSTS

I&R COST & POST STEP-DOWN ADJS TOTAL

		26	27	
	GENERAL SERVICE COST CENTERS			
1	OLD CAP REL COSTS-BLDG & FIXT			
2	OLD CAP REL COSTS-MVBLE EQUIP			
3	NEW CAP REL COSTS-BLDG & FIXT			
4	NEW CAP REL COSTS-MVBLE EQUIP			
5	EMPLOYEE BENEFITS			
6	ADMINISTRATIVE & GENERAL			
7	MAINTENANCE & REPAIRS			
8	OPERATION OF PLANT			
9	LAUNDRY & LINEN SERVICE			
10	HOUSEKEEPING			
11	DIETARY			
12	CAFETERIA			
13	MAINTENANCE OF PERSONNEL			
14	NURSING ADMINISTRATION			
15	CENTRAL SERVICES & SUPPLY			
16	PHARMACY			
17	MEDICAL RECORDS & LIBRARY			
18	SOCIAL SERVICE			
	STAFF DEVELOPMENT			
	PSYCHOLOGY			
18.30	RECREATION			
	INPATIENT ROUTINE SERV COST CENTERS		143678	
35	NURSING FACILITY		110010	
	ANCILLARY SERVICE COST CENTERS		2854	
50	PHYSICAL THERAPY		67	
51	OCCUPATIONAL THERAPY		64	
52	SPEECH PATHOLOGY		**	
52.10	DENTAL			
	OUTPATIENT SERVICE COST CENTERS			8
60	CLINIC			
62	OBSERVATION BEDS (NON-DISTINCT			
	OTHER REIMBURSABLE COST CENTERS			
71	HOME HEALTH AGENCY			
	SPECIAL PURPOSE COST CENTERS		146663	
95	SUBTOTALS			
	NONREIMBURSABLE COST CENTERS		219	
96	GIFT, FLOWER, COFFEE SHOP & CAN		236	
	D BARBER AND BEAUTY			
96.2	O RELIGION		100	•
	MISCELLANEOUS NON-ALLOWABLE			
101	CROSS FOOT ADJUSTMENTS			
102	NEGATIVE COST CENTER		147218	
103	TOTAL			

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COST ALLOCATION - STATISTICAL BASIS

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	COST ALLOCATION - STATISTICAL BASIS								
	COST CENTER DESCRIPTION	OLD CAP BLDGS & FIXTURES SQUARE FEET	OLD CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	CILIATION	ACCUM COST	MAIN- TENANCE 6 REPAIRS SQUARE FEET 7	OPERATION OF PLANT SQUARE FEET 8	
		1	2	5	6A	6	•	Ü	
1 0	SENERAL SERVICE COST CENTERS DLD CAP REL COSTS-BLDG & FIXT DLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	73431	73431	4399100					1 2 3 4 5
6 7 8 9	EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	3246 8216 90. 2055 316 312 201	821 1 90 8 205 6 31 1 312	331930 6 197155 1 73786 6 335275 1 331259	-183740	7556538 366290 216978 303404 555726 911168	61975 901 2058 316	61074 2058 316 3121	11 12
13 14 15	CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	48 1212	7 48 3 1212	7 3 51494		976 104116	12123	3 12123	13 14 15 16 17
17 18 18.10 18.20	PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF DEVELOPMENT PSYCHOLOGY	321 67				144365 127715	1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	7	18 18.10 18.20 18.30
18.30 35	RECREATION. INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	3571	4 3571	4 2790313		457033	8 3571	4 35714	35
50 51 52	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DENTAL		25 2	75 118724 25 25		18808 902 579	0 2	5 1075 25 25 25 25	51
60 62	OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTINC								60 62
71	OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS				10274	04 750802	0 6175	57 60856	71 5 95
95	SUBTOTALS NONREIMBURSABLE COST CENTERS	732		13 4399100 93	-18374	16	37 9	93 93	
96 96.10	GIFT, FLOWER, COFFEE SHOP & C BARBER AND BEAUTY RELIGION	1	00 1	00		51 4782	****		96.10 96.20 5 96.30
96.20 96.30 101	MISCELLANEOUS NON-ALLOWABLE CROSS FOOT ADJUSTMENTS		25	25					101
102 103 104	NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I	667	1.0951	64		18374	7.3473		104
104 105	UNIT COST MULT-WS B PT I	, 9096	84	.52710	ช	64	95 167 .2708	87 2231 67	8 105 106
106 106 107 108 108	UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT II COST TO BE ALLOC PER B PT III UNIT COST MULT-WS B PT III UNIT COST MULT-WS B PT III					.0008	60	. 03664	106 107 108 108

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	COST ALLOCATION - STATISTIC	AL BASIS									
		LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		SERVICE POUNDS OF LAUNDRY 9	SQUARE FEET 10		MEALS SERVED 12	NUMBER HOUSED 13	DIRECT NRSING HRS 14	COSTED	COSTED REQUIS. 16		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18 19 10 18 19 10 10 10 11 11 11 11 11 11 11 11 11 11	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-BUBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF DEVELOPMENT PSYCHOLOGY	134800 37975 16489	58700	99019 1258	49 3 1	0 2 1 7	0 100	0 10		18	
18.30 35	RECREATION INPATIENT ROUTINE SERV COST C NURSING FACILITY	ENTERS 8033	2 3571	97761	42	10	0 10	0 10	0 10	0 35	Ś
50 51 52 52.10 60 62	ANCILLARY SERVICE COST CENTER PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DENTAL OUTPATIENT SERVICE COST CENTE CLINIC OBSERVATION BEDS (NON-DISTING OTHER REIMBURSABLE COST CENTER	ers	107 2 2	5	1	6				50 51 52 52 60 63	1 2 2 2.10 0 2
96.20	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & D BARBER AND BEAUTY D RELIGION	13480	10	3	9 4	90 1	00 10	00 10	00 10	9 9 9	6.10 6.20 6.30
96.30 101 102 103 104 105 106 106 107 108	O MISCELLANEOUS NON-ALLOWABLE CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT II UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT II COST TO BE ALLOC PER B PT II UNIT COST MULT-WS B PT III	.0372	11 80775 10 13.76075 19 263	56 126184 12.74349 50 23 875 .08839	4 148.3755 3 48	10	136.9600	49 289 289.8300	00 83	10 10 10 10 10 10 10 10 10	02 04 04 05 06 06 07

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## COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT 18	CE CE	
18.20 18.30	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF DEVELOPMENT PSYCHOLOGY RECREATION INPATIENT ROUTINE SERV COST	CENTERS		100	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 18 19 18.10 18.20 18.30
50 51 52 52.10	NURSING FACILITY ANCILLARY SERVICE COST CENTE PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DENTAL	RS			50 51 52 52.10
60 62	OUTPATIENT SERVICE COST CENT CLINIC OBSERVATION BEDS (NON-DISTIN OTHER REIMBURSABLE COST CENT	ıc			60 62 71
96.20	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP 6 BARBER AND BEAUTY RELIGION MISCELLANEOUS NON-ALLOWABLE CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT III UNIT COST MULT-WS B PT III UNIT COST MULT-WS B PT III	2635 2635.8700 1 78.1800	1772.18 18 100	177218 .180000 1780 .800000	95 96 96.10 96.20 96.30 101 102 103 104 104 105 106 107 108 108

PROVIDER NO. 5125401 LAKIN HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C

(	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27)	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS	9044592					35
35	NURSING FACILITY ANCILLARY SERVICE COST CENTERS	263748					50
50	PHYSICAL THERAPY	11854					51 52
	OCCUPATIONAL THERAPY	7845					52.10
52	SPEECH PATHOLOGY	7015					32.10
52.10	DENTAL OUTPATIENT SERVICE COST CENTERS						60
60	CLINIC						60 62
62	OBSERVATION BEDS (NON-DISTI						
	OTHER REIMBURSABLE COST CENTERS	0200020					101
101	SUBTOTAL	9328039					102
102	LESS OBSERVATION BEDS	9328039					103
103	TOTAL.	2220022					

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I (CONT)

	OST CENTER DESCRIPTION		CHARGES		COST OR OTHER	TEFRA INPATIENT	PPS INPATIENT	
(	COST CENTER DESCRIPTION	INPATIENT 6	OUTPATIENT 7	TOTAL 8	RATIO 9	RATIO 10	RATIO 11	
35	INPATIENT ROUTINE SERV COST CENT NURSING FACILITY	ERS						35
50	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY	4272		4272	61.738764			50 51
51 52	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	9750 5505		9750 5505	1.215795 1.425068			52 52,10
52.10	DENTAL OUTPATIENT SERVICE COST CENTERS							60
60 62	CLINIC OBSERVATION BEDS (NON-DISTI							62
20.0	OTHER REIMBURSABLE COST CENTERS	19527		19527				101
101 102	SUBTOTAL LESS OBSERVATION BEDS	19527		2000000000				102 103
103	TOTAL			19527				103

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WORKSHEET D-1 PART I

## COMPUTATION OF INPATIENT OPERATING COST

[ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT | } TITLE V-INPT

PAR	T I - ALL PROVIDER COMPONENTS	HOSPITAL (OTHER) (51-25401	SUB	I	SUB II	SUB III	SUB IV	NF (OTHER) (51-25401	
	INPATIENT DAYS	1	1		1	1	1	1	
	THE ANALYSIA OF THE PAGE BOOM DAYS AND SWING-BED DAYS							32587	1
	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)							32587	2
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)								3
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							32587	4
4	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)								5
	DOOM DAVEL THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD								6
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD								7
7	TATAL CHING-RED NE-TYPE INPATIENT DAYS (INCL. PRIVALE								
	POOM DAYS! THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD								8
	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							31978	9
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE								***
10	PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS) SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII								10
10	ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE								
0.4040	COST REPORTING PERIOD SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII								11
11	ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE								
	COCT REPORTING PERIOD								12
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XI) ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE	80							
	COCT DEPORTING PERIOD	•							13
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE	•							
	COCT PERORTING PERIOD								14
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE								
15	PROGRAM (EXCLUDING SWING-BED DAYS) TOTAL NURSERY DAYS								15 16
16	TITLE V OR XIX NURSERY DAYS								

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### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART I (CONT)

[ ] TITLE V-INPT [ ] TITLE XVI	II-PART A	(XX) TITLE XIX-I	NPT	100	
(OT) (51-	THER) -25401	SUB II SUB III	SUB IV	NF (OTHER) (51-25401	
SWING-BED ADJUSTMENT	1 1	1 1	•	•	17
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD					0.000
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO					18
SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO					19
SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO					20
SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST				9044592	21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH					22
DECEMBER 31 OF THE COST REPORTING PERIOD 23 SNING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER					23
DECEMBER 31 OF THE COST REPORTING PERIOD 24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH					24
DECEMBER 31 OF THE COST REPORTING PERIOD 25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER					25
DECEMBER 31 OF THE COST REPORTING PERIOD					26
26 TOTAL SWING-BED COST 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST				9044592	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES					28
(EXCLUDING SWING-BED CHARGES) 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)					29 30
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO					31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE					32 33
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE 34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL					34 35
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL 36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT					36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST				9044592	37
AND PRIVATE ROOM COST DIFFERENTIAL					

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## COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART II

	[ ] TITLE V-INPT [ ] TITLE XVI	II-PART F	Ĭ.		(XX) TITLE	XIX-INPT		
PART )		HOSPITAL (OTHER) 51-25401	SUB	I	SUB II	SUB III		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1		1	1	1	38
38 39 40 41	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST				mount.	AVERAGE	PROGRAM	39 40 41 PROGRAM
			OTAL P COS 1	T	2	PER DIEM		COST 5
								42
42 43 44 45 46 47	NURSERY (TITLES V AND XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							43 44 45 46 47
		HOSPI'	R)	SUB	s I SUB	II SUB 1	VI AUS IV	
		1	401	1	. 1	1	1	
48 49	PROGRAM INPATIENT ANCILLARY SERVICE COST TOTAL PROGRAM INPATIENT COSTS	***						48 49
*	PASS THROUGH COST ADJUSTMENTS							50
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES							51
51 52 53	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES TOTAL PROGRAM EXCLUDABLE COST TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS							52 53

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## COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART II (CONT)

	[ ] TITLE V-INPT [ ] TITLE X	(VIII-PART A		(XX) TITLE	XIX-INPT		tant II (oon)
PART I	I - HOSPITAL AND SUBPROVIDERS ONLY	HOSPITAL (OTHER) (51-25401	SUB I	SUB II	SUB III	SUB IV	
55 56 57 58 58.01 58.02 58.03 58.04 59.01 59.02 59.03 59.04 59.05 59.05	TARGET AMOUNT AND LIMITATION COMPUTATION PROGRAM DISCHARGES TARGET AMOUNT PER DISCHARGE TARGET AMOUNT DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT BONUS PAYMENT LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED 6 COMPOUNDED BY THE MARKET BASKET LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT RELIEF PAYMENT ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) PROGRAM DISCHARGES RIOR TO JULY 1 PROGRAM DISCHARGES AFTER JULY 1 PROGRAM DISCHARGES (SEE INSTRUCTIONS) REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)	T	1	1	1	1	54 55 56 57 58 58.01 58.02 58.03 59.01 59.02 59.03 59.04 59.05 59.06 59.06 59.07
	PROGRAM INPATIENT ROUTINE SWING BED COS	T					60
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						61
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER						62
62 63	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH						63
64	DECEMBER 31 OF THE COST REPORTING PERIOD TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER						64
65	DECEMBER 31 OF THE COST REPORTING PERIOD TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III & IV

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III & IV

( ) TITLE V-INPT

[ ] TITLE XVIII-PART A

(XX) TITLE XIX-INPT

HOSPITAL SUB I SUB II SUB III SUB IV (OTHER) (51-25401 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 85 OBSERVATION BED COST

83

85

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WORKSHEET D-4 IMPATIENT ANCILLARY COST APPORTIONMENT

	INPATIENT ANCILLARY COST	APPORTIONMENT				
( ) T	ITLE V ITLE XVIII-PT A ITLE XIX	[XX] HOSPITAL ( [ ] SUB I [ ] SUB III [ ] SUB III [ ] SUB IV	(51-25401)	[ ) SNF [ ) NF [ ) S/B-SNF [ ) S/B-NF [ ) ICF/MR	[ ) PPS [ ) TEFRA (XX) OTHER	
	COST CENTER DESCRIPTION		RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
50 51 52	INPATIENT ROUTINE SERVICE CO ANCILLARY SERVICE COST CENTE PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY	ST CENTERS RS	61,738764 1,215795 1,425068			50 51 52 52,10
60	OUTPATIENT SERVICE COST CENT CLINIC					60 62
62 101 102 103	OBSERVATION BEDS (NON-DISTINOTHER REIMBURSABLE COST CENT TOTAL LESS PBP CLINIC LAB SVCS-PGN NET CHARGES	ERS				101 102 103

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WORKSHEET D-4

INP	ATIENT ANCILLARY COST AF	PORT:	IONNEN	1T						WORKSHEET D-	4
[ ] TITLE V [ ] TITLE XV [XX] TITLE XI		[ ] [ ] [ ]	HOSPI SUB I SUB I SUB I	I II III		( ) ( ) ( ) ( )	SNF NF (51-2540 S/B-SNF S/B-NF ICF/MR	01)	( ) PPS ( ) TEFF (XX) OTHE	RA	
COST	CENTER DESCRIPTION				RATIO OF COST TO CHARGES 1		ATIENT M CHARGES 2	INPATIENT PROGRAM COST	rs		
	ENT ROUTINE SERVICE COST		TERS								
	ARY SERVICE COST CENTERS AL THERAPY	5			61,738764		4272	263748		50 51 52	
	TIONAL THERAPY				1,215795		9750	11854		51	
	PATHOLOGY				1.425068		5505	7845		52.	10
52.10 DENTAL										52.	10
	TENT SERVICE COST CENTER	RS								. 60	
60 CLINIC 62 OBSERV	ATION BEDS (NON-DISTINC)	r								62	
	REIMBURSABLE COST CENTE									101	
101 TOTAL							19527	283447		101 102	
102 LESS F 103 NET CH	PBP CLINIC LAB SVCS-PGM ( LARGES	DNLY	CHARG	ĖS			19527			103	

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## WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	I ) TITLE V	[ ] TITLE V [ ] TITLE XVIII			(XX) TITLE XIX			
		HOSPITAL (51-25401) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (51-25401) (OTHER)	
1 2 3 4 5	COMPUTATION OF NET COST OF COVERED SERVICES INPATIENT HOSPITAL/SNF/NF SERVICES MEDICAL AND OTHER SERVICES INTERNS AND RESIDENTS ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O COST OF TEACHING PHYSICIANS	1	1.	1	1	1	1 9158941 9158941	1 2 3 4 5 6
6 7 8 9	SUBTOTAL INPATIENT PRIMARY PAYER PAYMENTS OUTPATIENT PRIMARY PAYER PAYMENTS SUBTOTAL						9158941	7 8 9
10 11 12 13	COMPUTATION OF LESSER OF COST OR CHARGES ROUTINE SERVICE CHARGES ANCILLARY SERVICE CHARGES INTERNS AND RESIDENTS SERVICE CHARGES ORGAN ACQUISITION CHARGES, NET OF REVENUE TEACHING PHYSICIANS						8039543 19527	
15 16	INCENTIVE FROM TARGET AMOUNT COMPUTATION TOTAL REASONABLE CHARGES						8059070	
17 18	CUSTOMARY CHARGES AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							17 18
19	RATIO OF LINE 17 TO LINE 18 TOTAL CUSTOMARY CHARGES						8059070	19 20 21
21 22 23	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES COST OF COVERED SERVICES						1099871 9158941	
24 25 26 27	PROSPECTIVE PAYMENT AMOUNT OTHER THAN OUTLIER PAYMENTS OUTLIER PAYMENTS PROGRAM CAPITAL PAYMENTS CAPITAL EXCEPTION PAYMENTS ROUTINE SERVICE OTHER PASS THROUGH COSTS				*			24 25 26 27 28 29
28 29 30	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						9158941	
31 32 33	CUSTOMARY CHARGES (TITLE XIX PPS COVERED LESSER OF LINES 30 OR 31 DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)				,		9158941	32 33

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(XX) TITLE XIX

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#### WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

( ) TITLE V

	, , , , , , , , , , , , , , , , , , , ,									
		HOSPITAL (51-25401)	SUB	I	SUB	II SUB	111	SUB IV	NF I (51-25401)	
		(OTHER)	1		1		1	1	(OTHER)	
		1	1				•		2	
34 35 36 37 38 38.01	COMPUTATION OF REIMBURSEMENT SETTLEMENT EXCESS OF REASONABLE COST SUBTOTAL COINSURANCE SUM OF AMOUNTS FROM WKST E, PARTS C, D AND E, REIMBURSABLE BAD DEBTS REDUCED REIMBURSABLE BAD DEBTS REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE									
40	BENEFICIARIES (SEE INSTRUCTIONS) UTILIZATION REVIEW SUBTOTAL INPATIENT ROUTINE SERVICE COST								8059070	41
42	MEDICARE INPATIENT ROUTINE CHARGES AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM									42 43 44
45 46 47 48 49	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) RATIO OF LINE 43 TO LINE 44 TOTAL CUSTOMARY CHARGES EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES RECOVERY OF EXCESS DEPRECIATION RESULTING FROM									45 46 47 48 49
50 51	UTILIZATION OTHER ADJUSTMENTS AMOUNTS APPLICABLE TO PRIOR COST REPORTING									50 51
52 53	DEPRECIABLE ASSETS SUBTOTAL INDIRECT MEDICAL EDUCATION ADJUSTMENT	*							8059070	52 53 54
54 55 56	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS TOTAL AMOUNT PAYABLE TO THE PROVIDER SEQUESTRATION ADJUSTMENT								8059070	55 56
57	INTERIM PAYMENTS								7058140	57 57.01
57.01 58 59	TENTATIVE SETTLEMENT (FOR FI USE ONLY) BALANCE DUE PROVIDER/PROGRAM PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2								1000930	

[ ] TITLE XVIII

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WORKSHEET G

#### BALANCE SHEET

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
1 2	CURRENT ASSETS CASH ON HAND AND IN BANKS TEMPORARY INVESTMENTS	66953				1 2 3
4 5	NOTES RECEIVABLE ACCOUNTS RECEIVABLE OTHER RECEIVABLES	109119				4 5
7 8	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE INVENTORY PREPAID EXPENSES	64290				6 7 8 9
9 10 11	OTHER CURRENT ASSETS DUE FROM OTHER FUNDS TOTAL CURRENT ASSETS	240362				10 11
13 13.01 14 14.01 15.01 16.01 17 17.01 18.01	FIXED ASSETS LAND ACCUMULATED DEPRECIATION LAND IMPROVEMENTS ACCUMULATED DEPRECIATION BUILDINGS ACCUMULATED DEPRECIATION LEASEHOLD IMPROVEMENTS ACCUMULATED AMORTIZATION FIXED EQUIPMENT ACCUMULATED DEPRECIATION AUTOMOBILES AND TRUCKS ACCUMULATED DEPRECIATION MAJOR MOVABLE EQUIPMENT ACCUMULATED DEPRECIATION MINOR EQUIPMENT DEPRECIABLE ACCUMULATED DEPRECIATION MINOR EQUIPMENT DEPRECIABLE ACCUMULATED DEPRECIATION MINOR EQUIPMENT-NONDEPRECIABLE TOTAL FIXED ASSETS	322106 -235981 2550589 -2171093 1784373 -1708198 101667 -97698 1623249 -1404225				12 12.01 13.01 14 14.01 15.01 16.01 17 17.01 18 18.01 19.01 20 21
22 23 24 25 26	OTHER ASSETS INVESTMENTS DEPOSITS ON LEASES DUE FROM OWNERS/OFFICERS OTHER ASSETS TOTAL OTHER ASSETS					22 23 24 25 26
27	TOTAL ASSETS	1005151				27
	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	CURRENT LIABILITIES	1	2	3	4	121
28	ACCOUNTS PAYABLE	144493				28 29
29 30	SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE	584226 5959				30 31
31	NOTES & LOANS PAYABLE (SHORT TERM) DEFERRED INCOME					32
32 33	ACCELERATED PAYMENTS	66953				33 34
34 35	DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES					35 36
36	TOTAL CURRENT LIABILITIES	801631				50
	LONG-TERM LIABILITIES					37
37 38	MORTGAGE PAYABLE NOTES PAYABLE					38 39
39	UNSECURED LOANS LOANS FROM OWNERS .01 PRIOR TO 7/1/66					40
40	.02 ON OR AFTER 7/1/66					41
41 42 43	OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES TOTAL LIABILITIES	801631				42 43
44 45 46 47 48	CAPITAL ACCOUNTS GENERAL FUND BALANCE SPECIFIC PURPOSE FUND BALANCE DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED GOVERNING BODY CREATED - ENDOWMENT FUND BAL PLANT FUND BALANCE - INVESTED IN PLANT	203520				44 45 46 47 48 49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION	0.0500				51
51	TOTAL FUND BALANCES	203520				52
52	TOTAL LIABILITIES AND FUND BALANCES	1005151				34

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TOTAL DEDUCTIONS

FUND BALANCE AT END OF PERIOD PER BALANCE SHEET

18

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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18

19

PER	105 ERON 01/01/2005 10 00/00/2010				
	STATEMENT OF CHANGES IN FUND BALAN	ICES			WORKSHEET G-1
		GENERAL FUND	SPECIFIC PURPOSE 2	FUND ENDOWMENT	FUND PLANT FUND
1	FUND BALANCES AT BEGINNING OF PERIOD	245475			1
2	NET INCOME (LOSS)	-1010896			2
3	TOTAL	-765421			3
4	ADDITIONS (CREDIT ADJUSTMENTS)	968941			4
5					5
6					6
7					7
8					8
9					9
10	TOTAL ADDITIONS	968941			10
11	SUBTOTAL	203520			11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13					13
14					14
15					15
16					16
17					17

203520

VERSION: 2008.05 90

### STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PART I - PATIENT REVENUES

WORKSHEET G-2 PARTS I & 11

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 2 4 5	GENERAL INPATIENT ROUTINE CARE SERVICES HOSPITAL SUBPROVIDER I SWING BED - SNF SWING BED - NF				1 2 4 5
6	SKILLED NURSING FACILITY NURSING FACILITY	8209255		8209255	7
8 9	OTHER LONG TERM CARE TOTAL GENERAL INPATIENT CARE SERVICES INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES	8209255		8209255	9
10 11 12 13 14 15 16 17 18 19 20 21 22 23	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE TOTAL INPATIENT ROUTINE CARE SERVICES ANCILLARY SERVICES OUTPATIENT SERVICES HOME HEALTH AGENCY AMBULANCE CORF ASC HOSPICE	8209255		8209255	10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
24 25	TOTAL PATIENT REVENUES	8209255		8209255	25
	PART II - OPE	RATING EXPENSES	1.	2	
26 27 28 29 30 31	OPERATING EXPENSES ADD (SPECIFY)	•	•	8224342	26 27 28 29 30 31 32
33 34 35 36 37 38	TOTAL ADDITIONS DEDUCT (SPECIFY)				33 34 35 36 37 38 39
39 40	TOTAL DEDUCTIONS TOTAL OPERATING EXPENSES			8224342	40

91 PROVIDER NO. 5125401 LAKIN HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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WORKSHEET G-3

### STATEMENT OF REVENUES AND EXPENSES

#### DESCRIPTION

TOTAL PATIENT REVENUES LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS NET PATIENT REVENUES LESS - TOTAL OPERATING EXPENSES NET INCOME FROM SERVICE TO PATIENTS	8209255 1000930 7208325 8224342 -1016017	1 2 3 4 5
CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. INCOME FROM INVESTMENTS REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE REVENUE FROM TELEPHONE AND RADIO SERVICE PURCHASE DISCOUNTS REBATES AND REFUNDS OF EXPENSES PARKING LOT RECEIPTS REVENUE FROM LAUNDRY AND LINEN SERVICE REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS REVENUE FROM RENTAL OF LIVING QUARTERS REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN RENTAL OF VENDING MACHINES RENTAL OF VENDING MACHINES	5121	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22
GOVERNMENTAL APPROPRIATIONS OTHER (SPECIFY) TOTAL OTHER INCOME TOTAL  TOTAL OTHER EXPENSES	5121 -1010896	23 24 25 26 27 28 29 30 31
	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS NET PATIENT REVENUES LESS - TOTAL OPERATING EXPENSES NET INCOME FROM SERVICE TO PATIENTS  CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. INCOME FROM INVESTMENTS REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE REVENUE FROM TELEPHONE AND RADIO SERVICE PURCHASE DISCOUNTS REBATES AND REFUNDS OF EXPENSES PARKING LOT RECEIPTS REVENUE FROM LAUNDRY AND LINEN SERVICE REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS REVENUE FROM RENTAL OF LIVING QUARTERS REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN RENTAL OF VENDING MACHINES RENTAL OF VENDING MACHINES RENTAL OF HOSPITAL SPACE GOVERNMENTAL APPROPRIATIONS OTHER (SPECIFY) TOTAL OTHER INCOME	TOTAL PATIENT REVENUES LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS NET PATIENT REVENUES NET INTENT REVENUES TOTAL OFERATING EXPENSES NET INCOME FROM SERVICE TO PATIENTS  CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. INCOME FROM INVESTMENTS REVENUE FROM INVESTMENTS REVENUE FROM INVESTMENTS REVENUE FROM TELEVISION AND RADIO SERVICE REVENUE FROM TELEVISION AND RADIO SERVICE REVENUE FROM TELEVISION AND RADIO SERVICE REVENUE FROM TELEVISION AND LINEN SERVICE REVENUE FROM MEALDS SOLD TO EMPLOYEES AND GUESTS REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS REVENUE FROM MEALS SOLD TO EMPLOYEES AND FROM THE PATIENTS REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) REVENUE FROM GETTS, FLOMER, COFFEE SHOPS, CANTEEN RENTAL OF VENDING MACHINES RENTAL OF VENDING MACHINES RENTAL OF VENDING MACHINES RENTAL OF HOSPITAL SPACE GOVERNMENTAL APPROPRIATIONS OTHER (SPECIFY) TOTAL OTHER INCOME  TOTAL OTHER EXPENSES

MEDICAID COST REPORT

JOHN MANCHIN SR. HEALTH CARE CENTER

JUNE 30, 2010

John Manchin Sr. Health Care Center 401 Guffey Street Fairmont, WV 26554

To The Board of Directors:

We have compiled the Medicaid Cost Report Form 2552 of John Manchin Sr. Health Care Center as of June 30, 2010, included in the accompanying prescribed form, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. We also have compiled the supplementary information presented in the prescribed form.

Our compilation was limited to presenting, in the form prescribed by H.C.F.A., information that is the representation of the Company whose financial statements are presented. We have not audited or reviewed the financial statement and supplementary information referred to above and, accordingly do not express an opinion or any other form of assurance on them.

The financial statement (including related disclosures) and the supplementary information are presented in accordance with the requirements of H.C.F.A., which differ from generally accepted accounting principles. Accordingly these financial statements and the supplementary information are not designed for those who are not informed about such differences.

We are not independent with regard to John Manchin Sr. Health Care Center

Pruitte & Associates

Certified Public Accountants

November 30, 2010 Fairmont, West Virginia

OUTPATIENT REHABILITATION PROVIDER

HEALTH CLINIC

8

100

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT

WORKSHEET S PARTS I & II

341725

100

	CERTIFICATION AND SETTLEMENT SUMMARY						thuis I a
	INTERMEDIARY ( ) AUDITED USE ONLY: ( ) DESK REVIEWED	DATE RECEIVED INTERMEDIARY NO	), <u> </u>	[ ]	INITIAL FINAL	[ ]	RE-OPENING MCR CODE
		PART I - CERTIE	CATION				
		ONICALLY FILED COST RELY SUBMITTED COST REPO		DATE:			
AND ADM	RESENTATION OR FALSIFICATION OF ANY INFORMATIONISTRATIVE ACTION, FINE AND/OR IMPRISONMENT OF ROUTED OR PROCURED THROUGH THE PAYMENT DIRENAMENT DIRENAMENT OF THE AND/OR IMPRISON ADMINISTRATIVE ACTION, FINES AND/OR IMPRISON	NT UNDER FEDERAL LAW. ECTLY OR INDIRECTLY O	FURTHERMORE.	IF SERVICE	CO IDENTIFIE	D IN IUTO VI	CLOUT
	CERTIFICATION	ON BY OFFICER OR ADMIT	VISTRATOR OF	Provider (s	)		
OR MANU JOHN MA BEGINNI COMPLET	BY CERTIFY THAT I HAVE READ THE ABOVE STATE DALLY SUBMITTED COST REPORT AND THE BALANCE ANCHIN SR. HEALTH CARE (51-15701) HIG 07/01/2009 AND ENDING 06/30/2010, AND THE STATEMENT PREPARED FROM THE BOOKS AND RECD. I FURTHER CERTIFY THAT I AM FAMILIAR WIES AND THAT THE SERVICES IDENTIFIED IN THIS	SHEET AND STATEMENT (PROVIDER ) HAT TO THE BEST OF THE PROVIDER	OF REVENUE AND NI NAME(S) AND NI KNOWLEDGE AND IN ACCORDANC ATIONS REGARD VIDED IN OOK	D EXPENSES UMBER(S)) D BELIEF, E WITH APP ING THE PR	FOR THE COST IT IS A TRUE LICABLE INST OVISION OF H	REPORTING , CORRECT A RUCTIONS, E EALTH CARE AND REGULAT	PERIOD ND XCEPT
		PART II - SETTLEME	NT SUMMARY				352
		TITLE V	TITL PART A	E XVIII	кт В	TITLE XI	IX
1 2 3 4	HOSPITAL SUBPROVIDER I SWING BED - SNF SWING-BED - NF	1	2	774	3	4	1 2 3 4 5 25
5	SKILLED NURSING FACILITY NURSING FACILITY					34172	25 6 7

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (05/2007)

VERSION: 2008.05 11/30/2010 11:56

WORKSHEET S-2

### HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

	L AND HOSPITAL HEALTH CARE COMPLEX ADD STREET: 401 GUFFEY STREET CITY: FAIRMONT	DRESS: STATE: WV	P.O.BOX: 2IP CODE:	26554 (	COUNTY: MARION				1 1.01
HOSPITA	L AND HOSPITAL-BASED COMPONENT IDENTI	FICATION:		22417222	DATE		MENT SY		
	COMPONENT 0	COMPONENT NAME		PROVIDER NUMBER 2	CERTIFIED 3		XVIII 5		
3 4 5	HOSPITAL SUBPROVIDER I SWING BEDS - SNF SWING BEDS - NF	JOHN MANCHIN SR. HEA	LTH CARE	51-15701	05/31/1983	N	N	0	2 3 4 5 6
7 8 9 11 12 14	HOSPITAL-BASED SNF HOSPITAL-BASED NF HOSPITAL-BASED NF HOSPITAL-BASED OLTC HOSPITAL-BASED HHA SEPARATELY CERTIFIED ASC HOSPITAL-BASED HOSPICE HOSP-BASED RHC OUTPATIENT REHABILITATION PROVID RENAL DIALYSIS	JOHN MANCHIN SR. HE	ALTH CARE	51-15701	05/31/1983	3 11		0	7 8 9 11 12 14 15
17	COST REPORTING PERIOD (MM/DD/YYYY)			FROM:	07/01/2009 T	06/30, 2	/2010		17
18	TYPE OF CONTROL				ĩ				18
TYPE OF 19 20	PHOSPITAL/SUBPROVIDER HOSPITAL SUBPROVIDER I				2				19 20
OTHER 1	INFORMATION INDICATE IF YOUR HOSPITAL IS EITHER ( COST REPORTING PERIOD IN COLUMN 1. IE OR LOCATED IN A RURAL AREA, IS YOUR E	F YOUR HOSPITAL IS GEO SED SIZE IN ACCORDANCE	GRAPHICALLY O WITH CFR 42	412.105					21
21.01	LESS THAN OR EQUAL TO 100 BEDS, ENTER DOES YOUR FACILITY QUALIFY AND IS CUR	R IN COLUMN 2 'Y' FOR REENTLY RECEIVING PAYM	AER OK .W. E.	OR NO.	ио				21.01
21.02	DISPROPORTIONATE SHARE IN ACCORDANCE HAS YOUR FACILITY RECEIVED GEOGRAPHIC	RECLASSIFICATION? EN	TER 'Y' FOR '	YES					21.02
21.03	AND 'N' FOR NO. IF YES, REPORT IN COL ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOC URBAN IN COLUMN 1 INDICATE IF YOU REC RECLASSIFICATION TO A RURAL LOCATION, IS YES, ENTER IN COLUMN 3 THE EFFECT! FACILITY CONTAIN 100 OR FEWER BEDS IN	CATION EITHER (1) URBA CEIVED EITHER A WAGE O E ENTER IN COLUMN 2 'Y (VE DATE (mm/dd/yyyy)( N ACCORDANCE WITH 42 C	N (2) RURAL. R STANDARD G ' AND 'N' FO SEE INSTRUCT FR 412.105?	R NO. IF COLU ION). DOES YOU ENTER IN COLU	JMN 2 DUR		Y		21.03
21.04	'Y' FOR YES AND 'N' FOR NO. ENTER IN FOR STANDARD GEOGRAPHIC RECLASSIFICATION	COLUMN 5 THE PROVIDER FION (NOT WAGE), WHAT	S ACTUAL MSA IS YOUR STAT	OR CBSA.					21.04
21.05	OF THE COST REPORTING PERIOD. ENTER FOR STANDARD GEOGRAPHIC RECLASSIFICA' COST REPORTING PERIOD. ENTER (1) URBI	TION (NOT WAGE), WHAT	IS YOUR STAT	US AT THE EN	D OF THE 1				21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE TO SMALL RURAL HOSPITAL UNDER THE PROSPI UNDER DRA SECTION 5105? ENTER 'Y' FOR	HREE-YEAR TRANSITION O ECTIVE PAYMENT SYSTEM	F HOLD HARML FOR HOSPITAL	ESS PAYMENTS OUTPATIENT	SERVICES				21.06
22 23 23.01	ARE YOU CLASSIFIED AS A REFERRAL CENDES THIS FACILITY OPERATE A TRANSPLIF THIS IS A MEDICARE CERTIFIED KIDN IN COL. 2 AND TERMINATION IN COL. 3.	TER? ANT CENTER? IF YES, EN	TER CERTIFIC ENTER THE CE	ATION DATE(S	) BELOW NO DATE				23 23.01
	IF THIS IS A MEDICARE CERTIFIED HEAR IN COL. 2 BND TERMINATION IN COL. 3.						Ģ.		23.02
	IF THIS IS A MEDICARE CERTIFIED LIVE	R TRANSPLANT CENTER, E							23.03
	IF THIS IS A MEDICARE CERTIFIED LUNG	TRANSPLANT CENTER, EN							23.04
	IF MEDICARE PANCREAS TRANSPLANTS ARE								23.05
	IF THIS IS A MEDICARE CERTIFIED INTE	I 3.							23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLE	T TRANSPLANT CENTER EN			TE				23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZ	ATION (OPO), ENTER THE							24
24.01 25	IF THIS A MEDICARE TRANSPLANT CENTER CERTIFICATION DATE OR RECERTIFICATION IS THIS A TEACHING HOSPITAL OR AFFIL	N DATE (AFTER DECEMBER	R 26, 2007)	IN COL 3.					24.01
25.01 25.02	PAYMENTS FOR I & R? IS THIS TEACHING PROGRAM APPROVED IN IF LINE 25.01 IS YES, WAS MEDICARE F IN EFFECT DURING THE FIRST MONTH OF	ARTICIPATION AND APPROTHE COST REPORTING PE	OVED TEACHING RIOD? IF YES,	G PROGRAM STA	NO NO				25.01 25.02
25.03	WORKSHEET E-3, PART IV. IF NO, COMPL	ETE WORKSHEET D-2, PA	RT 11. FOR PHYSICIAL	NS' SERVICES	AS NO				25.03
00.04	DEFINED IN CMS PUB. 15-1, SECTION 21 ARE YOU CLAIMING COSTS ON LINE 70 OF HAS YOUR FACILITY DIRECT GME FTE CAR 42 CFR 413.79(c)(3) OR 42 CFR 412.10	WORKSHEET A? IF YES,	COMPLETE WOL	9. RKSHEET D-2 BEEN REDUCEI	NO UNDER				25.04 25.05
25.06	42 CFR 413.79(c) (3) ON 42 CFR 412.10 THE APPLICABLE COLUMNS. (SEE INSTRUC HAS YOUR FACILITY RECEIVED ADDITION/ RESIDENT CAP SLOTS UNDER 42 CFR 413. YES AND 'N' FOR NO IN THE APPLICABLE	CTIONS) AL DIRECT GME FTE RESI .79(c)(4) OR 42 CFR 41	DENT CAP SLO	TS OR IME FT	3				25.06

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WORKSHEET S-2 (CONTINUED)

### HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

į	26	NFORMATION  IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT.  ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR				26
	26.01 26.03	NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.  ENTER THE APPLICABLE SCH DATES:  EN				26.01 26.03
		THE NUMBER OF FERIODS WITHIN INTO A CLASSIFIED IN A RURAL AREA.  AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.  IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):  ENDING:				26.04
		BEGINNING: ENDING: BEGINNING: ENDING: DOES THIS ROSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913	ИО			27
		FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (MM/GG/YYYY) IN COUNTY IN COUNTY OF THE COUNTY OF T				28
		FOR SWING BEDS? IT IES, ENTER THE AGREEMENT ARE ALL PATIENTS UNDER MANAGED CARE IF THIS FACILITY CONTAINS A HOSPITAL BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28.01
	28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE INVASITION BEFORE AND ON OR AFTER OCTOBER 1st				28.02
	28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC AND TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				
		A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SHE REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED				
		EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS) STAFFING	0.00	N N		28.03
	28.04	RECRUITMENT RETENTION OF EMPLOYEES	0.00	N N		28.05 28.06
	28.06	TRAINING	0.00	N		28.07
		OTHER (SPECIFY)  IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNE WHICH HAS FEWER THAN 50 BEDS IN THE  OFFICE OF THE SPECIFIC OF	NO			29
	29 30	AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OFFICIAL METHOD OF RESIDENCE ACCESS DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS	по	ie.		30
	30.01	HOSPITAL (CAH)? SEE 42 CFR 485.606ff.  IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH?				30.01
	30.02	SEE 42 CFR 413.70. IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF				30.02
	30.03	PAYMENT FOR OUTPATIENT SERVICES! IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE				30.03
	30.04	ON OR AFTER 12/21/2000) IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR 1&R TRAININ PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE	G			30.04
	31	WORKSHEET D-2, PART II. IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	ИО		#	31
	MISCEL	LANEOUS COST REPORTING INFORMATION IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY)	YES	A		32
	32		NO			33
	33	IN COLUMN 2.  IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N'				***
	34 35	FOR NO IN COLUMN 2.  IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(1) TEFRA?  HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(1)?	NO NO			34 35
			V 1	XVIII 2	XIX 3	
		CCTIVE PAYMENT SYSTEM (PPS) - CAPITAL  DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?  DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE	NO NO	NO NO	NO NO	36 36.01
		WITH 42CFR412.320?  DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?  I IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	ИО	Ю	NO	37 37.01

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HOCDITAL.	AND	HEALTH	CARE	COMPLEX	IDENTIFICATION	DATA

WORKSHEET	S-2
(CONTINU	ED)

38 38.01 38.02	IX INPATIENT HOSPITAL SERVICES  DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?  IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN  DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?  ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?  DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO PART? NO NO NO		38 38.01 38.02 38.03 38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION,	YES	>	40
	ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	FI/CONTRAC	CTOR'S NUMBER:	40.01
40.01	NAME:	P.O.BOX:		40.02
	STREET:	STATE:	ZIP CODE:	40.03
40.03	CITY:	NO		41
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	NO		42
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.01
42 01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?			42.02
12 02	ARE SEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	МО		43
4.3	ARE RECOVERATORY TURBERY CERVICES PROVIDED BY OUTSIDE PROVIDERS?	ИО		
43	TO UNIT ADD CLATHING COCK FOR DENAL SERVICES ON WORKSHEET A. ARE THEI INPAL SERVICES OF	NLY? NO		44
	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT	T? NO	•	45
. 45	SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COL	UMN 2.		
	SEE CMS PUB. 15-11, SECTION 3617. IF 1ES, ENTER THE ACTIONAL DATA (Main 65,777).			45.01
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			45.02
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			45.03
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?	en chel		46
46	THE A CHARGE TO THE STREET HE NHEMO DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BAS) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.	ED SHI)		

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

DITTEL	n i ton bion outries									
		PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY		TPATIENT AGNOSTIC			
		1	2	3	4		5			
		Ñ	N	N	N		N			47
	HOSPITAL	N	N	N	N		N			48
	SUBPROVIDER I		N	1.53	15 °					49
49	SKILLED NURSING FACILITY	N	5.0							50
50	HOME HEALTH AGENCY	И	И							100000
						110				52
52	DOES THIS HOSPITAL CLAIM EXPENDITURES FO	R EXTRAORDINA	ARY CIRCUMSTAL	ices in accordan	NCE WITH	NO				VL.
	10 gpp 410 740/e\2									52.01
E2 01	TE VOIL BOE A FILLY PROSPECTIVE OR HOLD I	MARMLESS PROVI	DER ARE YOU I	ELIGIBLE FOR THE	E SPECIAL	ИО				32.01
	PURPORTON DRVNENT DIDCHANT TO 42 CFR 412	148(0) 7 11 1	IES, COMPLETE	D' LWWI TA.						
	IF THIS IS A MEDICARE DEPENDENT HOSPITAL	. (MDH). ENTER	THE NUMBER	OF PERIODS MDH S	STATUS IN					53
53	EFFECT. ENTER BEGINNING AND ENDING DATES	OF MOU STATE	IS ON LINE 53	O1. SUBSCRIPT I	LINE					
	53.01 FOR NUMBER OF PERIODS IN EXCESS OF	ONE AND ENTE	O SURSPOUENT	DATES.						
		ONE MAD PIATE	BEGINNING:	0111551	ENDING:					53.01
53.01	MDH PERIOD:									54
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND	) PAID LOSSES	; 	auphuce.						
	PREMIUMS: PAID LOSSES:	A	ND/OR SELF IN	SURANCE:	UP DAID	МО				54.01
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES	REPORTED IN	OTHER THAN T	HE ADMINISTRATI	APPOINTS	110				
INTERNATION INTERNATION	GENERAL COST CENTER? IF YES, SUBMIT SUP	PORTING SCHED	ULE LISTING C	OST CENTERS AND	AMOUNTS					
	CONTRINED TUEDEIN					110				55
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONA	AL PROSPECTIVE	E PAYMENT IN	ACCORDANCE WITH		NO				33
33	42 CFR 412.107. ENTER 'Y' FOR YES AND 'I	N' FOR NO.						W /W	CODC	
	42 Olk 112.12011 Buton 1 Ten aut				DATE	Y/N	LIMIT	A\N	FEES	
					0	1	2	3	4	
	ARE YOU CLAIMING AMBULANCE COSTS? IF YE	S ENTER IN C	OT. 2 THE PAYM	ENT LIMIT	1 1	ИО	0.00	NO		56
56	PROVIDED FROM YOUR FISCAL INTERMEDIARY.	TE TUTE TE F	IRST YEAR OF	OPERATIONS,						
	PROVIDED FROM YOUR FISCAL INTERMEDIANT.	TO IVI PHITE	D IN, UD IN.	IN COL 3						
	NO ENTRY IS REQUIRED IN COL 2. IF COL 1	19 1 , DIVID	NUCESTRIC WHELL	DNCE SERVICES.						
	WHETHER THIS IS YOUR FIRST YEAR OF OPER	ATIONS FOR RE	MADENTING WINDON	DEBTOD						
	ENTER IN COL 4, IF APPLICABLE, THE FEE	SCHEDULES AMO	ONIS FOR THE	PERTOD						
	REGINATED ON OR AFTER 4/1/2002.					NO				57
57	ARE YOU CLAIMING NURSING AND ALLIED HEA	LTH COSTS?			nnaurnna	ИО				58
58	THE WALL BU TURNEY BURN DEURDIT TOROTON FRO	TITTY (IRF)	OR DO YOU CON	TAIN AN IRE SUE	PROVIDER:	NO				50
00	BUMBE THE COLUMN 1 IN EXP VEC AND 'N' F	OR NO IF YES	HAVE TOO MAL	E THE EDUCATOR	ron root					
	non correspondence charp IN COLIMN 7 'V	FOR YES AND	. W. FOR NO.	TUTO OFITON TO	OHANA					
	WINTERDID DOD COOM DEDODTING DEPIODS RE	GINNING ON OR	AFTER 1/1/20	OZ MND DDIONG I	O/ L/ LOVE.					CO 01
FA 01	THE TANK TO COLUMN 1 TO V DODE THE PACT	TITY HAVE A T	EACHING PROGE	AM IN IND MOST	MOCOLLY					58.01
58.01	soom anagometric pentan cunting on on Beech	RE NOVEMBER I	n. ZUU4 ? ENIE	W TH CONDING T	1 1011 120					
	OR 'N' FOR NO. IS THE FACILITY TRAINING	DESTREMTS IN	A NEW TEACH	NG PROGRAM IN F	ACCORDANCE					
	WITH FR VOL 70, NO 156 DATED AUGUST 15,	2005 0000 47	10202 FNTER TH	COLUMN 2 'Y' E	FOR YES OR					
	WITH FR VOL 70, NO 156 DATED AUGUST 15,	2003 PMOD 47	COTUDIA IN CO	TIMM 3 (SEE THE	STRUCTIONS)					
	'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1,	Z, OK 3 KESPE	CITARDI TH C	FOURTH FATER A	TH COLUMN 3	2				
						S.				
	OR IF THE SUBSEQUENT ACADEMIC YEARS OF	THE NEW TEACH	TING PROGRAM	IN EVISIENCE, EI	iiny 3.					
	LODE INCOMICATIONS!					NO				59
59	AND YOU A LONG TERM CARE HOSPITAL LLTCH	I), OR DO YOU	CONTAIN A LTC	CH SUBPROVIDER?	DOD 1000	110				~ *
	DUMPE THE COLLEGE I IN THE EAD VEC DWD 'N'	OB NO IF AFE	S HAVE IOU MAI	IN THE CHECKTON	TOW YOUR					
	PPS REIMBURSEMENT? ENTER IN COLUMN 2 '	" FOR YES AND	'N' FOR NO.	(SEE INSTRUCTION	ONS)					
	FES KOTTIDOROLITORIA, BILTORIA, CODOLINIA	THE STATE OF THE S								

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## HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 (CONTINUED)

60

ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?

ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A

NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)

10.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT

COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N'

FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH

42 CFR SEC. 412.424(d) (1) (iii) (2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2

IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST

REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE

SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)

60.01

MULTICAMPUS 61

61

DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2,

ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5. COUNTY:

FTE/ CAMPUS CBSA STATE: ZIP CODE 5

NO

NO

99
PROVIDER NO. 5115701 JOHN MANCHIN SR. HEALTH CARE
PERIOD FROM 07/01/2009 TO 06/30/2010

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HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	TITLE V 3	TITLE XVIII	/ O/P VISITS LTCH NONCOVERED DAYS 4.01	/ TRIPS TITLE XIX 5	OBS. BEDS ADMITTED 5.01
1	HOSPITAL ADULTS & PEDS, EXCL								1
	SWING BED, OBSERV & HOSPICE DAYS								2
2	НМО								3
3	HOSPITAL ADULTS & PEDS -								•
4	SWING BED SNF HOSPITAL ADULTS & PEDS -								4
4	SWING BED NF								2
5	TOTAL ADULTS & PEDS								5
	EXCL OBSERVATION BEDS								6
6	INTENSIVE CARE UNIT								7
7	CORONARY CARE UNIT								8
8	BURN INTENSIVE CARE UNIT								9
9	SURGICAL INTENSIVE CARE UNIT								10
10	OTHER SPECIAL CARE (SPECIFY)								11
11	NURSERY								12
1.2	TOTAL HOSPITAL								13
13	RPCH VISITS								14
14	SUBPROVIDER I								15
15	SKILLED NURSING FACILITY	41	14965					13669	16
16	NURSING FACILITY	41	14903						17
17	OTHER LONG TERM CARE								18
18	HOME HEALTH AGENCY								20
20	ASC (DISTINCT PART) HOSPICE (DISTINCT PART)								21
21 23	O/P REHAB PROVIDER								23
24	RHC I								24
25	TOTAL	41							25
26	OBSERVATION BED DAYS								26
27	AMBULANCE TRIPS								27
28	EMPLOYEE DISCOUNT DAYS								28

COMPONENT

HOSPITAL ADULTS & PEDS -SWING BED SNF HOSPITAL ADULTS & PEDS -

OTHER SPECIAL CARE (SPECI NURSERY TOTAL HOSPITAL RPCH VISITS SUBPROVIDER I SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY ASC (DISTINCT PART) HOSPICE (DISTINCT PART) O/P REHAB PROVIDER RHC I

OBSERVATION BED DAYS AMBULANCE TRIPS EMPLOYEE DISCOUNT DAYS

HMO XIX

RHC I

TOTAL

4

5

6789

10

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WORKSHEET S-3

31.25

26 27

28

### HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

PART I (CONTINUED) ---INTERNS & RES FTES---- --FULL TIME EQUIV-LESS I&R
REPL NON- EMPLOYEES NONPAID ----I/P DAYS / O/P VISITS / TRIPS----OBS.
BEDS NOT TOTAL ALL
BEDS
ADMITTED PATIENTS ADMITTED
6 6.01 OBS. BEDS NOT ADMITTED EMPLOYEES NONPAID
NET ON PAYROLL WORKERS
9 10 11 TOTAL PHYS ANES 6.02 8 1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS 4 HOSPITAL ADULTS & PEDS SWING BED NF
TOTAL ADULTS & PEDS
EXCL OBSERVATION BEDS
INTENSIVE CARE UNIT
CORONARY CARE UNIT
BURN INTENSIVE CARE UNIT
SURGICAL INTENSIVE CARE UNIT
OTHER SPECIAL CARE (SPECIFY)
NURSERY 8 9 10 11 12 13 14 15 16 17 18 20 21 23 24 25 31.25 14445

 $101\,$  provider no. 5115701  $\,$  John manchin Sr. Health care period from 07/01/2009 to 06/30/2010

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HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	6
1	HOSPITAL ADULTS & PEDS, EXCL.					1
•	SWING BED, OBSERV & HOSPICE DAYS					2
2	HMO XIX HOSPITAL ADULTS & PEDS -					3
3	SWING BED SNF					0.40
4	HOSPITAL ADULTS & PEDS -					4
- 4	SWING BED NF					5
5	TOTAL ADULTS & PEDS					3
	EXCL OBSERVATION BEDS					6
6	INTENSIVE CARE UNIT					ž
7	CORONARY CARE UNIT					8
8	BURN INTENSIVE CARE UNIT					9
9	SURGICAL INTENSIVE CARE UNIT					10
10	OTHER SPECIAL CARE (SPECIFY)					11
11	NURSERY					12
12	TOTAL HOSPITAL					13
13	RPCH VISITS					14
14	SUBPROVIDER I					15
15	SKILLED NURSING FACILITY					16
16	NURSING FACILITY					17
17	OTHER LONG TERM CARE					18
18	HOME HEALTH AGENCY ASC (DISTINCT PART)					20
20	HOSPICE (DISTINCT PART)					21
21 23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25 26
26	OBSERVATION BED DAYS					27
27	AMBULANCE TRIPS					28
28	EMPLOYEE DISCOUNT DAYS					20
200000						

TOTAL OVERHEAD COSTS

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WORKSHEET S-3 AVERAGE ADJUSTED PAID HOURS RECLASS. HOSPITAL WAGE INDEX INFORMATION RELATED TO SALARY HOURLY WAGE PART II OF SALARIES SALARIES DATA FROM WKST. (COL.1 + THUOMA PART II - WAGE DATA COL.4) SOURCE A-6 IN COL. 3 REPORTED COL. 2) SALARIES 1 2 3 2013549 TOTAL SALARIES NON-PHYSICIAN ANESTHETIST PART A NON-PHYSICIAN ANESTHETIST PART B NON-PHYSICIAN ARESTHETIST PART B
PHYSICIAN - PART A
4.01 TEACHING PHYSICIAN SALARIES
PHYSICIAN - PART B
5.01 NON-PHYSICIAN - PART B
6.10 TONTRACT SERVICES, 14R

1.02 OPER OF PERSONNEL 4.01 5 5.01 6.01 HOME OFFICE PERSONNEL SNE 8.01 EXCLUDED AREA SALARIES OTHER WAGES & RELATED COSTS 8.01 880918 9 CONTRACT LABOR
9.01 PHARMACY SERVICES UNDER CONTRACT
9.02 LABORATORY SERVICES UNDER CONTRACT
9.03 MANAGEMENT AND ADMINISTRATIVE SERVICES'
10 CONTRACT LABOR: PHYSICIAN PART A
10.01 TEACHING PHYSICIAN UNDER CONTRACT 9.01 9.02 10 10.01 10.01 TEACHING PHYSICIAN UNDER CONTRACT
11 HOME OFFICE: SALARIES & WAGE REL COSTS
12 HOME OFFICE: PHYSICIAN PART A
12.01 TEACHING PHYSICIAN SALARIES
WAGE-RELATED COSTS
13 WAGE RELATED COSTS (CORE)
14 WAGE RELATED COSTS (OTHER)
15 EXCLUDED AREAS 11 12.01 13 CMS 339 CMS 339 14 CMS 339 15 16 NON-PHYSICIAN ANESTHETIST PART A NON-PHYSICIAN ANESTHETIST PART B PHYSICIAN PART A CMS 339 16 339 CMS 18 18.01 CMS 339 18 CMS 339 18.01 PART A TEACHING PHYSICIANS 18.01 PART A TEACHING PHYSICIANS
19 PHYSICIAN PART B
19.01 WAGE RELATED COSTS (RHC/FQHC)
20 INTERNS & RESIDENTS (IN APPR PGM)
 OVERHEAD COSTS - DIRECT SALARIES
21 EMPLOYEE BENEFITS
22 ADMINISTRATIVE & GENERAL
23.01 ADMINISTRATIVE & GENERAL UNDER CONTACT
23 MAINTENANCE & REPAIRS
24 OPERATION OF PLANT
25 LAUNDRY & LINEN SERVICE
26 HOUSEKEEPING CMS 339 19.01 CMS 339 20 21 22 22.01 243166 23 24 92996 25 26 HOUSEKEEPING
26.01 HOUSEKEEPING UNDER CONTRACT
27 DIETARY 47200 99027 26.01 27 187134 27.01 DIETARY UNDER CONTRACT 28 CAFETERIA MAINTENANCE OF PERSONNEL 28 29 29 30 30 59593 NURSING ADMINISTRATION 31 CENTRAL SERVICES AND SUPPLY 31 32 32 33 34 PHARMACY 33 MEDICAL RECORDS & MEDICAL RECORDS LIBR 28639 34 SOCIAL SERVICE OTHER GENERAL SERVICE 31120 35 WORKSHEET S-3 HOSPITAL WAGE INDEX INFORMATION PART III PAID HOURS AVERAGE ADJUSTED RECLASS HOURLY WAGE SALARIES RELATED OF SALARIES TO SALARY FROM WKST. (COL. 1 + (COL. 3 / AMOUNT COL. 4) REPORTED COL. 2) IN COL. 3 PART III - HOSPITAL WAGE INDEX SUMMARY A-6 2013549 2013549 NET SALARIES NET SALARIES
EXCLUDED AREA SALARIES
SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)
SUBTOTAL OTHER WAGES & REL COSTS
SUBTOTAL WAGE-RELATED COSTS
TOTAL (SUM OF LINES 3 THRU 5)
NET SALARIES
MANUFACTURE AREA CALARIES 880918 880918 1132631 1132631 1132631 1132631 EXCLUDED AREA SALARIES SUBTOTAL SALARIES (LINE 7 MINUS LINE 8) SUBTOTAL OTHER WAGES & REL COSTS 10 SUBTOTAL WAGE-RELATED COSTS 11 TOTAL (SUM OF LINES 9 THRU 11) 12 847339 847339

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER	SALARIES	OTHER 2	TOTAL	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS		72607	72607		72607		72607	1
1		OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP		12601	12001		12001		27.05.35.05.05.	2
2		NEW CAP REL COSTS-BLDG & FIXT		11380	11380		11380		11380	3
4		NEW CAP REL COSTS-MYBLE EQUIP		52057	52057	5256	57313		57313	4
5		EMPLOYEE BENEFITS		768119	768119	-44519	723600	406303	723600 702394	5 6
6	0600	ADMINISTRATIVE & GENERAL	243166	57684	300850	-4253	296597	405797	102394	7
7		MAINTENANCE & REPAIRS	00006	210283	303279		303279		303279	8
8		OPERATION OF PLANT	92996 47200	13347	60547		60547		60547	9
9	0900	LAUNDRY & LINEN SERVICE	99027	23344	122371		122371		122371	10
10 11		HOUSEKEEPING DIETARY	187134	152262	339396		339396	-42776	296620	11
12		CAFETERIA	20.20							12
13		MAINTENANCE OF PERSONNEL							50503	13
14		NURSING ADMINISTRATION	59593		59593		59593		59593	14 15
15		CENTRAL SERVICES & SUPPLY		177						16
16		PHARMACY	00000	00	28738		28738		28738	17
17		MEDICAL RECORDS & LIBRARY	28639 31120	99 985	32105		32105		32105	18
18		SOCIAL SERVICE	58464	9802	68266		68266		68266	19
19 20		RECREATION NONPHYSICIAN ANESTHETISTS	30101	2002						20
21		NURSING SCHOOL								21
22		I&R SERVICES-SALARY & FRINGES A							• •	22
23		I&R SERVICES-OTHER PRGM COSTS A								23 24
24	2400	PARAMED ED PRGM-(SPECIFY)								24
	10	INPATIENT ROUTINE SERV COST CENTERS	000010	211000	1192718	877	1193595		1193595	35
35	3500	NURSING FACILITY	880918	311800	1192110	077	1175555			
	4100	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC	32538	20301	52839		52839		52839	41
41	4100	BLOOD CLOTTING FACTORS ADMIN CO	32330	20002						46.30
50	5000	PHYSICAL THERAPY		1762	1762	-1762				50
00		OUTPATIENT SERVICE COST CENTERS					071000	150614	21 6256	60
60	6000	CLINIC	252754	77745	330499	44401	374900	-158644	216256	62
62	6200	OBSERVATION BEDS (NON-DISTINCT								63.50
	6310									63.60
63.60	6320									
60 10	6910	OTHER REIMBURSABLE COST CENTERS								69.10
		OUTPATIENT PHYSICAL THERAPY								69.20
		OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40 71
71		HOME HEALTH AGENCY								11
		SPECIAL PURPOSE COST CENTERS								85.01
		PANCREAS ACQUISITION								85.02
85.0	8520	INTESTINAL ACQUISITION								85.03
95.0	8530	ISLET CELL ACQUISITION SUBTOTALS	2013549	1783577	3797126		3797126	204377	4001503	95
23		NONREIMBURSABLE COST CENTERS	LANCE - CONTRACTOR TO SCI	2000 m m m m 200 m 200			150 to 100 (140)			100
100	7950	RENTAL SPACE	10000000000000000000000000000000000000	505	505		505	204377		100
101		TOTAL	2013549	1784082	3797631		3797631	204311	4002000	101

RECLASSIFICATIONS

WORKSHEET A-6 PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE		- INCREASE		SALARY	OTHER	
	The state of the s	1	COST CENTER	3	н	4	5	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 9 20 22 23 24 5 26 27 28 9 30 31 2 33 33 35 5	RECLASS EQUIPMENT RENTAL RECLASS EQUIPMENT RENTAL REMOVE PHYSICIAN BENEFITS RECLASS PT	1 C C C C C	NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP CLINIC NURSING FACILITY	3 4 4 4 60 35		•	4253 885 118 44519 1762	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 27 28 29 30 31 31 31 31 31 31 31 31 31 31 31 31 31
36	TOTAL RECLASSIFICATIONS							

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RECLASSIFICATIONS

WORKSHEET A-6 PAGE 1

	EXPLANATION OF CODE		DECREASE			WKST A-7		
	RECLASSIFICATION ENTRY	CODE	COST CENTER	LINE #	SALARY	OTHER		F.
	NBOBROTT TOTAL BRIDE	1	6	7	8	9	10	)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	RECLASS FIGATION ENTRI RECLASS EQUIPMENT RENTAL RECLASS EQUIPMENT RENTAL REMOVE PHYSICIAN BENEFITS RECLASS PT	1 C C C C C			8	9 4253 885 118 44519 1762	10 10 10	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36	.  TOTAL RECLASSIFICATIONS		,		¥	51537		17 18 19 20 21 22 23 24 25 26 27 28 29 31 32 33 34 35 36

RECONCILING ITEMS

TOTAL

12258

VERSION: 2008.0106

WORKSHEET A-7 PARTS I & II

1259208

227653 9

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

# PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

		9		ACQUISITIONS		DISPOSALS	ENDING	FULLY DEPRECIATED
	DESCRIPTION	BEGINNING BALANCES 1	PURCHASE 2	DONATION 3	TOTAL	AND RETIREMENTS 5	BALANCE 6	ASSETS 7
,	LAND	12353					12353	9333 1
2 3	LAND IMPROVEMENTS BUILDINGS AND FIXTURES BUILDING IMPROVEMENTS	3630315					3630315	3 4
5	FIXED EQUIPMENT MOVABLE EQUIPMENT SUBTOTAL	262115 3904783					262115 3904783	252752 6 262085 7
8	RECONCILING ITEMS TOTAL	3904783					3904783	262085 9
	PART II - ANALYSIS OF CHANGES IN NE	W CAPITAL AS	SET BALANCES	3				
		enerillirus.		ACQUISITIONS		DISPOSALS AND	ENDING	FULLY DEPRECIATED
	DESCRIPTION	BEGINNING BALANCES 1	PURCHASE 2	DONATION 3	TOTAL 4	RETIREMENTS 5	BALANCE 6	ASSETS 7
1 2 3	LAND LAND IMPROVEMENTS BUILDINGS AND FIXTURES	455761					455761	1 2 3 4
4 5 6 7	BUILDING IMPROVEMENTS FIXED EQUIPMENT MOVABLE EQUIPMENT SUBTOTAL	791189 1246950	12258 12258		12258 12258		803447 1259208	227653 6 227653 7 8
8	RECONCILING ITEMS						1260200	227653 9

12258

1246950

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PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7 PARTS III & IV

			- COMPUTATION	OF RATIOS GROSS		ALLO	CATION OF	OTHER CAPITAL	L	
	DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
		1	2	3	4	5	6	7	8	
1 2 3 4 5	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP TOTAL				.000000 .000000 .000000 .000000				1 2 3 4 5	
					SUMMARY OF	OLD AND NEW	CAPITAL			
	DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL	
			9	10	11	12	13	14	15	
1 2 3 4 5	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MYBLE EQUIP TOTAL		72607 11380 52057 136044	5256 5256					72607 1 2 11380 3 57313 4 141300 5	
	PART IV - RECONCILIATION O	F AMOUNTS F	ROM WORKSHEET	A, COLUMN	2, LINES 1	THRU 4				
			DEPREC-		- SUMMARY O	F OLD AND NEW		OTHER CAPITAL-		
	DESCRIPTION		IATION	LEASE	INTEREST	INSURANCE	TAXES	RELATED COSTS	TOTAL	
			9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT		72607						72607 1	
2 3 4 5	OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP TOTAL		11380 52057 136044						11380 3 52057 4 136044 5	

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## ADJUSTMENTS TO EXPENSES

FERTOD	tron 07/01/2009 10 00/30/2010		IN DIEO	OF FORT CHS-2552-90 (11/90)	11/	30/2010 11.30
	ADJUSTMENTS TO EXPENSES			EXPENSE CLASSIFICATION ON WORK	CUEET A TO!	WORKSHEET A-8
	DESCRIPTION	BASIS 1	THUOMA 2	FROM WHICH THE AMOUNT IS TO BE COST CENTER 3		
1 2 3 4 5 6 7 8 9 10 11	INVESTMENT INCOME-OLD BLDGS & FIXTURES INVESTMENT INCOME-OLD MOVABLE EQUIPMENT INVESTMENT INCOME-NEW BLDGS & FIXTURES INVESTMENT INCOME-NEW MOVABLE EQUIPMENT INVESTMENT INCOME-OTHER TRADE, QUANTITY, AND TIME DISCOUNTS REFUNDS AND REBATES OF EXPENSES RENTAL OF PROVIDER SPACE BY SUPPLIERS TELEPHONE SERVICES (PAY STATIONS EXCL) TELEVISION AND RADIO SERVICE PARKING LOT PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST		OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	1 2 3 4	1 2 3 4 5 6 7 8 9 10
13	SALE OF SCRAP, WASTE, ETC. RELATED ORGANIZATION TRANSACTIONS	A-8-2 WKST				12 13
		A-8-1	405797			14
15 16 17 18	LAUNDRY AND LINEN SERVICE CAFETERIA - EMPLOYEES AND GUESTS RENTAL OF QUARTERS TO EMPLOYEES & OTHERS SALE OF MEDICAL AND SURGICAL SUPPLIES TO	В	-42776	DIETARY	11	15 16 17
19 20 21 22 23	OTHER THAN PATIENTS SALE OF DRUGS TO OTHER THAN PATIENTS SALE OF MEDICAL RECORDS AND ABSTRACTS NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.) VENDING MACHINES INCOME FROM IMPOSITION OF INTEREST,					18 19 20 21 22
24	FINANCE OR PENALTY CHARGES INTEREST EXP ON MEDICARE OVERPAYMENTS &					23
25	BORROWINGS TO REPAY MEDICARE OVERPAYMENT ADJ FOR RESPIRATORY THERAPY COSTS IN	WKST				24
26	EXCESS OF LIMITATION - HOSPITAL ADJ FOR PHYSICAL THERAPY COSTS IN	A-8-4 WKST		RESPIRATORY THERAPY	49	25
	EXCESS OF LIMITATION - HOSPITAL	A-8-4		PHYSICAL THERAPY	50	26
27 28 29 30 31 32 33	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION UTIL REVIEW-PHYSICIANS' COMPENSATION DEPRECIATION-OLD BUILDINGS & FIXTURES DEPRECIATION-NEW BUILDINGS & FIXTURES DEPRECIATION-NEW BUILDINGS & FIXTURES DEPRECIATION-NEW MOVABLE EQUIPMENT NON-PHYSICIAN ANESTHETIST	WKST A-8-3		HOME HEALTH AGENCY UTILIZATION REVIEW-SNF OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NONPHYSICIAN ANESTHETISTS	71 89 1 2 3 4 20	27 28 29 30 31 32 33
34 35	PHYSICIANS' ASSISTANT ADJ FOR OCCUPATIONAL THERAPY COSTS IN	WKST				34
36	EXCESS OF LIMITATION - HOSPITAL ADJ FOR SPEECH PATHOLOGY COSTS IN	WKST A-8-4 WKST				35
37 38 39 40 41 42 43 44 45 46 47 48	EXCESS OF LIMITATION - HOSPITAL OUTPATIENT PHYSICIAN	WKST A-8-4	-150644	CTINIC	60	36 37 38 39 40 41 42 43 44 45 46 47 48
50	TOTAL		204377			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

2 3 4

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ- USTMENTS	WKST A-7 REF 7
1 2 3	6	ADMINISTRATIVE & GENERAL	HOME OFFICE	405797		405797	1 2 3 4
5		TOTALS		405797		405797	5

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814 (b) (1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

*********		25.572.5 (5.2.)	### (#################################				RELATED	ORGANIZATION(S)	AND/OR	HOME	OFFICE	
				PERCI	THE			PERC	ENT			
	SYMBO	L NA	ME	0		MAM	Ε	0	F		rype of	
	(1)			OWNER:	SHIP			OWNER	SHIP	BI	JSINESS	
	1		2	3		4		5			6	
1	A	DHHR		100.00	STATI	E OF WV		100	.00			
2												
3												
4												
5												
									A - 1 1 7 7 7 2 4 - 7 7 7 7			

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

  A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.

  B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.

  C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.

  D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.

  E. HADIVIDIAL IS DIRECTOR. OFFICER. ADMINISTRATOR.

  - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
    F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
  - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0		NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
1 2 3	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-HYBLE EQUIP	72607 11380	72607	11380		19 (2)				1 2 3
4 5	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS	57313 723600			57313	723600	****			4 5
6	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	702394	10290	1613	5786	87385	807468	807468		6 7
8 9 10	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING	303279 60547 122371	12033 1940 1290	1886 304 202	15635 2351 63	33420 16962 35587	366253 82104 159513	92576 20753 40319	458829 17700 11771	
11 12 13	DIETARY CAFETERIA MAINTENANCE OF PERSONNEL	296620	8460	1326	7063	67249	380718	96232	77199	11 12 13
14 15	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	59593	436	68	920	21416	82433	20836	3982	14 15 16
16 17	PHARMACY MEDICAL RECORDS & LIBRARY	28738	137	22	313	10292	39502	9985	1252	17 18
18 19	SOCIAL SERVICE RECREATION	32105 68266	356 1027	56 161	113 143	11183 21010	43813 90607	11074 22902	3251 9372	19
20 21 22 23	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL 14R SERVICES-SALARY & FRINGES A 14R SERVICES-OTHER PROM COSTS A									20 21 22 23
24	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENT	ERS								24
35	NURSING FACILITY ANCILLARY SERVICE COST CENTERS	1193595	28300	4436	13523	316572	1556426	393412	258216	35
41 46.30 50	RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMIN CO PHYSICAL THERAPY	52839	2067	324	7974	11693	74897	18931	18865	41 46.30 50
60 62 63.50 63.60		216256	5840	915	3287	90831	317129	80159	53292	60 62 63.50 63.60
69.10 69.20 69.30	OTHER REIMBURSABLE COST CENTERS									69.10 69.20 69.30 69.40
85.01 85.02	SPECIAL PURPOSE COST CENTERS PANCREAS ACQUISITION INTESTINAL ACQUISITION									85.01 85.02
85.03 95	ISLET CELL ACQUISITION SUBTOTALS	4001503	72176	11313	57171	723600	4000863	807179	454900	85.03 95
100 101	NONREIMBURSABLE COST CENTERS RENTAL SPACE CROSS FOOT ADJUSTMENTS	505	431	67	142		1145	289	3929	101
102 103	NEGATIVE COST CENTER TOTAL	4002008	72607	11380	57313	723600	4002008	807468	458829	102 103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING	DIETARY 11	NURSING ADMINIS- TRATION 14	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE	RECREATION	SUBTOTAL	
		9	10	1.1	A-90					
1 2 3 4 5	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION	120557 8171 2181	219774 23365	579695	107251					1 2 3 4 5 6 7 8 9 10 11 12 13
15	CENTRAL SERVICES & SUPPLY									15 16
16 17	PHARMACY MEDICAL RECORDS & LIBRARY		2284			53023				17
18	SOCIAL SERVICE		878				59016			18
19	RECREATION		1054					123935		19 20
20 21	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A					T)				22 23
23	I&R SERVICES-OTHER PRGM COSTS A									24
24	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTER	RS								
35	NURSING FACILITY	109424	155125	579695	97284	10605	59016	123935	3343138	35
41	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC	306	3162						116161	41
	BLOOD CLOTTING FACTORS ADMIN CO	300	0100							46.30
50	PHYSICAL THERAPY									50
60	OUTPATIENT SERVICE COST CENTERS CLINIC	475	33906		9967	42418			537346	60
62	OBSERVATION BEDS (NON-DISTINCT	5,00,000	1,735,37,37,370							62 63.50
63.50										63.60
63.60	OTHER REIMBURSABLE COST CENTERS									
69.10	СМНС									69.10
	OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY									69.30
	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
85.02	SPECIAL PURPOSE COST CENTERS PANCREAS ACQUISITION INTESTINAL ACQUISITION									85.01 85.02 85.03
85.03 95	ISLET CELL ACQUISITION SUBTOTALS	120557	219774	579695	107251	53023	59016	123935	3996645	95
	NONREIMBURSABLE COST CENTERS								5363	100
100	RENTAL SPACE CROSS FOOT ADJUSTMENTS								5565	101
102	NEGATIVE COST CENTER				Partition on the Section of				1000000	102
103	TOTAL	120557	219774	579695	107251	53023	59016	123935	4002008	103

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WORKSHEET B PART I

# COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27	
1 2 3 4 5 6 7 8 9 10 11	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLOG & FIXT OLD CAP REL COSTS-BLOG & FIXT NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION NONPHYSICIAN ANESTHETISTS NURSING SCHOOL 1&R SERVICES-SALARY & FRINGES A 1&R SERVICES-OTHER PRGM COSTS A PARAMED ED PRGM (SPECIFY)	rpe.		1 2 3 4 5 5 6 7 8 9 9 110 111 122 13 14 15 16 17 18 19 20 21 22 23 24
	INPATIENT ROUTINE SERV COST CENT NURSING FACILITY	ERS	3343138	35
35 41 46.30 50	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMIN CO PHYSICAL THERAPY		116161	41 46.30 50
60 62 63.50	OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTINCT RHC		537346	60 62 63.50 63.60
69.30	OTHER REIMBURSABLE COST CENTERS			69.10 69.20 69.30 69.40
85.01 85.02	SPECIAL PURPOSE COST CENTERS PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET CELL ACQUISITION		3996645	85.01 85.02 85.03 95
95 100 101	SUBTOTALS NONREIMBURSABLE COST CENTERS RENTAL SPACE CROSS FOOT ADJUSTMENTS		5363	100 101 102
102 103	NEGATIVE COST CENTER TOTAL		4002008	103

WORKSHEET B PART II

## ALLOCATION OF OLD CAPITAL RELATED COSTS

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS	BLDGS & FIXTURES	CAP REL COST TO BE ALLOC	ADMINIS- TRATIVE 6 GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING	DIETARY	
		0	1	4A	ь	8	9	10	**	
	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP		8							1 2 3 4
5 6 7	EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL		10290	10290	10290					5 6 7
8	MAINTENANCE & REPAIRS OPERATION OF PLANT		12033	12033	1180	13213				8
9	LAUNDRY & LINEN SERVICE		1940	1940	264	510	2714			9
10	HOUSEKEEPING		1290	1290	514	339	184	2327		10
11	DIETARY		8460	8460	1226	2223	49	247	12205	11
12	CAFETERIA		g-200000							12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION		436	436	266	115				14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY			-00.7698000	2000					16 17
17	MEDICAL RECORDS & LIBRARY		137	137	127	36		24		18
18	SOCIAL SERVICE		356	356	141	94		11		19
19	RECREATION		1027	1027	292	270		11		20
20	NONPHYSICIAN ANESTHETISTS	5								21
21	NURSING SCHOOL									22
22	I&R SERVICES-SALARY & FRINGES A									23
23	IGR SERVICES-OTHER PRGM COSTS A									24
24	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTE	DC.								
35	NURSING FACILITY	110	28300	28300	5014	7435	2463	1644	12205	35
33	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC		2067	2067	241	543	7	33		41
	BLOOD CLOTTING FACTORS ADMIN CO									46.30
50	PHYSICAL THERAPY									50
702.	OUTPATIENT SERVICE COST CENTERS		5557.000	100000000	2121212			200		60
60	CLINIC		5840	5840	1021	1535	11	359		62
62	OBSERVATION BEDS (NON-DISTINCT									63.50
63.50										63.60
63.60										
co 10	OTHER REIMBURSABLE COST CENTERS									69.10
69.10	OUTPATIENT PHYSICAL THERAPY									69.20
	OUTPATIENT OCCUPATIONAL THERAPY									69.30
	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
• •	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
	INTESTINAL ACQUISITION									85.02 85.03
85.03	ISLET CELL ACQUISITION		12212		20006	12100	2714	2327	12205	
95	SUBTOTALS		72176	72176	10286	13100	2/19	2321	12203	93
	NONREIMBURSABLE COST CENTERS			421	4	113				100
100	RENTAL SPACE		431	431	4	113				101
101	CROSS FOOT ADJUSTMENTS									102
102	NEGATIVE COST CENTER		72607	72607	10290	13213	2714	2327	12205	103
103	TOTAL		12001							

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WORKSHEET B PART II

#### ALLOCATION OF OLD CAPITAL RELATED COSTS

	COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	RECREATION	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	Ž.
		14	17	18	19	25	26	27	
1 2 3 4 5 6 7	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA								1 2 3 4 5 6 7 8 9 10 11 12 13
13 14 15 16 17 18 19 20 21 22 23 24	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION NONPHYSICIAN ANESTHETISTS NURSING SCHOOL 1&R SERVICES-SALARY & FRINGES A 1&R SERVICES-OTHER PRGM COSTS A PARAMED ED PRGM-(SPECIFY)	817	324	600	1600				14 15 16 17 18 19 20 21 22 23 24
35	INPATIENT ROUTINE SERV COST CENT NURSING FACILITY	ERS 741	65	600	1600	60067		60067	35
41 46.30 50	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMIN CO PHYSICAL THERAPY					2891		2891	41 46.30 50
60 62 63.50 63.60	OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTINCT RHC	76	259			9101	8	9101	60 62 63.50 63.60
69.10 69.20 69.30	OTHER REIMBURSABLE COST CENTERS								69.10 69.20 69.30 69.40 71
85.01 85.02	SPECIAL PURPOSE COST CENTERS PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET CELL ACQUISITION SUBTOTALS	817	324	600	1600	72059		72059	85.01 85.02 85.03 95
100	NONREIMBURSABLE COST CENTERS RENTAL SPACE					548		548	100 101
101 102 103	CROSS FOOT ADJUSTMENTS . NEGATIVE COST CENTER TOTAL	817	324	600	1600	72607		72607	102 103

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ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL	BLDGS &	NEW CAP MOVABLE	CAP REL	ADMINIS- TRATIVE &	OPERATION OF PLANT	LAUNDRY & LINEN	HOUSE- KEEPING	
	****	COSTS 0	FIXTURES 3	EQUIPMENT 4	BE ALLOC	GENERAL 6	8	SERVICE 9	10	
1 2 3	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT									1 2 3 4
5 6	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL		1613	5786	7399	7399				5 6 7
8 9 10	MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY		1886 304 202 1326	15635 2351 63 7063	17521 2655 265 8389	848 190 369 882	18369 709 471 3091	3554 241 64	1346 143	8 9 10 11
12 13 14	CAPETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY		68	920	988	191	159			12 13 14 15 16
17 18 19	PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION		22 56 161	313 113 143	335 169 304	91 101 210	50 130 375		14 5 6	17 18 19 20
20 21 22 23	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I&R SERVICES-SALARY & FRINGES A I&R SERVICES-OTHER PRGM COSTS A PARAMED ED PRGM-(SPECIFY)									21 22 23 24
24 35	INPATIENT ROUTINE SERV COST CENTER NURSING FACILITY	RS	4436	13523	17959	3607	10338	3226	951	35
	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMIN CO		324	7974	8298	173	755	9	19	41 46.30 50
50 60 62 63.50			915	3287	4202	734	2134	14	208	60 62 63.50 63.60
69.30 69.40	OTHER REIMBURSABLE COST CENTERS CHIC OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY OUTPATIENT SPEECH PATHOLOGY									69.10 69.20 69.30 69.40
85.02 85.03	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET CELL ACQUISITION		11313	57171	68484	7396	18212	3554	1346	85.01 85.02 85.03 95
95 100	SUBTOTALS NONREIMBURSABLE COST CENTERS RENTAL SPACE		67		209	3	157			100 101
101 102 103	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER TOTAL		11380	57313	68693	7399	18369	3554	1346	102 103

# ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B

	COST CENTER DESCRIPTION	DIETARY 11	NURSING ADMINIS- TRATION 14	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE	RECREATION	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION NONPHYSICIAN ANESTHETISTS NURSING SCHOOL L&R SERVICES-OTHER PROM COSTS A	12569	1338	490	405	895				1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
24 35	PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERV COST CENTER NURSING FACILITY	12569	1214	98	405	895	51262		51262	35
41 46.30	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMIN CO PHYSICAL THERAPY						9254		9254	41 46.30 50
60 62 63.50	OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTINCT RHC		124	392			7808		7808	60 62 63.50 63.60
69.30 69.40	OTHER REIMBURSABLE COST CENTERS									69.10 69.20 69.30 69.40
85.02	PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET CELL ACQUISITION SUBTOTALS	12569	1338	490	405	895	68324		68324	85.01 85.02 85.03 95
100	NONREIMBURSABLE COST CENTERS RENTAL SPACE				,		369		369	100 101
101 102 103	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER TOTAL	12569	1338	490	405	895	68693		68693	102 103

WORKSHEET B-1

COST ALLOCATION - ST	ATISTICAL BASIS
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	COST CENTER DESCRIPTION	OLD CAP BLDGS & FIXTURES SQUARE FEET	OLD CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON- CILIATION 6A	ADMINIS- TRATIVE & GENERAL ACCUM COST	
1 2 3 4	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-WBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-BUDG & FIXT	38104	1066587	38104	1066587	2013549			1 2 3 4 5
5 6 7	EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	5400	107680	5400	107680		-807468	3194540	6 7
8 9 10 11	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	6315 1018 677 4440	43748 1181	1018 677	43748 1181	47200 99027		366253 82104 159513 380718	8 9 10 11 12
12 13 14 15 16	CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	229	17126	229	17126			82433	13 14 15 16
17 18 19 20 21 22 23 24	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION NONPHYSICIAN ANESTHETISTS NURSING SCHOOL 1&R SERVICES-SALARY & FRINGES 1&R SERVICES-OTHER PROM COSTS PARAMED ED PRGM-(SPECIFY)	72 187 539	2095	187	2095	31120		39502 43813 90607	17 18 19 20 21 22 23 24
35	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	14851	251663	1485)	251663	880918		1556426	35
41 46.30 50	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMIN PHYSICAL THERAPY	1085	148394	1085	148394	32538		74897	41 46.30 50
60 62 63.50 63.60	FQHC	3069	5 61167	3069	6116	252754		317129	60 62 63.50 63.60
69.20 69.30	OTHER REIMBURSABLE COST CENTERS CMHC OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERA OUTPATIENT SPEECH PATHOLOGY HOME HEALTH AGENCY								69.10 69.20 69.30 69.40
85.01 85.02	SPECIAL PURPOSE COST CENTERS PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET CELL ACQUISITION SUBTOTALS	3787	8 106393	8 3787	8 106393	8 2013549	-80746	8 3193395	85.01 85.02 85.03 95
100	NONREIMBURSABLE COST CENTERS RENTAL SPACE	22			6 264	9		1145	100 101
101 102 103	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I	7260	7	1138	0 5731	3 723600	)	807468	102 103
104 104 105 106	UNIT COST MULT-WS B PT I UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT II UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT II	1.90549		.29865	.05373	5 .359365		.252765 10290 .003221 7399	105 106 106
107 108 108	COST TO BE ALLOC PER B PT III UNIT COST MULT-WS B PT III UNIT COST MULT-WS B PT III							.002316	108

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WORKSHEET B-1

	COST ALLOCATION - STATISTIC	CAL BASIS							WOMMONDO!	
	COST CENTER DESCRIPTION	OPERATION OF PLANT	& LINEN	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION		OCIAL RE	CREATION	
		SQUARE FEET	LAUNDRY	SERVICE	MEALS SERVED 11	DIRECT NRSING HRS	TIME T		RECT DURS 19	
		8	9	, 10	11					
1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SENERAL SERVICE COST CENTERS DLD CAP REL COSTS-BLDG & FIXT DLD CAP REL COSTS-WBLE EQUIF NEW CAP REL COSTS-WBLE EQUIF NEW CAP REL COSTS-WBLE EQUIF NEW CAP REL COSTS-WBLE EQUIF EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RECREATION NONPHYSICIAN ANESTHETISTS NURSING SCHOOL 16R SERVICES-SALARY & FRINGE 16R SERVICES-SALARY & FRINGE 16R SERVICES-OTHER PRGM COST PARAMED ED PRGM-(SPECIFY)	26389 1018 677 4440 229 72 187 539	63414 4298 1147	1251 133 13 5 6	43016	71668	3	489	856	1 2 3 4 5 6 7 8 9 10 11 11 12 13 14 15 16 17 18 19 20 22 22 23 24
	INPATIENT ROUTINE SERV COST NURSING FACILITY	CENTERS 1485	1 57558	883	4301	6 6500	8 83	489	856	35
41 46.30	ANCILLARY SERVICE COST CENTE RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMIN PHYSICAL THERAPY	108	5 161	18				š		41 46.30 50
50 60 62 63.50	OUTPATIENT SERVICE COST CENT CLINIC OBSERVATION BEDS (NON-DISTIN RHC	306	5 250	193	i,	666	332			60 62 63.50 63.60
69.30 69.40	OTHER REIMBURSABLE COST CENT CMHC OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THE OUTPATIENT SPEECH PATHOLOGY									69.10 69.20 69.30 69.40
85.02	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTER: PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET CELL ACQUISITION SUBTOTALS	2616	53 6341	4 125	1 430	16 716	68 415	489	856	
100 101 102	NONREIMBURSABLE COST CENTER: RENTAL SPACE CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER	22		7 21977	4 5796	95 1072	51 53023	3 59016	123935	
103 104 104 105	COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT I	17.38713 I 1323	31 1.90111 13 271	175.67865 0	7 13.4762 7 122	1.4964 65	98 127.766265 17 324	120,687117	144.783879	105 106
106 106 107 108 108	UNIT COST MULT-WS B PT II UNIT COST MULT-WS B PT II COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT III UNIT COST MULT-WS B PT III	.5007	.04279 69 355	8 4 134 1.07593	. 2837 6 125	32 69 13 .0186	.780723	0 405 .828221	1.869159 895 1.045561	107

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WORKSHEET B-1

#### COST ALLOCATION - STATISTICAL BASIS

#### COST CENTER DESCRIPTION

	GENERAL SERVICE COST CENTERS	
	OLD CAP REL COSTS-BLDG & FIXT	1
1	OLD CAP REL COSTS-MVBLE EQUIP	2
2	NEW CAP REL COSTS-BLDG & FIXT	. 3
3	NEW CAP REL COSTS-MUBLE EQUIP	4
4	NEW CAP RED COSIS-INDED EXOTE	5
5		6
6	ADMINISTRATIVE & GENERAL	,
7	MAINTENANCE & REPAIRS	8
8	OPERATION OF PLANT	9
9	LAUNDRY 6 LINEN SERVICE	10
10	HOUSEKEEPING	11
11	DIETARY	12
12	CAFETERIA	13
13	MAINTENANCE OF PERSONNEL	14
14	NURSING ADMINISTRATION	15
15	CENTRAL SERVICES & SUPPLY	16
16	PHARMACY	17
17	MEDICAL RECORDS & LIBRARY	18
18	SOCIAL SERVICE	1.9
19	RECREATION	20
20	NONPHYSICIAN ANESTHETISTS	21
21	NURSING SCHOOL	22
22	14R SERVICES-SALARY & FRINGES	23
23	14R SERVICES-OTHER PROM COSTS	24
24	PARAMED ED PRGM-(SPECIFY)	<u>1811</u> 0
	INPATIENT ROUTINE SERV COST CENTERS	35
35	NURSING FACILITY	
	AND	
	ANCILLARY SERVICE COST CENTERS	41
41	RADIOLOGY-DIAGNOSTIC	46.30
	BLOOD CLOTTING FACTORS ADMIN	50
50	PHYSICAL THERAPY	100,000
	OUTPATIENT SERVICE COST CENTERS	60
60	CLINIC	62
62	OBSERVATION BEDS (NON-DISTINC	63.50
63.50		63.60
63.60	FQHC	
	OTHER REIMBURSABLE COST CENTERS	69.10
69.10	CMHC	69.20
69.20	OUTPATIENT PHYSICAL THERAPY	69.30
	OUTPATIENT OCCUPATIONAL THERA	69.40
69.40	OUTPATIENT SPEECH PATHOLOGY	71
71	HOME HEALTH AGENCY	
	SPECIAL PURPOSE COST CENTERS	85.01
	PANCREAS ACQUISITION	85.02
85.02	2 INTESTINAL ACQUISITION	85.03
85.03	3 ISLET CELL ACQUISITION	95
95	SUBTOTALS	
	NONREIMBURSABLE COST CENTERS	100
100	RENTAL SPACE	101
101	CROSS FOOT ADJUSTMENTS	102
102	NEGATIVE COST CENTER	103
103	COST TO BE ALLOC PER B PT I	104
104	UNIT COST MULT-WS B PT I	104
1.04	UNIT COST MULT-WS B PT I	105
105	COST TO BE ALLOC PER B PT II	106
106	UNIT COST MULT-WS B PT II	106
106	UNIT COST MULT-WS B PT II	107
107	COST TO BE ALLOC PER B PT III	108
108	UNIT COST MULT-WS B PT III	108
108	UNIT COST MULT-WS B PT III	
200		

PROVIDER NO. 5115701 JOHN MANCHIN SR. HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (5/1999) VERSION: 2008.0120 11/30/2010 11:56

WORKSHEET C PART I

#### COMPUTATION OF RATIO OF COST TO CHARGES

C	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27)	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						35
35	NURSING FACILITY	3343138					33
41	ANCILLARY SERVICE COST CENTERS RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTORS ADMI PHYSICAL THERRPY	116161					41 46.30 50
60 62 63.50 63.60	OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTI RHC	537346					60 62 63.50 63.60
101	OTHER REIMBURSABLE COST CENTERS SUBTOTAL	3996645					101 102
102	LESS OBSERVATION BEDS	3996645					103

 $121_{\tiny{\mbox{\footnotesize PROVIDER NO.}}}$  5115701  $_{\tiny{\mbox{\footnotesize JOHN MANCHIN SR.}}}$  HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (5/1999) VERSION: 2008.05 11/30/2010 11:56

> WORKSHEET C PART I (CONT)

# COMPUTATION OF RATIO OF COST TO CHARGES

			CHARGES		COST OR OTHER	TEFRA INPATIENT	PPS INPATIENT	
(	COST CENTER DESCRIPTION	INPATIENT 6	OUTPATIENT 7	TOTAL 8	RATIO 9	RATIO 10	RATIO 11	
2.5	INPATIENT ROUTINE SERV COST CEN	TERS 3105675		3105675				35
35	NURSING FACILITY ANCILLARY SERVICE COST CENTERS	3103073						Taran
41	RADIOLOGY-DIAGNOSTIC		3747	3747	31.001068			41
								46.30
50	PHYSICAL THERAPY							30
274	OUTPATIENT SERVICE COST CENTERS	i	00.010	201010	2.633416			60
60	CLINIC		204049	204049	2.633410			62
62	OBSERVATION BEDS (NON-DISTI							63.50
63.50								63.60
63.60								
	OTHER REIMBURSABLE COST CENTERS		207796	3313471				101
101	SUBTOTAL	3105675	201196	3313411				102
102	LESS OBSERVATION BEDS			3313471				103
103	TOTAL			3313471				

TOTAL

101

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/97) VERSION: 2008.05122 11/30/2010 11:56

WORKSHEET D PART I

# APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

TITLE V CHECK TITLE XVIII-PT A APPLICABLE TITLE XIX ----- NEW CAPITAL -----BOXES ----- OLD CAPITAL -----REDUCED CAPITAL CAPITAL SWING-BED CAPITAL RELATED CAPITAL SWING-BED RELATED ADJUSTMENT RELATED ADJUSTMENT COST CENTER DESCRIPTION COST COST COST COST 3 INPAT ROUTINE SERV COST CTRS ADULTS 6 PEDIATRICS INTENSIVE CARE UNIT 25 26 27 28 29 25 26 27 28 29 30 CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) 30 31 33 SUBPROVIDER I 101 NURSERY 33 101 TOTAL ---- NEW CAPITAL -------- OLD CAPITAL ----INPATIENT INPATIENT PROGRAM PER PROGRAM PER TOTAL INPATIENT CAPITAL CAPITAL DIEM DIEM PATIENT PROGRAM COST CENTER DESCRIPTION COST 10 COST DAYS DAYS 11 12 9 INPAT ROUTINE SERV COST CTRS ADULTS & PEDIATRICS INTENSIVE CARE UNIT 25 26 27 28 29 30 31 33 25 26 27 28 29 30 31 CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) SUBPROVIDER I NURSERY 33

 $\frac{123}{\text{PROVIDER NO. 5115701}}$  John Manchin SR. Health care period from 07/01/2009 to 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96) VERSION: 2008.05 11/30/2010 11:56

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D PART II

CHECK APPLICA BOXES	BLE	( ) ( ) (XX)	TITLE V TITLE XVII TITLE XIX	I-PT A	(XX) ( ) ( )	SUB	SPITAL B I B II	(xx)	SUB III SUB IV OTHER	l l		PPS TEFRA		
	COST CENTER D	ESCRI	PTION	OLD CAPITAL RELATED COST 1	CAPI RELA COS 2	TAL TED T	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	COS	NEW CAP TIO OF ST TO ARGES 7	CAPITAL COSTS 8	
41 46.30 50	ANCILLARY SERVIC RADIOLOGY-DIAGNO BLOOD CLOTTING F PHYSICAL THERAPY	STIC		2891	925	4	3747		.771551		2.4	169709		41 46.30 50
60 62 63.50 63.60				9101	780	18	204049		.044602		. (	38265		60 62 63.50 63.60
101	OTHER REIMBURSAS	LE CO	ST CENTERS	11992	1706	52	207796							101

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98) VERSION: 2008.0124 11/30/2010 11:56

WORKSHEET D PART III

# APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

CHECK APPLICABLE BOXES	( ) TITLE ( ) TITLE (XX) TITLE	XVIII-PT A							INPATIENT PROGRAM
COST CENTE	R DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	PASS THRU COSTS 8
25 ADULTS 6 PEDI 26 INTENSIVE CAR 27 CORONARY CARE 28 BURN INTENSIV 29 SURGICAL INTE	E UNIT UNIT E CARE UNIT INSIVE CARE UNIT CARE (SPECIFY) ING FACILITY	r							25 26 27 28 29 30 31 33 34 35

 $125_{\tiny \mbox{\footnotesize PROVIDER NO.}}$  5115701  $_{\tiny \mbox{\footnotesize JOHN MANCHIN SR.}}$  HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/2000) VERSION: 2008.05 11/30/2010 11:56

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D

APPORTIONMEN	T OF INPATIENT	ANCILLARY SERV.	CE OTHER PASS	5 Inkough C	0313				PART	r iv
CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE X	A T9-IIIV	(X) HOSPITAL ) SUB I ) SUB II ) SUB III		( ) ( ) ( )	SUB IV SNF NF ICF/MR		[ ] PPS [ ] TEFRA [ ] OTHER		
COST CENTER	DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	OUTPATIENT NONPHYSICIAN ANESTHETIST COST 1.01			N/A 2.01	N/A 2.02	N/A 2.03	TOTAL COSTS 3	
ANCILLARY SERV 41 RADIOLOGY-DIAG 46.30 BLOOD CLOTTING 50 PHYSICAL THERA	NOSTIC FACTORS ADMIN	s .								41 46.30 50
	VICE COST CENTE								ä	60 62 63.50 63.60
	ABLE COST CENTE	RS						ŧ		101

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/2000) VERSION: 2008.0126 11/30/2010 11:56

# APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART IV

CHECK APPLICABLE BOXES	( ) TITLE V ( ) TITLE XV (XX) TITLE XI	X)	HOSPITAL SUB I SUB II SUB III		[ ] SUB IV [ ] SNF [ ] NF [ ] ICF/MR		[ ) PPS [ ) TEFR [ ] OTHE		
COST CE	NTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	RATIO OF COST	NPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
41 RADIOLOGY- 46.30 BLOOD CLOT 50 PHYSICAL T			3747						41 46.30 50
60 CLINIC	SERVICE COST CENTER N BEDS (NON-DISTINC	RS	204049						60 62 63.50 63.60
	BURSABLE COST CENTE	RS	207796						101

PROVIDER NO. 5115701 JOHN MANCHIN SR. HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05 11/30/2010 11:56

ANGLIANDY OFFICE OTHER PASS THROUGH COSTS

WORKSHEET D

APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE OTHER PASS THROUGH	COSTS		PART IV
CHECK [ ] TITLE V APPLICABLE [ ] TITLE XVIII-PT A BOXES [XX] TITLE XIX	(XX) HOSPITAL [	[ ] SUB IV [ ] SNF [ ] NF [ ] ICF/MR	i i i	PPS TEFRA OTHER
COST CENTER DESCRIPTION	OUTPATIENT OUTPATIENT PROGRAM CHARGES CHARGES 8.01 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	PROGRAM PROGRAM PASS THROUGH PAS	TPATIENT ROGRAM S THROUGH COSTS 9.02
ANCILLARY SERVICE COST CENTERS 41 RADIOLOGY-DIAGNOSTIC 46.30 BLOOD CLOTTING FACTORS ADMIN 50 PHYSICAL THERAPY				41 46.30 50
OUTPATIENT SERVICE COST CENTERS CLINIC OBSERVATION BEDS (NON-DISTINC 63.50 RHC				60 62 63.50 63.60
63.60 FQHC OTHER REIMBURSABLE COST CENTERS 101 TOTAL				101

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART IV

CHECK APPLICA BOXES	8LE (XX)	TITLE XV		) ] ]	HOSE SUB SUB	II		( ) (xx) ( )	SUB IV SNF NF ICF/MR		[ [	}	PPS TEFRA OTHER		
	COST CENTER DESCRI	PTION	NONPHYSICIAN ANESTHETIST COST 1	NO	TPATI NPHYSI NESTHE COST	CIAN ETIST C	MEDICAL EDUCATION COST 2		N/A 2.01	N/A 2.02		N/I 2.0		TOTAL COSTS 3	
41 46.30	ANCILLARY SERVICE COS RADIOLOGY-DIAGNOSTIC BLOOD CLOTTING FACTOR		\$												41 46.30 50
60	PHYSICAL THERAPY OUTPATIENT SERVICE CO CLINIC OBSERVATION BEDS (NO) RHC														60 62 63,50 63,60
63.60 101		OST CENTER	RS												101

101

TOTAL

 $129_{\tiny{\mbox{\footnotesize PROVIDER NO.}}}$  si15701  $_{\tiny{\mbox{\footnotesize JOHN MANCHIN SR.}}}$  HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM VERSION: 2008.05 IN LIEU OF FORM CMS-2552-96 (9/2000) 11/30/2010 11:56

NMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D

	APPORTIONMENT	OFI	NPATIEN	T ANCILLAR	Y SERVI	CE	OTHER PASS	THROUGH CO	1515						PART		
CHECK APPLICA BOXES	BLE	( ) [ ] [ ]	TITLE TITLE TITLE	XVIII-PT A	[ [ [	]	HOSPITAL SUB I SUB II SUB III		( ) (XX) ( )	SUB IV SNF NF ICF/MR		( (	} ]	PPS TEFRA OTHER			
	COST CENTER	DESCRI	noita i	cos	HROUGH	(	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	RATIO	PATIENT O OF COST CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPA PRO PASS T CO	GRA	M UGH	OUTPATIENT PROGRAM CHARGES 8		
41 46.30	ANCILLARY SERVIORADIOLOGY-DIAGNOBLOOD CLOTTING PHYSICAL THERAP	OSTIC FACTOR														41 46.30 50	0
60	OUTPATIENT SERV CLINIC OBSERVATION BED RHC	ICE CO														60 62 63.5 63.6	
63.60	OTHER REIMBURSA	BLE C	OST CEN	TERS												101	

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05130

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART IV

CHECK APPLICABLE BOXES	(XX) TITLE XXX (XX) TITLE XXX	OR [] AT	SPITAL 3 I 3 II 3 III	( ) SUB IV ( ) SNF (XX) NF ( ) ICF/MR	[	PPS TEFRA OTHER	
COST CENTER	R DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
41 RADIOLOGY-DIAG 46.30 BLOOD CLOTTING	G FACTORS ADMIN						41 46.30 50
OUTPATIENT SEL  60 CLINIC  62 OBSERVATION BI  63.50 RHC	EDS (NON-DISTINC						60 62 63.50 63.60
63.60 FQHC OTHER REIMBUR 101 TOTAL	SABLE COST CENTERS	3					101

TOTAL NURSERY DAYS 16 TITLE V OR XIX NURSERY DAYS

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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> WORKSHEET D-1 PART I

> > 15

# COMPUTATION OF INPATIENT OPERATING COST

(XX) TITLE XIX-INPT [ ] TITLE XVIII-PART A ( ) TITLE V-INPT PART I - ALL PROVIDER COMPONENTS NF SUB II SUB III SUB IV HOSPITAL SUB I (OTHER) (OTHER) (51-15701 (51-15701 1 1 1 INPATIENT DAYS 14445 1 1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN) 2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS) 14445 3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)
SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)
TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE 14445 5 ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE 8 ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)
SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII 13669 10 ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD

11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE 11 COST REPORTING PERIOD SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE 12 COST REPORTING PERIOD
SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX
ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE 13 COST REPORTING PERIOD MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS) 14 · KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

PROVIDER NO. 5115701 JOHN MANCHIN SR. HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

#### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART I (CONT)

	[ ] TITLE V-INPT [	) TITLE	XVIII-PAR	T A		(XX)	TITL	E XIX~	THRT			
PART	I - ALL PROVIDER COMPONENTS		HOSPITAL (OTHER) (51-15701		I	SUB I	Ι	SUB II		B IV	NF (OTHER) (51-15701	
	SWING-BED ADJUSTMENT		1	1		1		1		1	1	
17 P	EDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO											17
18 1	ERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERICEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO											18
10 1	SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD SERVICES APPLICABLE TO											19
20 1	SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERI-											20
21 T	SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD TOTAL GENERAL INPATIENT ROUTINE SERVICE COST SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH	)									3343138	21 22
23 (	DECEMBER 31 OF THE COST REPORTING PERIOD WING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER											23
1	DECEMBER 31 OF THE COST REPORTING PERIOD SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH											24
1	DECEMBER 31 OF THE COST REPORTING PERIOD											25
	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD											26
27	TOTAL SWING-BED COST SENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED	COST									3343138	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT											
28 (	GENERAL INPATIENT ROUTINE SERVICE CHARGES										3105675	28
29	(EXCLUDING SWING-BED CHARGES) PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)										3105675	29 30
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	)									1.076461	31
31	SENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO											32
32 .	AVERAGE PRIVATE ROOM PER DIEM CHARGE AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE										215.00	33
33 .	AVERAGE SEMI-PRIVATE ROOM FER DIEM CHARGE AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL											34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL											35 36
36 37	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BEI AND PRIVATE ROOM COST DIFFERENTIAL	D COST									3343138	37

1	2	2
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-4		-

PROVIDER NO. 5115701 JOHN MANCHIN SR. HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

# KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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WORKSHEET D-1

	COMPUTATION OF INPATIENT	OPERATING	COST				WORKSHEET D-1 PART II
	[ ] TITLE V-INPT [ ] TITLE XVI	II-PART A		[XX] TITLE	XIX-INPT		
PART		HOSPITAL (OTHER)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 39 40 41	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST						38 39 40 41
			OTAL P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLES V AND XIX ONLY)						42
43	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS INTENSIVE CARE UNIT						43 44
44 45 46 47	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						45 46 47
		HOSPITA (OTHER	AL SUE	I SUB I	I SUB I	II SUB IV	
		(51-157		1	1	1	
48 49	PROGRAM INPATIENT ANCILLARY SERVICE COST TOTAL PROGRAM INPATIENT COSTS						48 49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 53	ANCILLARY SERVICES TOTAL PROGRAM EXCLUDABLE COST TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						52 53

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# COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART II (CONT)

( ) TITLE V-INPT [ ] TITLE XVIII-PART A (XX) TITLE XIX-INPT	
( ) TITLE V-INPT ( ) TITLE XVIII-PART A (XX) IIILBS XIO XIV	
PART II - HOSPITAL AND SUBPROVIDERS ONLY  HOSPITAL SUB I SUB II S	
TARGET AMOUNT AND LIMITATION COMPUTATION 1 1 1 1 1  54 PROGRAM DISCHARGES 55 TARGET AMOUNT PER DISCHARGE 56 TARGET AMOUNT 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	54 55 56 57
58 BONUS PAYMENT 58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING	58.01
CONTAC CANTAC 1996 HEDRIED & COMPOUNDED BY THE PARKET DOORS.	58.02
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET 58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01	58.03
OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT  58.04 RELIEF PAYMENT ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1 59.03 PROGRAM DISCHARGES AFTER JULY 1 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS) 59.05 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) 59.08 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)	58.04 59 59.01 59.02 59.03 59.04 59.05 59.06 59.07 59.08
PROGRAM INPATIENT ROUTINE SWING BED COST	60
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH	
DECEMBER 31 OF THE COST REPORTING PERIOD 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER	61
DECEMBER 31 OF THE COST REPORTING PERIOD  62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS  63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH	62 63
PROPURED 21 AF MUF COST REPORTING PERIOD	64
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	65

 $135_{\tiny \mbox{\footnotesize PROVIDER NO.}}$  5115701  $_{\tiny \mbox{\footnotesize JOHN MANCHIN SR.}}$  HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

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# COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III & IV

		IMMID III G L.
[ ] TITLE V-INPT [ ] TITLE XVI	II-PART A (XX) TITLE XIX-INPT	
PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY	NF (OTHER) (51-15701	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST 67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 68 PROGRAM ROUTINE SERVICE COST 69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM 70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS 71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS 72 PER DIEM CAPITAL RELATED COSTS 73 PROGRAM CAPITAL RELATED COSTS 74 INPATIENT ROUTINE SERVICE COST 75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS 76 TOTAL PEM ROUTINE SERVICE COST FOR COMPARISON TO COST LIMIT 77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION 78 INPATIENT ROUTINE SERVICE COST LIMITATION 79 REASONABLE INPATIENT ROUTINE SERVICES 80 PROGRAM INPATIENT ANCILLARY SERVICES 81 UTILIZATION REVIEWPHYSICIAN COMPENSATION 82 TOTAL PROGRAM INPATIENT OPERATING COSTS	3343138 231.44 3163553 3163553 111329 7.71 105388 3058165 400.00 5467600 3163553	66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III & IV

[ ] TITLE V-INPT

[ ] TITLE XVIII-PART A

(XX) TITLE XIX-INPT

SUB II SUB III SUB IV HOSPITAL SUB I (OTHER) (51-15701 1 1 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 84 85

83 TOTAL OBSERVATION BEDS 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 85 OBSERVATION BED COST

 $137_{\tiny{\mbox{\footnotesize PROVIDER NO. }5115701}}$  John Manchin Sr. Health care period from 07/01/2009 to 06/30/2010

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WORKSHEET D-4

INPATIENT	ANCILLARY	COST	APPORTIONMENT

[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL [ ] SUB I [ ] SUB II [ ] SUB III [ ] SUB IV	(51-15701)	[ ] SNF [ ] NF [ ] S/B-SNF [ ] S/B-MF [ ] ICF/MR	( ) PPS [ ) TEFRA [XX] OTHER	
COST CENTER DESCRIPTION		RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
INPATIENT ROUTINE SERVICE CO ANCILLARY SERVICE COST CENTE RADIOLOGY-DIAGNOSTIC 46.30 BLOOD CLOTTING FACTORS ADMIN 50 PHYSICAL THERAPY	RS	31.001068			41 46.30 50
OUTPATIENT SERVICE COST CENT 60 CLINIC 62 OBSERVATION BEDS (NON-DISTIN		2.633416	*46	×	60 62
OTHER REIMBURSABLE COST CENT OTHER REIMBURSABLE COST CENT 63.50 RHC 63.60 FOHC 101 TOTAL 102 LESS PBP CLINIC LAB SVCS-PGI 103 NET CHARGES	'ERS			* s	63.50 63.60 101 102 103

PROVIDER NO. 5115701 JOHN MANCHIN SR. HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

WORKSHEET D-4

# INPATIENT ANCILLARY COST APPORTIONMENT

	THENTIEMS MICTIFIED COST WE	PON	LOM	,,,,,,							
( )	TITLE V TITLE XVIII-PT A TITLE XIX		SUB SUB			( ) ( ) ( )	SNF NF (51-157 S/B-SNF S/B-NF ICF/MR	01)	( ) ( ) (xx)	PPS TEFRA OTHER	
	COST CENTER DESCRIPTION				RATIO OF COST TO CHARGES 1		PATIENT M CHARGES 2	INPATIENT PROGRAM COS 3	rs		
41 46. 50	INPATIENT ROUTINE SERVICE COS' ANCILLARY SERVICE COST CENTER: RADIOLOGY-DIAGNOSTIC 30 BLOOD CLOTTING FACTORS ADMIN PHYSICAL THERAPY	3	NTERS	3	31.001068						41 46.30 50
60 62	OUTPATIENT SERVICE COST CENTE CLINIC OBSERVATION BEDS (NON-DISTINC				2.633416						60 62
63.	OTHER REIMBURSABLE COST CENTE 50 RIC 60 FOHC TOTAL LESS PBP CLINIC LAB SVCS-PGM NET CHARGES	RS	CHAI	RGES							63.50 63.60 101 102 103

PROVIDER NO. 5115701 JOHN MANCHIN SR. HEALTH CARE PERIOD FROM 07/01/2009 TO 06/30/2010

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/1999)

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> WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	{ } TITLE V	[ ] TIT	LE XVIII		[XX] TI	TLE XIX		
		HOSPITAL (51-15701) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (51-15701) (OTHER)	
1 2 3 4 5	COMPUTATION OF NET COST OF COVERED SERVICES INPATIENT HOSPITAL/SNF/NF SERVICES MEDICAL AND OTHER SERVICES INTERNS AND RESIDENTS ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O COST OF TEACHING PHYSICIANS SUBTOTAL	1	1	1	1	1	3163553 3163553	1 2 3 4 5 6
7 8 9	INPATIENT PRIMARY PAYER PAYMENTS OUTPATIENT PRIMARY PAYER PAYMENTS SUBTOTAL	e					3163553	9
10 11 12 13	COMPUTATION OF LESSER OF COST OR CHARGES ROUTINE SERVICE CHARGES ANCILLARY SERVICE CHARGES INTERNS AND RESIDENTS SERVICE CHARGES ORGAN ACQUISITION CHARGES, NET OF REVENUE TEACHING PHYSICIANS						2938835	10 11 12 13 14
15 16	INCENTIVE FROM TARGET AMOUNT COMPUTATION TOTAL REASONABLE CHARGES						2938835	
17 18	CUSTOMARY CHARGES AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN							17 18
19	ACCORDANCE WITH 42 CFR 413.13(E) RATIO OF LINE 17 TO LINE 18						2938835	19 20
20 21	TOTAL CUSTOMARY CHARGES EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						224718	21
22 23	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES COST OF COVERED SERVICES						3163553	
24 25 26 27 28	PROSPECTIVE PAYMENT AMOUNT OTHER THAN OUTLIER PAYMENTS OUTLIER PAYMENTS PROGRAM CAPITAL PAYMENTS CAPITAL EXCEPTION PAYMENTS ROUTINE SERVICE OTHER PASS THROUGH COSTS			8				24 25 26 27 28 29
29 30	ANCILLARY SERVICE OTHER PASS THROUGH COSTS SUBTOTAL						3163553	
31 32 33	CUSTOMARY CHARGES (TITLE XIX PPS COVERED LESSER OF LINES 30 OR 31 DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						3163553	

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## WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	PART III - TITLE V OK TITLE ATA OBATEODS OF							
	( ) TITLE V	( ) TIT	TE XAIII		(XX) TIT	LTE XIX		
		HOSPITAL (51-15701)	SUB I	SUB II	SUB III	SUB IV	NF I (51-15701) (OTHER)	
		(OTHER)	1	1	1	1	1	
		-						
34 35 36 37 38	COMPUTATION OF REIMBURSEMENT SETTLEMENT EXCESS OF REASONABLE COST SUBTOTAL COINSURANCE SUM OF AMOUNTS FROM WKST E, PARTS C, D AND E, REIMBURSABLE BAD DEBTS REDUCED REIMBURSABLE BAD DEBTS						224718 2938835	
38.02 39 40 41	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) UTILIZATION REVIEW SUBTOTAL INPATIENT ROUTINE SERVICE COST MEDICARE INPATIENT ROUTINE CHARGES AMOUNT BETUBLLY COLLECTED FROM PATIENTS LIABLE	ä					2938835	39 40 41 42 43 44
44 45 46 47 48	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) RATIO OF LINE 43 TO LINE 44 TOTAL CUSTOMARY CHARGES EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES RECOVERY OF EXCESS DEPRECIATION RESULTING FROM							45 46 47 48 49
49 50	UTILIZATION OTHER ADJUSTMENTS AMOUNTS APPLICABLE TO PRIOR COST REPORTING							50 51
51 52	DEPRECIABLE ASSETS						2938835	52 53 54
53 54 55	INDIRECT MEDICAL EDUCATION ADJUSTMENT DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS TOTAL AMOUNT PAYABLE TO THE PROVIDER						2938835	5 55 56
56	SEQUESTRATION ADJUSTMENT						2597110 34172	57.01
57.01 58 59	TENTATIVE SETTLEMENT (FOR FI USE ONLY) BALANCE DUE PROVIDER/PROGRAM PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2						34172	59

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WORKSHEET G

## BALANCE SHEET

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
1 2	CURRENT ASSETS CASH ON HAND AND IN BANKS TEMPORARY INVESTMENTS	8743				1 2 3
3 4 5	NOTES RECEIVABLE ACCOUNTS RECEIVABLE OTHER RECEIVABLES	1297993				4 5
6 7 8	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE INVENTORY PREPAID EXPENSES	66309				6 7 8 9
9 10 11	OTHER CURRENT ASSETS DUE FROM OTHER FUNDS TOTAL CURRENT ASSETS	1373045				10 11
13	FIXED ASSETS LAND ACCUMULATED DEPRECIATION LAND IMPROVEMENTS	12352			(2)	12 12.01 13 13.01
14 14.01 15	ACCUMULATED DEPRECIATION BUILDINGS ACCUMULATED DEPRECIATION LEASEHOLD IMPROVEMENTS ACCUMULATED AMORTIZATION	4086075 -2181820				14 14.01 15 15.01 16
16.01 17 17.01 18	FIXED EQUIPMENT ACCUMULATED DEPRECIATION AUTOMOBILES AND TRUCKS ACCUMULATED DEPRECIATION MAJOR MOVABLE EQUIPMENT	1065563 -725990				16.01 17 17.01 18 18.01
19	ACCUMULATED DEPRECIATION MINOR EQUIPMENT DEPRECIABLE ACCUMULATED DEPRECIATION MINOR EQUIPMENT-NONDEPRECIABLE TOTAL FIXED ASSETS	2256180				19 19.01 20 21
22 23 24 25 26	OTHER ASSETS INVESTMENTS DEPOSITS ON LEASES DUE FROM OWNERS/OFFICERS OTHER ASSETS TOTAL OTHER ASSETS	v				22 23 24 25 26
27	TOTAL ASSETS	3629225				27
21	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
28 29 30 31	CURRENT LIABILITIES ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (SHORT TERM) DEFERRED INCOME	44203 82107				28 29 30 31 32 33
32 33 34 35 36	ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES	815566 941876				34 35 36
37 38 39	LONG-TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS					37 38 39 40
41 42	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66 OTHER LONG TERM LIABILITIES TOTAL LONG TERM LIABILITIES	941876				41 42 43
44	TOTAL LIABILITIES  CAPITAL ACCOUNTS GENERAL FUND BALANCE	2687349				4 4 4 5
45 46 47 48 49 50	SPECIFIC PURPOSE FUND BALANCE DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED GOVERNING BODY CREATED - ENDOWMENT FUND BAL PLANT FUND BALANCE - INVESTED IN PLANT DIANT FUND RAJANCE - RESERVE FOR PLANT					46 47 48 49 50
51	IMPROVEMENT, REPLACEMENT AND EXPANSION TOTAL, FUND BALANCES	2687349				51
52	TOTAL LIABILITIES AND FUND BALANCES	3629225				52

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TOPHENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	STATEMENT OF CHANGES IN FUND BALANCES	5							
		GENERAL 1	FUND	SPECIFIC	PURPOSE 2	FUND	ENDOWMENT FUNI	PLANT FUND	
1	FUND BALANCES AT BEGINNING OF PERIOD		2321739						1
			365610						2
2	NET INCOME (LOSS)		2687349						3
3	TOTAL								4
4	ADDITIONS (CREDIT ADJUSTMENTS)								5
5									6
6					12				7
7				£1					8
8						W.			9
9									10
10	TOTAL ADDITIONS								
11	SUBTOTAL		2687349						11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)								12
13									13
									14
14									15
15									16
16									17
17									18
18	TOTAL DEDUCTIONS								19
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		2687349	9					iani

143 provider no. 5115701  $\,$  John manchin Sr. Health care period from 07/01/2009 to 06/30/2010

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### STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

NORKSHEET G-2 PARTS I & II

### PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT 2	TOTAL 3	
1 2	GENERAL INPATIENT ROUTINE CARE SERVICES HOSPITAL SUBPROVIDER I SWING BED - SNF SWING BED - NF	-			1 2 4 5
6	SKILLED NURSING FACILITY	3105675		3105675	6 7
7 8	NURSING FACILITY OTHER LONG TERM CARE	3105675		3105675	8 9
9	TOTAL GENERAL INPATIENT CARE SERVICES INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES	3105073		21000.0	10
10 11 12	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT			Ÿ	11 12 13
13 14	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				14
15 16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE TOTAL INPATIENT ROUTINE CARE SERVICES	3105675		3105675	15 16 17
17 18 18.50	ANCILLARY SERVICES OUTPATIENT SERVICES RHC		215223	215223	18 18.50
18.60					18.60 19
20 21	AMBULANCE CORF	*			20 21 22
22	ASC HOSPICE				23
24 25	TOTAL PATIENT REVENUES	3105675	215223	3320898	24 25
	PART II - OPERAT	ING EXPENSES			
	DISTRICT NO. CORRESPONDE CONTRACTOR CONTRACT		1	2 3797631	26
26 27	OPERATING EXPENSES ADD (SPECIFY)			3131032	27
28	100 (010011)				28 29
29					30
30 31					31
32					32 33
33	TOTAL ADDITIONS				34
34 35	DEDUCT (SPECIFY) ROUNDING		-1		35
36	************				36 37
37					38
38 39	TOTAL DEDUCTIONS		-1		39
40	TOTAL OPERATING EXPENSES			3797630	40

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

# STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

DEC	OD.	TOT	MOT

1 2 3 4 5	TOTAL PATIENT REVENUES LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS NET PATIENT REVENUES LESS - TOTAL OPERATING EXPENSES NET INCOME FROM SERVICE TO PATIENTS	3320898 449594 2871304 3797630 -926326	1 2 3 4 5
6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. INCOME FROM INVESTMENTS REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE REVENUE FROM TELEVISION AND RADIO SERVICE PURCHASE DISCOUNTS REBATES AND REFUNDS OF EXPENSES PARKING LOT RECEIPTS REVENUE FROM LAUNDRY AND LINEN SERVICE REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS REVENUE FROM RENTAL OF LIVING QUARTERS REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN RENTAL OF VENDING MACHINES	42776	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22
22 23 24	RENTAL OF HOSPITAL SPACE GOVERNMENTAL APPROPRIATIONS COST REPORT	964172 283788 1291936	23 24 25
25 26 27 28 29 30	TOTAL OTHER EXPENSES	365610	26 27 28 29 30
31	NET INCOME (OR LOSS) FOR THE PERIOD	365610	31

# John Manchin Sr. Health Care Center Statement of Net Assets June 30, 2010

### <u>ASSETS</u>

Current Assets Cash on hand Cash patient trust account Cash Trustee - Savings Accounts receivable - net Inventory TOTAL CURRENT ASSETS	\$ 50.00 1,534.61 7,158.09 1,297,992.97 66,308.67 \$ 1,373,044.34
PROPERTY and EQUIPMENT-(stated at cost  less allowance for depreciation) Land Improvements Building Machinery and equipment  Allowance for depreciation  \$ 12,352.60 4,086,075.53 1,065,562.78 5,163,990.91 2,907,810.00	
Allowance for depreciation 2,907,810.00	2,256,180.91
OTHER ASSETS Intangible assets Allowance for amortization	$\begin{array}{r} 560,785.61 \\ 560,785.61 \\ 3,629,225.25 \end{array}$
LIABILITIES AND FUND BALANCE	
CURRENT LIABILITIES Accounts Payable Accrued wages Accrued annual leave Accrued holiday pay Accrued Sick	\$ 44,202.73 82,107.37 126,818.15 9,301.33 679,446.33 941,875.91
TOTAL CURRENT LIABILITIES	2,687,349.34
FUND BALANCE	$\$ \frac{2,007,345.34}{3,629,225.25}$

## John Manchin Sr. Health Care Center Combined Operations Statement of Revenues and Expenses

For the Twelve Month Period Ending June 30, 2010

Current N	Month		Year To Da	<u>te</u>
Amount	Percent		Amount	Percent
		INCOME		
233,920.00	34.85	Room fees - Medicaid	2,938,835.00	63.76
18,275.00	2.72	Room fees - private pay	166,840.00	3.62
1,400.00	.21	Part B income	14,315.00	.31 .47
1,115.00	.17	Medical fees - Medicaid	21,551.00 13,060.00	.28
1,425.00	.21	Medical fees - Medicare	137,905.85	2.99
11,619.56	1.73	Medical fees - private pay Income - radiology - Medicaid	1,145.00	.02
97.00	.01	Income - radiology - Medicare	1,648.00	.04
71.00 1,018.28	.15	Income - radiology - private pay	12,128.37	.26
70.00	.01	Income EKG - Medicaid	140.00	
35.00	.01	Income EKG - Medicare	105.00	.03
105.00	.02	Income EKG - private pay	1,330.00 679.00	.01
145.00	.02	Income pharmacy - Medicaid	322.00	.01
20.00	0.4	Income pharmacy - Medicare Income pharmacy - private pay	4,421.20	.10
270.00	.04	Laboratory	3,564.00	.08
713.00 270,298.84	$\frac{.11}{40.27}$	TOTAL INCOME	3,317,989.42	71.99
270,298.04	40.47			
		CONTRACTURAL AND OTHER ALLOWANCES	21 420 10	.46
829.01	.12	Contractural allowances	21,429.19 341,725.00	7.41
27,200.00	4.05	Medicaid Cont Allow	78,004.84	1.69
6,319.00	.94	Sliding fee adjustment	4,371.33	.09
4,364.98	.65	Bad debts Bad debts - Part B	306.67	.01
58.96 482.25	.01	Part B allowance	3,756.48	.08
39,254.20	5.85	TOTAL ALLOWANCES	449,593.51	9.75
231,044.64	34.42	GROSS INCOME-NET OF ALLOWANCES	2,868,395.91	62.23
parameter de la constitución de				
	10.01	OPERATING EXPENSES	820,284.23	21.60
84,419.14	17.81	Wages - RN	213,470.74	5.62
(7,079.56)	(1.49 ) 3.81	Wages - LPN	270,643.59	7.13
18,061.15 50,778.06	10.71	Wages - Aides	540,395.73	14.23
(2,364,25)	(.50)	Wages - Physician	109,161.58	2.87
6,323.33	1.33	Wages - SNF director	59,593.33 5,951.34	1.57 .16
839.00	.18	Advertising	2,165.48	.06
466.00	.10	Auto and truck expense	59,326.65	1.56
10,506.75	2.22	Contractural & Professional Contractural - Accounting	8,955.00	.24
1,920.00	.41	Contractural - Physician	29,585.50	.78
1,500.00 152.50	.03	Contractural - other	3,329.09	.09
1,937.91	.41	Data processing services	8,881.53	.23
136,044.00	28.70	Depreciation expense	136,044.00	3.58
264.00	.06	Dues and subscriptions	801.20 141,677.71	3.73
12,042.20	2.54	Employee Benefits - Social Security	361,733.06	9.53
9,129.22	1.93	Employee Benefits - Insurance	53,731.76	1.41
53,731.76	11.33	Employee Benefits - Worker's Comp Employee Benefits - Unemployment	2,567.83	.07
1,711.92	.36	Employee Benefits - Retirement	208,409.12	5.49
17,770.60 15,198.48	3.75 3.21	Food products	132,395.01	3.49
(293.73)	(.06)	Interest	COO 00	.02
(2,0)		Licenses and permits	600.00 6,488.31	.17
477.13	.10	Maintenance contracts	30,076.87	.79
2,338.86	.49	Minor Equipment	5,009.14	.13
96.26	.02	Miscellaneous expenses	7,507.58	.20
102.44	.02	Office expense - postage	8,630.07	.23
1,146.00	.24	Rent	5,255.07	.14
280.00	.06	Repair and maintenance	25,688.13	.68 .15
84.50	.02	R&M - labor	5,655.32	,55
66.83	.01	R&M - equipment other	20,857.22 171.07	, 55
		R&M - other	117.77	
	4 00	Stationary and printing	123,837.26	3.26
8,683.72	1.83	Supplies - Medical Supplies - Pharmacy	22,476.33	.59
9,616.25	2.03	Supplies - recreational	1,084.27	.03
2,766.66	.58	supplies - other	43,654.46	1.15
(6,931.42)	14 40	cumpling - inventory change	(6,931.42)	(.18)
(E) # 70	Se	e accompanying accountants compilation report	• •	

### John Manchin Sr. Health Care Center Combined Operations Statement of Revenues and Expenses

For the Twelve Month Period Ending June 30, 2010

Current	Month		Year To D	ate
Amount	Percent	x .	Amount	Percent
Innouro				4 40
20,341.38	4.29	Taxes - Medicaid tax	158,572.92	4.18
1,057.36	.22	Telephone and telegraph	4,378.66	.12
624.77	.13	Travel	4,578.03	.12
11,329.13	2.39	Utilities - Electricity	68,835.77	1.81
3,014.58	.64	Utilities - Gas	47,090.35	1.24
783,71	.17	Utilities - Garbage	17,845.10	.47
4,903.37	1.03	Utilities - Water	24,320.36	.64
227.38	.05	Utilities - Cable	2,728.56	.07
474,067.39	100.00	TOTAL OPERATING EXPENSES	3,797,630.68	100.00
(243,022.75)	(51.26)	INCOME/(LOSS) FROM OPERATIONS	(929, 234.77)	(24.47)
		//- 0.00		
		OTHER INCOME/(LOSS)	064 171 01	25.39
112,817.27	23.80	Income State of West Virginia Receipts	964,171.91	.03
100.00	.02	Rental income	1,200.00 42,776.29	1.13
4,553.15	.96	Cafeteria revenue	283,788.00	7.47
283,788.00	59.86	Income Cost Reports	2,908.65	.08
82.50	.02	Income - other	1,294,844.85	34.10
401,340.92	84.66	TOTAL OTHER INCOME/(LOSS)	365,610,08	
158,318.17	33.40	NET INCOME/(LOSS)	303,010,08	9.63

John Manchin Sr. Health Care Center Detail Adjusted Trial Balance All Transactions Sorted By Account From 06012010 to 06302010

o - Combine	d Operations							
djusting En	try Format: AJE	nautuatea	Buding Bato	n F	tef	Adjustmen	ts	Adjusted
		Beginning Balance		10	No	Debits	Credits	Ending Bal
.cct/Number	Acct/Title	parance	Dukumor					5050 F204
	Cash on hand	50.00	50.00					50.00
10-101.00	Cash patient trust accoun	<2,024.63>	<2,656.89> 122	23 1		4,191.50	two conservations	1,534.61
10-105.00 10-105.50	Cash Trustee - Savings	9,329.70	9,329.70 122	23 1			2,171.61	7,158.09 1,300.00
)5-121.00	Accounts receivable - Val	1,200.00	1,300.00				4 264 00	706,896.55
15-121.00	Accounts receivable-Inpat	684,335.19	711,261.53 123	23 5			4,364.98	148,120.92
55-121.00	Accounts Receivable - Out	148,735.71	148,120.92	2020 200	_	002 002 00		438,304.00
15-122.00	Accounts receivable-Medic	154,501.00	154,501.00 123			283,803.00	15.00	438,289.00
			123	23 3			20,00	
			154,501.00			283,803.00	15.00	438,289.00
	Account Sub-total	154,501.00	154,501.00			2007000100		
	C. B. C. SANCERS CONTRACT MARKETON CO.	4 402 02	3,868.75 12	23 7	6		482.25	3,386.50
35-125.00	A/R - Medicare Part B	4,493.83	34,889.69					34,889.69
10-141,10	Inventory - nursing suppl	6,896.83	7,817.02					7,817.02
10-141.20	Inventory - linen Inventory - maintenance	4,544.52	4,921.12					4,921.12
)0-141.30 )0-141.40	Inventory - dietary	11,303.41	11,698.32					11,698.32
0-141.50	Inventory - Housekeeping	6,517.42	6,982.52					6,982.52 12,352.60
)0-201.00	Land Improvements	12,352.60	12,352.60					4,086,075.53
10-202.00	Building	4,086,075.53	4,086,075.53				83,987.00	<2,181,820.00>
10-202.50	Allowance - buildings	<2,097,833.00>	<2,097,833.00> 12	23 4			03/30/100	1,065,562.78
10-204.00	Machinery and equipment	1,065,562.78	1,065,562.78 <673,933.00> 12	122	4		52,057.00	<725,990.00>
)0-204.50	Allowance - equipment	<673,933.00>		123	*			560,785.61
25-297.00	Intangible assets	560,785.61	560,785.61 <560,785.61>					<560,785.61>
05-297.50	Allowance for amortizatio	<560,785.61>	<35,510.03>					<35,510.03>
00-311.75	Transmittals payable 09-1	<1,181.63> <7,305.07>	<6,672.81> 12	223	1.		2,019.89	<8,692.70>
00-313.00	Patient trust payable Accrued annual leave	<131,202.32>	<131,202.32> 12		2	4,384.17		<126,818.15>
00-320.00	Accrued holiday pay	<8,540.05>	<8,540.05> 12		2		761.28	<9,301.33>
00-321.00	Accrued Sick	<687,740.62>	<687,740.62> 12		2	8,294.29		<679,446.33>
00-323.00	Accrued wages	<87,222.10>	<82,107.37>					<82,107.37> .00
0.0-328.03	Accrued state unemploymen	,00	1,711.92 13	223	10		1,711.92	<2,321,739.26>
00-401.00	Fund Balance	<2,321,739.26>	<2,321,739.26>					<2,938,835.00>
25-501.10	Room fees - Medicaid	<2,704,915.00>	<2,938,835.00>					<166,840.00>
25-501.30	Room fees - private pay	<148,565.00>	<166,840.00>	000	-	482.25		3,756.48
25-503.00	Part B allowance	3,274.23	3,274.23 1	223	•	402.23		<14,315.00>
25-505.00	Part B income	<12,915.00>	<14,315.00> <21,551.00>					<21,551.00>
55-508.10	Medical fees - Medicaid	<20,436.00> <11,635.00>	<13,060.00>					<13,060.00>
55-508.20	Medical fees - Medicare Medical fees - private pa	<126,286.29>	<137,905.85>					<137,905.85>
55-508,30	Income - radiology - Medi	<1,048.00>	<1,145.00>					<1,145.00>
55-510.10 55-510.20	Income - radiology - Medi	<1,577.00>	<1,648.00>					<1,648.00>
25-510.30	Income - radiology - priv	<840.00>	<954.00>					<954.00>
55-510.30	Income - radiology - priv	<10,270.09>	<11,174.37>					<11,174.37>
55-511.10	Income BKG - Medicaid	<70.00>	<140.00>					<140.00>
55-511.20	Income BKG - Medicare	<70.00>	<105.00>					<105.00> <1,330.00>
55-511.30	Income BKG - private pay	<1,225.00>	<1,330.00>					<679.00>
55-513.10	Income pharmacy - Medicai	<534.00>	<679.00>					<322.00>
55-513.20	Income pharmacy - Medicar	<302.00>	<322.00>					<4,421.20>
55-513.30	Income pharmacy - private	<4,151.20>	<4,421.20>					<3,564.00>
55-515.00	Laboratory	<2,851.00>	<3,564.00>					<1,200.00>
86-560.00	Rental Income	<1,100.00>	<1,200,00>					<42,776.29>
10-570.00	Cafeteria revenue	<38,223.14>	<42,776.29>	1223	12		283,803.00	<283,803.00>
25-580.10	Income cost reports - Med	.00		1223		15.00	% = .*	<283,788.00>
			_			9844 (SPR48	-	7
	Account Sub-total	.00	.00			15.00	283,803.00	<283,788.00>
		eca.st	Sign Act					9 2550 9866 9664
00-590.00	Income State of West Virg	2,482,069.46	2,697,289.56					2,697,289.56
05-590.00	Income State of West Virg	<3,333,424.10>	<3,687,569.58> 1	1223	10	855.91		<3,686,713.67>
05 550.00			1	1223	6	25,252.20		<3,661,461.47>
								<3,661,461.47>
	Account Sub-total	<3,333,424.10>	<3,687,569.58>			26,108.11	.00	<3,001,401.47>
								<2,908.65>
55-595.00	O/P medical records	<2,826.15>	<2,908.65>					21,429.19
55-601.00	Contractural allowances	20,600.18	21,429.19					341,725.00
25-601.20	Medicaid Cont Allow	314,525.00	341,725.00					78,004.84
55-604.00	Sliding fee adjustment	71,685.84	78,004.84 6.35	1222	5	4,364.98		4,371.33
25-605.00	Bad debts	6.35	306.67	~~~	-	.,		306.67
25-605.50	Bad debts - Part B	247.71 216,399.43		1223	2	7,500.44		243,166.37
05-703.00	Wages	170,242.47	185,454.42			1,679.66		187,134.08
10-703.00	Wages	~141~20.31		10 O ST		and the second s		

10 - Combined Operations

### John Manchin Sr. Health Care Center Detail Adjusted Trial Balance All Transactions Sorted By Account From 06012010 to 06302010

alastrid pu	try Pormat: AJE	Pagintag	Ending 1	Ratch	Ref	Adjustr	ents	Adjusted
cct/Number	Acct/Title	Beginning Balance	Balance	No	No	Debits	Credits	Ending Bal
	Mana	90,615,23	99,454.26	1223	2		427.07	99,027.19
0-703.00	Wages	40,580.09	44,809.09		2	2,390.88		47,199.97
0-703.00 5-703.00	Wages Wages	26,687.41	29,018.91		2	#####################################	379.96	28,638.95
0-703.00	Wages	84,560.15	89,727.73			3,268.36		92,996.09
0-703.00	Wages	30,123.92	32,861.92				323.90	32,538.02
5-703.00	Hages	49,662.39	53,670.39		2	4,793.12		58,463.51
0-703.00	Wages	26,994.00	29,388.00	1223	2	1,732.05		31,120.05
5-703.05	Wages - RN	176,194.43	191,643.67	1223	2	10,195.84		201,839.51
5-703.05	Wages - RN	44,355.87	44,355.87		2		32,724.64	11,631.23
5-703.10	Wages - LPN	190,316.97	207,729.13	1223	2		3,030.43	204,698.70
5-703.10	Wages - LPN	62,265.47	68,558.40	1223			2,613.51	65,944.89
5-703.15	Wages - Aides	431,138.37	470,406.53	1223	2	3,973.36		474,379.89
5-703.15	Wages - Aides	58,479.30	63,633.30	1223	2	2,382.54		66,015.8
5-703.20	Wages - Physician	111,525.83	121,113.83	1223	2		11,952.25	109,161.5
5-703.30	Wages - SNF director	53,270.00	57,975.00	1223	2	1,618.33		59,593.33
5-711.00	Advertising	4,840.36	5,679.36					5,679.30
5-711.00	Advertising	271.98	271.98					271.9
5-715.00	Auto and truck expense	920.00	1,057.02					1,057.0
0-715.00	Auto and truck expense	779.48	1,108.46					1,108.4
0-721.00	Contractural & Profession	5,679.27	6,554.02					6,554.0
5-721.00	Contractural & Profession	16,110.00	20,730.00					20,730.0
5-721.00	Contractural & Profession	19,416.63	22,636.63					22,636.6
5-721.00	Contractural & Profession	800.00	1,762.00					1,762.0
0-721.00	Contractural & Profession	6,814.00	7,644.00					7,644.0
5-721.10	Contractural - Accounting	7,035.00	8,955.00					8,955.0
5-721.20	Contractural - Physician	4,875.00	6,375.00					6,375.0
5-721.20	Contractural - Physician	23,210.50	23,210.50					23,210.5
5-721.40	Contractural - other	55.74	55.74					55.7
0-721.40	Contractural - other	1,320.85	1,473.35					1,473.3
0-721.40	Contractural - other	1,800.00	1,800.00					1,800.0
5-725.00	Data processing services	6,943.62	8,881.53					8,881.5
5-731.00	Depreciation expense	.00		1223	4	136,044.00		136,044.0
5-733.00	Dues and subscriptions	537.20	801.20					801.2
5-737.11	Employee Benefits - Socia	129,635.51	141,383.98	1223	8	293.73		141,677.7
5-737.12	Employee Benefits - Insur	352,603.84	386,985.26				25,252.20	361,733.0
5-737.14	Employee Benefits - Worke	.00	53,731.76					53,731.7
5-737,15	Employee Benefits - Unemp	855.91	1,711.82	1223	10	1,711.92		3,423.7
5.757,15	Map 20100 Boardage Street			1223	10		855.91	2,567.8
	Account Sub-total	855,91	1,711.82			1,711.92	855.91	2,567.8
5-737.16	Employee Benefits - Retir	190,638.52	208,409.12				**	208,409.1
0-739.00	Pood products	116,025,17	131,142.98					131,142.9
75-739.00	Food products	1,171.36	1,252.03					1,252.0
5-743.00	Interest	293.73	293,73	1223	8		293.73	.0
70-747.00	Licenses & permits	600.00	600.00					600.0
0-749.00	Maintenance contracts	5,519.04	5,996.17					5,996.1
	Maintenance contracts	492.14	492,14					492.1
0-749.00	Minor Equipment	.00	1,197.00		11		1,197.00	
0-750.00		3,301.10	4,442.96		17.50		± 8	4,442.5
5-750.00	Minor Equipment	753.95	753.95					753.
0-750.00	Minor Equipment	949.77	949.77					949.
0-750.00	Minor Equipment	11,801.85	11,801.85					11,801.
5-750.00	Minor Equipment	200m 1875	2,214.76		11	1,197.00		3,411.
0-750.00	Minor Equipment	2,214.76			, 11	2,231.00		1,141.
5-750.00	Minor Equipment	1,141.56	1,141.56					2,140.
0-750.00	Minor Equipment	2,140.02	2,140.02					5,435.
15-750.00	Minor Equipment	5,435.00	5,435.00					1,663.
5-751,00	Miscellaneous expenses	1,593.44	1,663.44					28.
0-751.00	Miscellaneous expenses	28.00	28.00					965.
5-751,00	Miscellaneous expenses	939.06	965.32					99.
5-751.00	Miscellaneous expenses	99.00	99.00					593.
0-751.00	Miscellaneous expenses	593.83	593.83					155.
0-751.00	Miscellaneous expenses	155,00	155.00					900.
5-751.00	Miscellaneous expenses	900.55	900.55					604.
0-751.00	Miscellaneous expenses	604.00	604.00				(( <b>*</b> %	7,172.
5-753.00	Office expense	7,069.87	7,172.31					314.
55-753.00	Office expense	314.05	314.05					
70-753.00	Office expense	21.22	21.22					8,630.
05-753.50	Office expense - postage	7,484.07	8,630.07					
	AND	4 000 00	4 252 50					4,252.5
05-757.00	Rent	4,252.50 884.80	4,252.50 884.80					884.8

### John Manchin Sr. Health Care Center Detail Adjusted Trial Balance All Transactions Sorted By Account From 06012010 to 06302010

	d Operations try Format: AJE						* 3/
.cct/Number	53 28 2845 - 2	Beginning Balance	Ending Batch Balance No	Ref No	Debits	Credits	Adjusted Ending Bal
5-757.00	Rent	117.77	117.77				117.77
.0-761.00	Repair and maintenance	6,653.70	6,653.70				6,653.70
:0-761.00	Repair and maintenance	533.04	533.04				533.04
:5-761.00	Repair and maintenance	2,142.64	2,142.64				2,142.64 280.00
0-761.00	Repair and maintenance	,00	280.00				15,455.23
10-761.00	Repair and maintenance	15,455,23	15,455.23 504.52				504.52
5-761.00	Repair and maintenance	504.52 119.00	119.00				119.00
'0-761.00 15-761.60	Repair and maintenance R&M - labor	149.62	149.62				149.62
.0-761.60	Rem - labor	2,295.70	2,295.70				2,295.70
15-761.60	R&M - labor	483.00	483.00				483.00
0-761.60	REM - labor	2,064.50	2,064.50				2,064.50
0-761.60	R&M - labor	578.00	662.50				662.50 833.24
15-761.63	R&M - aquipment other	833.24	833.24		*6		1,495.89
.0-761.63	R&M - equipment other	1,495.89 698.97	1,495.89 698.97				698.97
15-761.63	R&M - equipment other R&M - equipment other	797.34	797.34				797.34
10-761.63	R&M - equipment other	16,390.37	16,457.20				16,457.20
10-761.63	R&M - equipment other	545.42	545,42				545.42
15-761.63	R&M - equipment other	29.16	29.16				29.16
10-761.68	R&M - other	42.78	42.78				42.78
10-761.68	R&M - other	128.29	128.29				128.29
35-767.00	Stationary and printing	117.77	117,77			304.66	117.77
15-769.10	Supplies	304.66	304.66 122	9		304.00	103,432.66
15-769.10	Supplies - Medical	97,190.07	103,432.66 12,314.56 122	. 0	304.66		12,619.22
35-769.10	Supplies - Medical X-ray Medical Supplies	9,873.43 7,785.38	7,785.38				7,785.38
10-769.10 25-769.20	Supplies - Pharmacy	.00	8,622.11				8,622.11
35-769.20	Supplies - Pharmacy	12,860.08	13,854.22				13,854,22
75~769.40	Supplies - recreational	1,084.27	1,084.27				1,084.27
35-769.90	Supplies - other	96.80	96.80				96.80
10-769.90	Supplies - other	3,032.48	3,404.60				3,404.60
20-769.90	Supplies - other	20,474.99	21,773.26				21,773.26 2,465.47
25-769.90	Supplies - other	2,141.40	2,465.47				12,269.98
30-769.90	supplies - other	11,497.78	12,269.98 2,665.73				2,665.73
50-769.90	Supplies - other Supplies - other	2,665.73 161.64	161.64				161.64
55-769.90	Supplies - other	816.98	816.98				816.98
75-769.90 10-770.00	Supplies - inventory chan	.00	<394.91>				<394.91>
20-770.00	Inventory change - HSKP	.00	<1,385.29>				<1,385.29>
25-770.00	supplies - inventory chan	.00	<4,774.62>				<4,774.62>
50-770.00	supplies - inventory chan	.00	<376.60>				<376.60>
25-771.50	Taxes - Medicaid tax	134,668.02	156,132.64				156,132.64 2,440.28
55-771.50	Taxes - Medicaid tax	3,563.52	2,440.28				2,051.45
05-779.00	Telephone and telegraph	1,617.80 138.33	2,051.45 191.13				191.13
10-779.00	Telephone and telegraph Telephone and telegraph	359.56	516.62				516.62
25-779.00 50-779.00	Telephone and telegraph	110.60	157,79				157.79
55-779.00	Telephone and telegraph	465.84	606.31				606.31
70-779.00	Telephone and telegraph	97.28	135.83				135.83
75-779.00	Telephone and telegraph	113.77	155.99				155.99
85-779.00	Telephone and telegraph	389.59	505.01				505.01
90-779.00	Telephone and telegraph	28.53	58.53				58.53 2,961.96
05-781.00	Travel	2,895.13	2,961.96				93.96
10-781.00	Travel	.00 673.07	93.96 1,051.57				1,051.57
25-781.00	Travel	.00	20,25				20,25
55-781.00 75-781.00	Travel Travel	62,30	127.53				127.53
90-781.00	Travel	322,76	322.76				322.76
50-783.10	Utilities - Blectricity	57,506.64	68,835.77				68,835.77
50-783.20	Utilities - Gas	44,075.77	47,090.35				47,090.35
50-783.30	Utilities - Garbage	17,061.39	17,845.10				17,845.10
50-783.40	Utilities - Water	19,416.99	24,320.36				24,320.36 2,728.56
50-783.50	Utilities - Cable	2,501.18	2,728.56				14,728.00
05-900.00	Hours	13,496.00	14,728.00				60,543.00
10-900.00	Meals served	55,420.00 10,464.00	60,543.00 ; 11,496.00				11,496.00
20-900.00	Hours Patient days	13,272.00	14,445.00				14,445.00
25-900.00 30-900.00	Pounds of laundry	275,986.72	275,986.72				275,986.72
35-900.00	Hours	1,928.00	2,104.00				2,104.00
45-900.00	Patient days	13,272.00	14,445.00				14,445.00
	AND						

23022651

John Manchin Sr. Health Care Center Detail Adjusted Trial Balance All Transactions Sorted By Account From 06012010 to 06302010

0 - Combined Operations djusting Entry Pormat: AJE

djusting Er,	ntry Pormat: AJE	Beginning	Ending Ba	tch	Ref	Adjustm	ents	Adjusted
.cct/Number	Acct/Title	Balance	Balance	No	No	pebits	Credits	Ending Bal
0-900.00 5-900.00 0-900.00 5-900.00	Hours worked Patient visits X-Ray proceedures Patient days Patient days	7,688.00 11,490.00 483.00 13,272.00 13,272.00	8,216.00 12,911.00 522.00 14,445.00 14,445.00					8,216.00 12,911.00 522.00 14,445.00 14,445.00 <444,286.72>
10-950.00	Statistical Offset Accoun	<430,043.72> 	<444,286.72>			510,729.19	510,729.19	.00

PROVIDER NO. 5095901 WITHROW HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

HOSPITAL

3

6

8

100

SUBPROVIDER I SWING BED - SNF SWING BED - NF

NURSING FACILITY HOME HEALTH AGENCY

HEALTH CLINIC

SKILLED NURSING FACILITY

OUTPATIENT REHABILITATION PROVIDER

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2008.05 52

WORKSHEET S PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT

CERTIFICATION AND SETTLEMENT SUMMARY RE-OPENING INITIAL DATE RECEIVED AUDITED MCR CODE DESK REVIEWED INTERMEDIARY NO. PART I - CERTIFICATION ELECTRONICALLY FILED COST REPORT DATE: CHECK TIME: MANUALLY SUBMITTED COST REPORT APPLICABLE BOX MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL

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

### CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD WITHROW HOSPITAL (50-95901)

BEGINNING 07/01/2009 AND ENDING 06/30/2010, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGRADING THE PROVISION OF HEALTH CARE.

AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGRADING THE PROVISION OF HEALTH CARE.

SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN CONTINUE WITH SUCH LAWE AND REGULATIONS.

(SIGNED)

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

OTHER STATES OF PROVIDER(S)

PART II - SETTLEMENT SUMMARY

TITLE V TITLE XVIII TITLE XIX

PART A PART B

1 2 3 4

2 3

4

5

1234449 100

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

### HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX  1 STREET: 105 S. EISENHOWER DRIVE  1.01 CITY: BECKLEY	STATE: WV	P.O.BOX: 21P CODE: 25801	COUNTY: RALEIGH			1
1.01 CITY: BECKLEY HOSPITAL AND HOSPITAL-BASED COMPONENT ID:		311 00001 00001		PAYMENT	SYSTEM	
		PROVIDER NUMBER	DATE CERTIFIED	(P,T,C) V XVII		
COMPONENT 0	COMPONENT NAME	2	3	4 5		
2 HOSPITAL 3 SUBPROVIDER I 4 SWING BEDS - SNF 5 SWING BEDS - NF	WITHROW HOSPITAL	50-95901	10/01/1981	и и	0	2 3 4 5 6
6 HOSPITAL-BASED SNF 7 HOSPITAL-BASED NF 8 HOSPITAL-BASED OLTC 9 HOSPITAL-BASED HHA 11 SEPARATELY CERTIFIED ASC 12 HOSPITAL-BASED HOSPICE 14 HOSP-BASED RHC 15 OUTPATIENT REHABILITATION PROVID	WITHROW HOSPITAL WITHROW HOSPITAL	50-95901	10/01/1981	N	0	7 8 9 11 12 14 15
16 RENAL DIALYSIS		FROM	: 07/01/2009 TO:	06/30/201	0	17
17 COST REPORTING PERIOD (MM/DD/YYYY  18 TYPE OF CONTROL	1		1 2 10			18
TYPE OF HOSPITAL/SUBPROVIDER			N HOLDERS			
19 HOSPITAL 20 SUBPROVIDER I			9			19 20
OTHER INFORMATION 21 INDICATE IF YOUR HOSPITAL IS EITH COST REPORTING PERIOD IN COLUMN 1 OR LOCATED IN A RURAL AREA, IS YO	. IF YOUR HOSPITAL IS GEO UR BED SIZE IN ACCORDANCE	GRAPHICALLY CLASSIFIED WITH CFR 42 412.105				21
LESS THAN OR EQUAL TO 100 BEDS, E 21.01 DOES YOUR FACILITY QUALIFY AND IS DISPROPORTIONATE SHARE IN ACCORDA	CURRENTLY RECEIVING PAYM	ENT FOR	МО			21.01
21.02 HAS YOUR FACILITY RECEIVED GEOGRA AND 'N' FOR NO. IF YES, REPORT IN	PHIC RECLASSIFICATION? EN	TER 'Y' FOR YES				21.02
21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC URBAN IN COLUMN 1 INDICATE IF YOU RECLASSIFICATION TO A RURAL LOCAT IS YES, ENTER IN COLUMN 3 THE EFF FACILITY CONTAIN 100 OR FEWER BET	: LOCATION EITHER (1) URBA RECEIVED EITHER A WAGE O TION, ENTER IN COLUMN 2 'Y TECTIVE DATE (mm/dd/yyy)( S IN ACCORDANCE WITH 42 C	IN (2) RURAL, IF YOU ANSWOR STANDARD GEOGRAPHIC '' AND 'N' FOR NO. IF COL (SEE INSTRUCTION). DOES Y	JUMN 2 OUR		N	21.03
'Y' FOR YES AND 'N' FOR NO. ENTER 21.04 FOR STANDARD GEOGRAPHIC RECLASSIE	ICATION (NOT WAGE), WHAT	IS YOUR STATUS AT THE BE	EGINNING 1			21.04
OF THE COST REPORTING PERIOD. ENT 21.05 FOR STANDARD GEOGRAPHIC RECLASSIE	ICATION (NOT WAGE), WHAT	IS YOUR STATUS AT THE EN	ND OF THE 1			21.05
COST REPORTING PERIOD. ENTER (1) 21.06 DOES THIS HOSPITAL QUALIFY FOR THE SMALL RURAL HOSPITAL UNDER THE PE UNDER DRA SECTION 5105? ENTER 'Y'	E THREE-YEAR TRANSITION COSPECTIVE PAYMENT SYSTEM	OF HOLD HARMLESS PAYMENTS FOR HOSPITAL OUTPATIENT	S FOR A NO SERVICES			21.06
22 ARE YOU CLASSIFIED AS A REFERRAL 23 DOES THIS FACILITY OPERATE A TRAI 23.01 IF THIS IS A MEDICARE CERTIFIED FIN COL. 2 AND TERMINATION IN COL.	CENTER? ISPLANT CENTER? IF YES, EN KIDNEY TRANSPLANT CENTER,	TER CERTIFICATION DATE (SENTER THE CERTIFICATION	NO DATE NO			22 23 23.01
23.02 IF THIS IS A MEDICARE CERTIFIED IN COL. 2 AND TERMINATION IN COL.	IEART TRANSPLANT CENTER, E	ENTER THE CERTIFICATION I	DATE			23.02
23.03 IF THIS IS A MEDICARE CERTIFIED IN COL. 2 AND TERMINATION IN COL.	LIVER TRANSPLANT CENTER, E	ENTER THE CERTIFICATION I	DATE			23.03
23.04 IF THIS IS A MEDICARE CERTIFIED IN COL. 2 AND TERMINATION IN COL	JUNG TRANSPLANT CENTER, EN	NTER THE CERTIFICATION DA	ATE			23.04
23.05 IF MEDICARE PANCREAS TRANSPLANTS	ARE PERFORMED SEE INSTRUC	CTIONS FOR ENTERING CERT	IFICATION			23.05
23.06 IF THIS IS A MEDICARE CERTIFIED		TER, ENTER THE CERTIFICA	TION			23.06
DATE IN COL. 2 AND TERMINATION IN 23.07 IF THIS IS A MEDICARE CERTIFIED	ISLET TRANSPLANT CENTER EN	NTER THE CERTIFICATION DA	ATE			23.07
IN COL. 2 AND TERMINATION IN COL 24 IF THIS AN ORGAN PROCUREMENT ORGAN	ANIZATION (OPO), ENTER THE	E OPO NUMBER IN COL 2.				24
AND TERMINATION IN COL. 3. 24.01 IF THIS A MEDICARE TRANSPLANT CE	NTER; ENTER THE CCN (PROVI	IDER NUMBER) IN COL 2, T	HE			24.01
CERTIFICATION DATE OR RECERTIFICATION DATE OF RECERTIFICATION AS IS THIS A TEACHING HOSPITAL OR A	FFILIATED WITH A TEACHING	HOSPITAL AND YOU ARE MA	KING NO	Ŧ.		25
PAYMENTS FOR I 6 R? 25.01 IS THIS TEACHING PROGRAM APPROVE 25.02 IF LINE 25.01 IS YES, WAS MEDICA IN EFFECT DURING THE FIRST MONTH	RE PARTICIPATION AND APPRO OF THE COST REPORTING PE	OVED TEACHING PROGRAM ST. RIOD? IF YES, COMPLETE	NO NO NO			25.01 25.02
WORKSHEET E-3, PART IV. IF NO, CO 25.03 AS A TEACHING HOSPITAL, DID YOU	ELECT COST REIMBURSEMENT	FOR PHYSICIANS' SERVICES	AS NO			25.03
DEFINED IN CMS PUB. 15-I, SECTIO 25.04 ARE YOU CLAIMING COSTS ON LINE 7 25.05 HAS YOUR FACILITY DIRECT GME FTE 42 CFR 413.79(c)(3) OR 42 CFR 41	O OF WORKSHEET A? IF YES, CAP (COLUMN 1) OR IME CA	P (COLUMN 2) BEEN REDUCE	D UNDER NO IN			25.04 25.05
THE APPLICABLE COLUMNS. (SEE INS 25.06 HAS YOUR FACILITY RECEIVED ADDIT RESIDENT CAP SLOTS UNDER 42 CFR YES AND 'N' FOR NO IN THE APPLIC	FRUCTIONS) IONAL DIRECT GME FTE RESI 413.79(c)(4) OR 42 CFR 41	DENT CAP SLOTS OR IME FT 2.105(f)(1)(iv)(C)? ENTE	E			25.06

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WORKSHEET S-2 (CONTINUED)

# HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

				0.0
OTHER INFORMATION  26 IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT.  ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR				26
NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.  BEGINNING:  ENDING:  ENDING:  ENDING:  ENDING:  ENDING:  THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER  THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT				26.01 26.03
				26.04
AND THE SCH WAS EITHER PHYSICALLY LOCATED ON CLASSITIVE DATES (SEE INSTRUCTIONS):  26.04 IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):  ENDING:  BEGINNING:  ENDING:  ENDING:  BEGINNING:  ENDING:  ENDING:	МО			27
DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913  FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	VROCEV.			28
28 IF THIS FACILITY CONTAINS A HOSPITAL BASED SHE, ARE ADD COMPLETE LINES 28.01 AND 28.02.				28,01
28.01 IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, 6				28.02
28.02 ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC NAME (THE THE FACILITY IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003, CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SHE REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED				
EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)	0.00	N		28.03
28.03 STAFFING 28.04 RECRUITMENT	0.00	n n		28.04 28.05
28.05 RETENTION OF EMPLOYEES 28.06 TRAINING	0.00	И		28.06 28.07
28.07 OTHER (SPECIFY)	NO			29
29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?  30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS	ио			30
HOSPITAL (CAH)? SEE 42 CFR 485.606ff. 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH?				30.01
SEE 42 CFR 413.70.  30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF				30.02
PAYMENT FOR OUTPATIENT SERVICES?				30.03
SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF EDIGIDITY				30.04
ON OR AFTER 12/21/2000) 30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR 16R TRAIN PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE	,			
WORKSHEET D-2, PART II.  11 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE?  SEE 42 CFR 412.113(c).	Ю			31
MISCELLANEOUS COST REPORTING INFORMATION	NO			32
32 IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IT IES, ENTER THE METHOD COST (1)	NO			33
IN COLUMN 2.  1S THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002 DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N'	2,			
FOR NO IN COLUMN 2.  34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?  35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO NO			34 35
	V 1	XVIII	XIX 3	
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL  36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?  36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE	NO	ио	NO NO	36 36.01
36.01 DOES YOUR FACILITY QUALITY AND RECEIVE FATHERY TOO BOSTAGE OF THE WITH 42CFR412.320?  37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?  37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE.	NO	NO	Ю	37 37.01
31.01 1. 100 May 0 1000 marine				

VERSION: 2008.05 11/30/2010 12:17

# HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 (CONTINUED)

	H.			
38 38.01 38.02 38.03	IX INPATIENT HOSPITAL SERVICES  DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?  IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?  ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?  DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	PART? NO NO NO NO		38 38.01 38.02 38.03 38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION,	ЭҮ	S	40
	ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	FI/CONTRA	ACTOR'S NUMBER:	40.01
40.01	NAME:	P.O.BOX:		40.02
	STREET;	STATE:	ZIP CODE:	40.03
40.03	CITY:	YE.		41
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	NC		42
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?			42.01
42 01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NC		
42 02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NC		42.02
	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NC	)	43
43	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ON	ILY? NO	)	44
44	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT	?? NO	)	45
45	HAVE YOU CHANGED YOUR COST ALLOCATION HEIRODOLOGI FROM THE FROM COLUMN IN COLUMN	IMN 2		
	SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLU			45.01
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			45.02
45 02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			45.03
45 03	Who THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?	2000 0000000		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASE	ED SNF)		46
30	DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.			
	DOKING THIS COST METONITION TEMPORY SHEET	#I		

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

11012010000										
			PART B	OUTPATIENT ASC	OUTPATIEN' RADIOLOGY		UTPATIEN? IAGNOSTI			
		PART A	2	3	4	- 3	5			
		Ŋ	Ñ	N	N		И			47
47	HOSPITAL	N	N	N	N		N			48
48	SUBPROVIDER I	N	N							49
49 50	SKILLED NURSING FACILITY HOME HEALTH AGENCY	N	N							50
50		125								
52	DOES THIS HOSPITAL CLAIM EXPENDITURES	FOR EXTRAORDI	NARY CIRCUMST	ances in accordal	NCE WITH	ИО				52
	42 000 412 349/013					***				52.01
52.01	TE VOU ARE A FULLY PROSPECTIVE OR HOLD	HARMLESS PRO	VIDER ARE YOU	ELIGIBLE FOR THE	E SPECIAL	NO				32.01
	SUCREMENT DEVOCATE DIDCHANT TO 42 CFR 4	12 348(0)7 11	YES, COMPLET	E DI PARI IV.						53
53	IF THIS IS A MEDICARE DEPENDENT HOSPIT	AL (MDH), ENT	ER THE NUMBER	2 OF PERIODS NON	LINE					
	EFFECT. ENTER BEGINNING AND ENDING DAT	ES OF MUN SIA	TED CHDCEVIER	T DATES	DIND					
1212 212	53.01 FOR NUMBER OF PERIODS IN EXCESS	OF ONE AND EN	BEGINNING:	i barbo.	ENDING:					53.01
	MDH PERIOD: LIST AMOUNTS OF MALPRACTICE PREMIUMS A	ND PAID LOSSE								54
54	DATA INCCES.		AND/OR SELF I	NSURANCE:						
54 01	AND MAI DEPOSITED DEPOSITING AND DATE LOSS	ES REPORTED I	N OTHER THAN	THE ADMINISTRATI	VE AND	ИО				54.01
39.01	GENERAL COST CENTER? IF YES, SUBMIT SU	IPPORTING SCHE	DULE LISTING	COST CENTERS AND	AMOUNTS					
	COMMATNED THERETH									55
55	DOES YOUR FACILITY QUALIFY FOR ADDITIO	NAL PROSPECTI	VE PAYMENT IN	ACCORDANCE WITH		ИО				33
0.000	42 CFR 412.107. ENTER 'Y' FOR YES AND	'N' FOR NO.			DATE	Y/N	LIMIT	Y/N	FEES	
					O	1	2	3	4	
5867.789	TO STATE OF THE ST	the Chack th	COI 2 TUE DAY	WENT LIMIT	1 1	NO	0.00			56
56	ARE YOU CLAIMING AMBULANCE COSTS? IF Y PROVIDED FROM YOUR FISCAL INTERMEDIARY	LES, ENIER IN	FIRST YEAR OF	OPERATIONS.						
	NO ENTRY IS REQUIRED IN COL 2. IF COL	1 TO 'Y' FNT	ER 'Y' OR 'N'	IN COL 3				12		
	WHETHER THIS IS YOUR FIRST YEAR OF OPE	ERATIONS FOR B	ENDERING AMBU	LANCE SERVICES.						
	ENTER IN COL 4, IF APPLICABLE, THE FEE	SCHEDULES AM	OUNTS FOR THE	PERIOD						
	BEGINNING ON OR AFTER 4/1/2002.					722				57
57	ADD YOU CLATHTHE MIDEING AND MILITED HE	EALTH COSTS?				NO				57 58
58	ADD VOIL BY THERMIENT DEURDITTENTION FL	CTLITY (IRF).	OR DO YOU CO	ntain an irf sue	BPROVIDER?	NO				50
	CUMED TH COTINN 1 IV! FOR YES AND 'N'	FOR NO. IF YE	S RAVE IOU M	IND THE PRECITOR	CON TOOS					
	DES DETURBOCENERS ENTER IN COLUMN 2	YY FOR YES AL	ID 'N' FOR NO.	THIS OPITON IS	OMPI					
	BURTERDIC FOR COCK DEPORTING DEPICOS	REGINNING ON (	OR APTER 1/1/2	TOUR WAY DELOVE I	10/1/2002.					58.01
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FAC	CILITY HAVE A	TEACHING PROC	THE THE COLUMN 1	Y' FOR YES					
	COST REPORTING PERIOD ENDING ON OR BEI	FORE NOVEMBER	13, 2009; EN	IING PROGRAM IN A	CCORDANCE					
8	WITH FR VOL 70, NO 156 DATED AUGUST 1	NG KESIDENIS	A TO 202 FNTER	IN COLUMN 2 'Y' I	FOR YES OR					
	'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1	2 OR 3 RESI	PECTIVELY IN O	COLUMN 3 (SEE INS	STRUCTIONS)					
	TO MUS CURRENT CACH DEPARTING DEPTAR	COVERS THE REC	SINNING OF THE	E FOURTH ENTER 4	TH COPOLIN 2	,				
	OR IF THE SUBSEQUENT ACADEMIC YEARS O	F THE NEW TEAC	CHING PROGRAM	IN EXISTENCE, EN	TER 5.					
	ACEC INCUDICATIONS!					222				
59	AND YOU A LOUG WEDN CARE HASPITAL LITT	CH), OR DO YOU	U CONTAIN A L'	TCH SUBPROVIDER?		ИО				59
33	CHEED TH COLUMN 1 IV! FOR VEC AND 'N'	FOR NO. IF Y	ES HAVE YOU M	AND THE CPECITOR	FOR 100%					
	PPS REIMBURSEMENT? ENTER IN COLUMN 2	'Y' FOR YES A	ND 'N' FOR NO	. (SEE INSTRUCTION	ONS)					

PROVIDER NO.	5095901	WITHROV	HOSPITAL
PERIOD FROM		TO (	06/30/2010

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 (CONTINUED)

60

ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A
NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)

60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT
COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N'
FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH
42 CFR SEC. 412.424(d) (1)(iii) (2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2
IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST
REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE
SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)

60.01

61

MULTICAMPUS

AMPUS
DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2,

ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

COUNTY:

FTE/ CAMPUS CBSA STATE: ZIP CODE 5

NO

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PROVIDER NO. 5095901 WITHROW HOSPITAL
PERIOD FROM 07/01/2009 TO 06/30/2010

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HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

PORKSHEET	S-3
PART	I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	TITLE V 3	TITLE XVIII	/ O/P VISITS LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01
	HOSPITAL ADULTS & PEDS, EXCL								1
1	SWING BED, OBSERV & HOSPICE DAYS								2
2	HMO								3
3	HOSPITAL ADULTS 4 PEDS - SWING BED SNF				(# fr)				4
4	HOSPITAL ADULTS & PEDS -								*
	SWING BED NF								5
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS								6
6	INTENSIVE CARE UNIT								7
7	CORONARY CARE UNIT								8
8	BURN INTENSIVE CARE UNIT								9
9	SURGICAL INTENSIVE CARE UNIT								10
10	OTHER SPECIAL CARE (SPECIFY)								11
11	NURSERY								12
12	TOTAL HOSPITAL								13
13	RPCH VISITS								14
14	SUBPROVIDER I								15
15	SKILLED NURSING FACILITY	199	72635					28353	16
16	NURSING FACILITY OTHER LONG TERM CARE	10							17
17	HOME HEALTH AGENCY		0000						18
18 20	ASC (DISTINCT PART)								20 21
21	HOSPICE (DISTINCT PART)								23
23	O/P REHAB PROVIDER								24
24	RHC I								25
25	TOTAL	209							26
26	OBSERVATION BED DAYS								27
27	AMBULANCE TRIPS								28
28	EMPLOYEE DISCOUNT DAYS								===

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# HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I (CONTINUED)

		I/P	DAYS / O/P	VISITS /	TRIPS	INTE	RNS & RES FTE	s	FULL TIME	(CONTINUED) EQUIV
	COMPONENT	OBS. BEDS NOT	TOTAL ALL PATIENTS	OBS. BEDS	BEDS NOT	TOTAL	LESS I&R REPL NON- PHYS ANES 8	NET 9		NONPAID WORKERS 11
1	HOSPITAL ADULTS & PEDS, EXCL.									1
	SWING BED, OBSERV & HOSPICE DA	YS								2
2	HMO XIX HOSPITAL ADULTS & PEDS -									3
-	SWING BED SNF									4
4	HOSPITAL ADULTS & PEDS - SWING BED NF									5
5	TOTAL ADULTS & PEDS									
	EXCL OBSERVATION BEDS INTENSIVE CARE UNIT									6 7
6 7	CORONARY CARE UNIT									8
8	BURN INTENSIVE CARE UNIT									9
9	SURGICAL INTENSIVE CARE UNIT									10
10	OTHER SPECIAL CARE (SPECIFY)									11
11	NURSERY									12
12	TOTAL HOSPITAL									13
13	RPCH VISITS									14
14	SUBPROVIDER I									15
15	SKILLED NURSING FACILITY NURSING FACILITY		28784						159.73	16 17
16 17	OTHER LONG TERM CARE									18
18	HOME HEALTH AGENCY									20
20	ASC (DISTINCT PART)									21
21	HOSPICE (DISTINCT PART)									23
23	O/P REHAB PROVIDER									24
24	RHC I								159.73	25
25	TOTAL									26
26	OBSERVATION BED DAYS									27 28
27 28	AMBULANCE TRIPS EMPLOYEE DISCOUNT DAYS									28
20	DITEDIED DECOUNT DITE									

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PROVIDER NO. 5095901 WITHROW HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

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### HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

			DISC	CHARGES			
		TITLE	TITLE	TITLE	TOTAL ALL		
	COMPONENT	V	XVIII	XIX	PATIENTS		
	COLIT CITALITY	12	13	14	1.5		
1	HOSPITAL ADULTS & PEDS, EXCL.						
	SWING BED, OBSERV & HOSPICE DAYS						
2	HMO XIX						
3	HOSPITAL ADULTS & PEDS -						
8	SWING BED SNF						
4	HOSPITAL ADULTS & PEDS -						
	SWING BED NF						
5	TOTAL ADULTS & PEDS						
-	EXCL OBSERVATION BEDS						
6	INTENSIVE CARE UNIT						
7	CORONARY CARE UNIT						
8	BURN INTENSIVE CARE UNIT						
9	SURGICAL INTENSIVE CARE UNIT						
10	OTHER SPECIAL CARE (SPECIFY)						
11	NURSERY			5.			
12	TOTAL HOSPITAL						
13	RPCH VISITS						
1.4	SUBPROVIDER I						
15	SKILLED NURSING FACILITY						
16	NURSING FACILITY						
17	OTHER LONG TERM CARE						
18	HOME HEALTH AGENCY						
20	ASC (DISTINCT PART)						
21	HOSPICE (DISTINCT PART)						
23	O/P REHAB PROVIDER						
24	RHC I						
25	TOTAL						
26	OBSERVATION BED DAYS						
27	AMBULANCE TRIPS						
28	EMPLOYEE DISCOUNT DAYS						

### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/2000)

WORKSHEET S-3 ADJUSTED PAID HOURS AVERAGE HOSPITAL WAGE INDEX INFORMATION RECLASS. HOURLY WAGE PART II SALARIES RELATED OF SALARIES DATA FROM WKST. (COL.1 + TO SALARY AMOUNT PART II - WAGE DATA COL. 4) SOURCE A-6 COL.2) IN COL.3 REPORTED 5 6 3 1 4949507 SALARIES 2 3 TOTAL SALARIES NON-PHYSICIAN ANESTHETIST PART A NON-PHYSICIAN ANESTHETIST PART B PHYSICIAN - PART A 3 4.01 4.01 TEACHING PHYSICIAN SALARIES 5 PHYSICIAN - PART B 5.01 NON-PHYSICIAN - PART B 5.01 interns & Residents (In Appr PGM)
6.01 CONTRACT SERVICES, I&R
7 HOME OFFICE PERSONNEL 6.01 8.01 8.01 EXCLUDED AREA SALARIES OTHER WAGES & RELATED COSTS 2806789 212150 OTHER WAGES & RELATED COSTS

CONTRACT LABOR

ON THANKACY SERVICES UNDER CONTRACT

LABORATORY SERVICES UNDER CONTRACT

ON MANAGEMENT AND ADMINISTRATIVE SERVICES' 9.01 9.02 9.03 9.03 MANAGEMENT AND ADMINISTRATIVE SERVICES
10 CONTRACT LABOR: PHYSICIAN PART A
10.01 TEACHING PHYSICIAN UNDER CONTRACT
11 HOME OFFICE: SALARIES & WAGE REL COSTS
12 HOME OFFICE: PHYSICIAN PART A
12.01 TEACHING PHYSICIAN SALARIES
WAGE-RELATED COSTS
13 WAGE RELATED COSTS (CORE)
14 WAGE RELATED COSTS (OTHER)
15 EXCLUDED AREAS
16 NON-PHYSICIAN ANESTHETIST PART A 10 10.01 12.01 13 CMS 339 14 CMS 339 CMS 339 15 EXCLUDED AREAS
16 NON-PHYSICIAN ANESTHETIST PART A
17 NON-PHYSICIAN ANESTHETIST PART B
18 PHYSICIAN PART A
18.01 PART A TEACHING PHYSICIANS
19 PHYSICIAN PART B
19.01 WAGE RELATED COSTS (RHC/FQHC)
20 INTERNS & RESIDENTS (IN APPR PGM)
OVERHEAD COSTS - DIRECT SALARIES
21 EMPLOYEE BENEFITS
22 ADMINISTRATIVE & GENERAL
22.01 ADMINISTRATIVE & GENERAL
23 MAINTENANCE & REPAIRS 16 17 CMS 339 CMS 339 CMS 339 18.01 CMS 339 CMS 339 19 19.01 20 CMS 339 21 22 22.01 513074 23 315528 MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE 24 LAUNDRY & LINEN SERVICE
HOUSEKEEPING
HOUSEKEEPING UNDER CONTRACT
DIETARY
DIETARY 25 26 377140 26.01 27 27.01 434423 28 28 29 30 CAFETERIA MAINTENANCE OF PERSONNEL 29 30 121166 NURSING ADMINISTRATION 31 CENTRAL SERVICES AND SUPPLY 46325 32 33 34 PHARMACY MEDICAL RECORDS & MEDICAL RECORDS LIBR 55507 33 67405 SOCIAL SERVICE OTHER GENERAL SERVICE 35 -212150

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3 PART III

PART	III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED 1	RECLASS. OF SALARIES FROM WKST. A-6 2	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL. 3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
1	NET SALARIES	4949507		4949507			1 2
2	EXCLUDED AREA SALARIES	2806789	212150	3018939			3
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	2142718	-212150	1930568			4
4	SUBTOTAL OTHER WAGES & REL COSTS						Ś
5	SUBTOTAL WAGE-RELATED COSTS						6
6	TOTAL (SUM OF LINES 3 THRU 5)	2142718	-212150	1930568			7
7	NET SALARIES						8
8	EXCLUDED AREA SALARIES						9
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						10
10	SUBTOTAL OTHER WAGES & REL COSTS						11
11	SUBTOTAL WAGE-RELATED COSTS						12
12	TOTAL (SUM OF LINES 9 THRU 11)	0110710	-212150	1930568			13
13	TOTAL OVERHEAD COSTS	2142718	-212150	1930300			

212150

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER	SALARIES	OTHER 2	TOTAL	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
1.01 2 3	0100 0101 0200 0300	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS - BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		246555 2522 177007	246555 2522 177007	19559	246555 2522 196566		246555 2522 196566	1 1.01 2 3
5 6 7 8	0500 0600 0700 0800	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE	513074 315528	2069166 749528 210743 543932 225754	2069166 1262602 526271 543932 225754	-19559	2069166 1243043 526271 543932 225754	350877 952074	2420043 2195117 526271 543932 225754	5 6 7 8 9
10 11 12	1000 1100 1200	HOUSEKEEPING DIETARY CAFETERIA	377140 434423	58001 392545	435141 826968		435141 826968 121464	-168	435141 826800 121464	10 11 12 14
15 16	1500 1600	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	121166 46325 55507	298 9843 11	121464 56168 55518		56168		56168 55518	15 16 17
18 19 19.01 19.02	1800 1950 1951 1952	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT PATIENT ADVOCATE	67405 116238 95912	99127 15990 5858	67405 99127 132228	-99127 -132228 -101770	67405		67405	18 19 19.01 19.02 19.03
35 36	3500	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS	2806789	484457	3291246	333125	3624371	-136000	3488371	35 36
62 71		OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY								71
95		SPECIAL PURPOSE COST CENTERS SUBTOTALS NONREIMBURSABLE COST CENTERS	4949507	5291337	10240844		10240844	1166783	11407627	95
100.02 100.03 100.04	7951 7952 7953 7954	BARBER & BEAUTY VOLUNTEERS OUTSIDE MEDICAL SERVICES RENTAL SPACE MISCELLANEOUS NON-ALLOWABLE								100 100.01 100.02 100.03 100.04 100.05
100.05	1955	VACANT SPACE TOTAL	4949507	5291337	10240844		10240844	1166783	11407627	101

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### RECLASSIFICATIONS

WORKSHEET A-6 PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER 2	INCREASE LINE #	SALARY 4	OTHER 5
1 2 3 4 4 5 6 7 8 9 10 11 12 13 14 15 16 6 17 18 19 20 12 22 23 4 25 26 27 28 29 30 1	RENTAL EQUIPMENT RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT	A B C D				
32 33 34 35 36					212150	33 34 35 140534 36

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RECLASSIFICATIONS

WORKSHEET A-6 PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY 8	OTHER 9	WKST RE 10	
1 2 3 4 5 5 6 7 8 9 9 0 1 1 1 1 2 1 3 1 4 1 5 5 1 6 6 7 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 3 3 3 1 2 2 2 3 3 3 1 2 2 3 3 3 1 2 2 3 3 3 1 2 2 3 3 3 1 2 3 3 1 2 3 3 3 1 3 3 3 3 3 3 3 3 3 3 3 3 3		A B C D	ADMINISTRATIVE & GENERAL RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT	6 19 19.01 19.02	116238 95912	19559 99127 15990 5858	10	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 31 31 31 31 31 31 31 31 31 31 31 31
32 33 34 35 36					212150	140534	8.	33 34 35 36

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WORKSHEET A-7 PARTS I & II

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

DART T	_	ANALYSIS	OF	CHANGES	IN	OLD	CAPITAL	ASSET	BALANCES
--------	---	----------	----	---------	----	-----	---------	-------	----------

	And the second section of the second			ACQUISITIONS		DISPOSALS AND	ENDING	FULLY DEPRECIATED	
	DESCRIPTION	BEGINNING BALANCES 1	PURCHASE 2	DONATION 3	TOTAL	RETIREMENTS 5	BALANCE 6	ASSETS 7	
1 2 3 4 5 6 7 8 9	LAND LAND IMPROVEMENTS BUILDINGS AND FIXTURES BUILDING IMPROVEMENTS FIXED EQUIPMENT MOVABLE EQUIPMENT SUBTOTAL RÉCONCILING ITEMS TOTAL	79						ř	1 2 3 4 5 6 7 8 9
	PART II - ANALYSIS OF CHANGES IN NEW	CAPITAL ASS	SET BALANCES	3				25.00	
		BEGINNING		ACQUISITIONS		DISPOSALS	ENDING	FULLY DEPRECIATED	
	DESCRIPTION	BALANCES 1	PURCHASE 2	DONATION 3	TOTAL	RETIREMENTS 5	BALANCE 6	ASSETS 7	
									1

LAND
LAND IMPROVEMENTS
BUILDINGS AND FIXTURES
BUILDING IMPROVEMENTS
FIXED EQUIPMENT
MOVABLE EQUIPMENT
SUBTOTAL
RECONCILING ITEMS
TOTAL 1 2 3 4 5 6 7 8 9

23456789

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PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7 PARTS III 6 IV

			COMPUTATION	OF RATIOS GROSS		ALLO	CATION OF	OTHER CAPITAL OTHER		
	DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
		1	2	3	4	5	6	7	8	
1.01	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS - BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT	246555 2522 196566		246555 2522 196566	.553257 .005659 .441084 .000000			, pri		1 1.01 2 3
	NEW CAP REL COSTS-MVBLE EQUIP TOTAL	445643	3	445643	1.000000					5
					- SUMMARY OF	OLD AND NEW	CAPITAL	OTHER		
	DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES	CAPITAL- RELATED COSTS	TOTAL	
			9	10	11	12	13	14	15	
1.01	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS - BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT	6	246555 2522 177007	19559					246555 2522 196566	1.01
	NEW CAP REL COSTS-MVBLE EQUIP TOTAL		426084	19559					445643	5
	PART IV - RECONCILIATION OF	AMOUNTS F	ROM WORKSHEET	r A, COLUMN	2, LINES 1 - SUMMARY OF	THRU 4 F OLD AND NEW	CAPITAL	OTHER		
	DESCRIPTION		DEPREC- IATION	LEASE	INTEREST	INSURANCE	TAXES'	CAPITAL- RELATED COSTS	TOTAL	
			9	10	11	12	13	14	15	
1.01	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS - BLDG & FIXT OLD CAP REL COSTS-BVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT		246555 2522 177007						246555 2522 177007	1.01
4 5	NEW CAP REL COSTS-MVBLE EQUIP TOTAL		426084						426084	5

WORKSHEET A-8

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

### ADJUSTMENTS TO EXPENSES

FERTOD						WORKSHEET A-8
	ADJUSTMENTS TO EXPENSES	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKS FROM WHICH THE AMOUNT IS TO BE COST CENTER	LINE NO.	WKST A-7 REF 5
	DESCRIPTION	1	2	3	4	3.
2 3 4 5 6 7 8 9	INVESTMENT INCOME-OLD BLDGS & FIXTURES INVESTMENT INCOME-OLD MOVABLE EQUIPMENT INVESTMENT INCOME-NEW BLDGS & FIXTURES INVESTMENT INCOME-NEW MOVABLE EQUIPMENT INVESTMENT INCOME-OTHER TRADE, QUANTITY, AND TIME DISCOUNTS REFUNDS AND REBATES OF EXPENSES RENTAL OF PROVIDER SPACE BY SUPPLIERS TELEPHONE SERVICES (PAY STATIONS EXCL) TELEVISION AND RADIO SERVICE PARKING LOT		×	OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BUBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-BUBLE EQUIP	1 2 3 4	1 2 3 4 5 6 7 8 9 10
11	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-136000			12 13
13 14	SALE OF SCRAP, WASTE, ETC. RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1	1303233	ξ.	4757	14 15
15 16 17	LAUNDRY AND LINEN SERVICE CAFETERIA - EMPLOYEES AND GUESTS RENTAL OF QUARTERS TO EMPLOYEES & OTHERS	В	-168	DIETARY	11	16 17
18 19 20 21	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS SALE OF DRUGS TO OTHER THAN PATIENTS SALE OF MEDICAL RECORDS AND ABSTRACTS NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)				ě	18 19 20 21 22
22 23	VENDING MACHINES INCOME FROM IMPOSITION OF INTEREST,					23
24	FINANCE OR PENALTY CHARGES INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50	26
27 28 29 30 31 32 33	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION UTIL REVIEW-PHYSICIANS' COMPENSATION DEPRECIATIONOLD BUILDINGS & FIXTURES DEPRECIATIONNEW MOVABLE EQUIPMENT DEPRECIATIONNEW MOVABLE EQUIPMENT NON-PHYSICIAN ANESTHETIST	WKST A-8-3		HOME HEALTH AGENCY UTILIZATION REVIEW-SNF OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP NONPHYSICIAN ANESTHETISTS	71 89 1 2 3 4 20	27 28 29 30 31 32 33 34
34 35	PHYSICIANS' ASSISTANT ADJ FOR OCCUPATIONAL THERAPY COSTS IN	WKST				35
36	EXCESS OF LIMITATION - HOSPITAL ADJ FOR SPEECH PATHOLOGY COSTS IN	WKST A-8-4 WKST				36
37 38 39 40 41 42 43 44 45 46 47 48	EXCESS OF LIMITATION - HOSPITAL MISCELLANEOUS-REVENUE	RKST A-8-4 B	-282 1166783		6	37 38 40 41 42 43 44 45 46 47 48
50	TOTAL		1100100			

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

1 2 3	LINE NO. 1 5 6	COST CENTER 2 EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	EXPENSE ITEMS 3 PEIA A & G	AMOUNT OF ALLOWABLE COST 4 1091725 952356	IN WKST A, COL 5) 5 740848	USTMENTS 6 350877 952356	A-7 REF 7	1 2 3
4		TOTALS		2044081	740848	1303233		5

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

MOZINDOMODIICITE VICTORIA	RE	LATED ORGANIZATION(S) AND/OR	HOME OFFICE
SYMBOL NAME (1) 1 2 1 B STATE OF WV 2 B STATE OF WV 3	PERCENT OF NAME OWNERSHIP 3 4 100.00 DEPT. OF HEALTH 100.00 DEPT. OF HEALTH	PERCENT OF OWNERSHIP 5 100.00 100.00	TYPE OF BUSINESS 6
5			¥

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.

B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.

C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.

D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.

E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.

F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.

G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER NO. 5095901 WITHROW HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96) VERSION: 2008.05 168

WORKSHEET A-8-2

PROVIDER-BASED	PHYSICIAN	ADJUSTMENTS

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERA- TION INCL FRINGES 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNAD- JUSTED RCE LIMIT 8	PERCENT OF UNAD- JUSTED RCE LIMIT 9
1 2 101	35 35	NURSING FACILITY NURSING FACILITY TOTAL	PHYSICIANS DENTAL	124000 12000 136000	124000 12000 136000					

169
PROVIDER NO. 5095901 WITHROW HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

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WORKSHEET A-8-2

1.	A ,INE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUST- MENT 18
		NURSING FACILITY NURSING FACILITY TOTAL	PHYSICIANS DENTAL							124000 12000 136000

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WORKSHEET B PART I

# COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	OLD CAP BLDGS & FIXTURES 1	OLD CAP BLDG & FIXTURES 1.01	OLD CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS- TRATIVE & GENERAL 6	MAIN- TENANCE + REPAIRS 7	
2	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT	246555 2522 196566	246555	2522	196566					1 · 1.01 2 3
4 5 6 7 8	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE	2420043 2195117 526271 543932 225754	23719 16146 693 379	153 244	14175 12580 414 4913	2420043 250865 154276	2483876 709426 545039 231290 623781	2483876 197464 151708 64378 173626	906890 2459 29181 9418	5 6 7 8 9
10 11 12 14	HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION	435141 826800 121464 56168	2653 8986 852 46094		1586 5370 509 27546	212409 59244 22650	1053565 182069 152458	293253 50678 42436	31896 3025 163606	11 12 14 15
15 16 17 18 19	CENTRAL SERVICES 6 SUPPLY PHARMACY MEDICAL RECORDS 6 LIBRARY SOCIAL SERVICE RESTORATIVE THERAPY. RECREATION	55518 67405	1567 11141		937 6658	27140 32957	85162 118161	23704 32889	5562 39543	16 17 18 19 19.01 19.02
19.02	STAFF DEVELOPMENT PATIENT ADVOCATE INPATIENT ROUTINE SERV COST CENT. NURSING FACILITY	ERS 3488371	96760		57821	1476101	5119053 7742	1424861 2155	343430 17199	19.03 35 36
36	OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT		4846		2896		1142	2133	11133	62
71	OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		213836	397	135405	2420043	11311622	2457152	645319	71 95
95 100	SUBTOTALS NONREIMBURSABLE COST CENTERS BARBER & BEAUTY	11407627	381	351	228		609	170	1353	100 100.01 100.02
100.0 100.0 100.0	DIVOLUNTEERS DIVOLUNTEERS DISCOUTSIDE MEDICAL SERVICES DISCOUTSIDE MEDICAL SERVICES DISCOUTSIDE MEDICAL SERVICES DISCOUTSIDE MEDICALENTS DISCOUTSIDE MEDICALENTS		4258 3091 24989	2011	2545 41268 17120		6803 46370 42223	1894 12907 11753		100.02 100.03 100.04 100.05 101
101 102 103	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER TOTAL	11407627	246555	2522	196566	2420043	11407627	2483876	906890	

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WORKSHEET B PART I

COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE 9	HOUSE- KEEPING	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES & SUPPLY 15	MEDICAL RECORDS & LIBRARY 17	
1 1.01 2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RESTORATIVE THERAPY RECREATION	699206 20372 6575 22267 2112 114218 3883 27606	345221 127991	941391 48698 4619 249790 8493 60374	1449679 903	903	242503	722508	126804	1 1.01 2 3 4 5 6 6 7 8 9 10 11 12 14 15 16 17 18 19 .01
19.02	RECREATION STAFF DEVELOPMENT PATIENT ADVOCATE INPATIENT ROUTINE SERV COST CENTE NURSING FACILITY OTHER LONG TERM CARE	ERS 239761 12007	217230	524341 26259	1448776	614	242503	722508	126804	19.02 19.03 35 36
62	ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	**************************************								62 71
71 95	HOME HEALTH AGENCY ' SPECIAL PURPOSE COST CENTERS SUBTOTALS	448801	345221	922574	1449679	614	242503	722508	126804	95
100.0 100.0 100.0	NONREIMBURSABLE COST CENTERS BARBER & BEAUTY 11VOLUNTEERS 12OUTSIDE MEDICAL SERVICES 13RENTAL SPACE 14MISCELLANEOUS NON-ALLOWABLE 15VACANT SPACE	945 10552 167923 70985		2066 16751	*	289				100 100.01 100.02 100.03 100.04 100.05
101 102 103	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER TOTAL	699206	345221	941391	1449679	903	242503	722508	126804	102 103

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WORKSHEET B PART I

# COST ALLOCATION - GENERAL SERVICE COSTS

		SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27	
1 1.01 2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19 19.01	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT	278573				1 1.01 2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19 19,01 19,02 19.03
19.03 35 36	PATIENT ADVOCATE INPATIENT ROUTINE SERV COST CENTER NURSING FACILITY OTHER LONG TERM CARE	RS 278573	10688454 65362		10688454 65362	35 36
62 71	ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY					62 71
95	SPECIAL PURPOSE COST CENTERS SUBTOTALS	278573	10753816		10753816	95
100.0 100.0 100.0	NONREIMBURSABLE COST CENTERS BARBER & BEAUTY 11VOLUNTEERS 12OUTSIDE MEDICAL SERVICES 13RENTAL SPACE 14MISCELLANEOUS NON-ALLOWABLE 15VACANT SPACE 15VACANT SPACE 15VACANT SPACE 15VACANT SPACE		5143 289 34363 489055 124967	! } 5	5143 289 34363 489055 124961	100 100.01 100.02 100.03 100.04 100.05 101
102 103	NEGATIVE COST CENTER TOTAL	278573	11407627	1	11407627	103

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WORKSHEET B

BIT OCD TON	OF	OID	CAPITAL.	RELATED	COSTS

COST CENTER DESCRIPTION	DIR ASSGND OLD CAP CAP-REL BLDGS & COSTS FIXTURES 0 1	OLD CAP BLDG & FIXTURES 1.01	OLD CAP MOVABLE EQUIPMENT 2	CAP REL COST TO BE ALLOC 4A	ADMINIS- TRATIVE & GENERAL 6	MAIN- TENANCE + REPAIRS 7	OPERATION OF PLANT 8	
GENERAL SERVICE COST CENTERS  1 OLD CAP REL COSTS-BLDG & FIXT  1.01 OLD CAP REL COSTS - BLDG & FIXT  2 OLD CAP REL COSTS-MYBLE EQUIP  3 NEW CAP REL COSTS-BLDG & FIXT  4 NEW CAP REL COSTS-BLDG & FIXT  5 EMPLOYEE BENEFITS  6 ADMINISTRATIVE & GENERAL  7 MAINTENANCE & REPAIRS  8 OPERATION OF PLANT  9 LAONDRY & LINEN SERVICE  10 HOUSEKEEPING  11 DIETARY  12 CAFETERIA	23719 16146 693 379 2653 8986	244	14175 12580 414 4913 1586 5370	37894 28879 1107 5536 4239 14356	37894 3012 2314 982 2649 4473	31891 86 1026 331 1122	3507 102 33 112	1 1.01 2 3 4 5 6 7 8 9 10 11 12 14
14 NURSING ADMINISTRATION	852 46094		27546	73640	647	5753	573	15
15 CENTRAL SERVICES & SUPPLY 16 PHARMACY 17 MEDICAL RECORDS & LIBRARY 18 SOCIAL SERVICE 19 RESTORATIVE THERAPY 19.01 RECREATION 19.02 STAFF DEVELOPMENT 19.03 PATIENT ADVOCATE	1567 11141		937 6658	2504 17799	362 502	196 1391	19 138	16 17 18 19 19.01 19.02 19.03
11 INPATIENT ROUTINE SERV COST CENT 125 NURSING FACILITY 136 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	rers 96760 4846		57821 2896	154581 7742	21739 33	12077 605	1203 60	35 36
OUTPATIENT SERVICE COST CENTERS								62
OTHER REIMBURSABLE COST CENTERS								71
71 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		. 207	135405	349638	37486	22693	2251	95
95 SUBTOTALS NONREIMBURSABLE COST CENTERS	21383	6 397	34.04.04.00.00.00.00			48	6	100
100 BARBER & BEAUTY 100.01VOLUNTEERS	38	1	228	609	3	46		100.01
100.020UTSIDE MEDICAL SERVICES 100.03RENTAL SPACE 100.04MISCELLANEOUS NON-ALLOWABLE 100.05VACANT SPACE 101 CROSS FOOT ADJUSTMENTS	425 309 2498	2011		6803 46370 42223	29 197 179	531 8619	842	100.03 100.04 100.05 101 102
102 NEGATIVE COST CENTER 103 TOTAL	24655	5 2522	196566	445643	37894	31891	3507	

PROVIDER NO. 5095901 WITHROW HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

ALLOCATION OF OLD CAPITAL RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTION	LAUNDRY + LINEN SERVICE	House- Keeping	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	14	15	17	18	
2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19 19.01	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-WVBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-WVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT	7646 2835	10087 522 49 2677 91 647	20585 13	13	2300	83290	3172	20477	1 1.01 2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19 19.01 19.02 19.03
19.03 35 36	PATIENT ADVOCATE INPATIENT ROUTINE SERV COST CENTI NURSING FACILITY OTHER LONG TERM CARE	ERS 4811	5619 281	20572	9	2300	83290	3172	20477	35 36
	ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS									62
62	OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS									71
71	HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	7646	9886	20585	9	2300	83290	3172	20477	95
95	SUBTOTALS NONREIMBURSABLE COST CENTERS	7040		20303	5					100
100.0 100.0 100.0	BARBER & BEAUTY DIVOLUNTEERS D20UTSIDE MEDICAL SERVICES D3RENTAL SPACE D4MISCELLANEOUS NON-ALLOWABLE D5VACANT SPACE CROSS FOOT ADJUSTMENTS		179		4					100.01 100.02 100.03 100.04 100.05 101
101 102 103	NEGATIVE COST CENTER TOTAL	7646	10087	20585	13	2300	83290	3172	20477	

ALLOCATION OF OLD CAPITAL RELATED COSTS

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96) VERSION: 2008.05 11/30/2010 12:17

> WORKSHEET B PART II

	COST CENTER DESCRIPTION	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL	
2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19 19.00	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MYBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT PATIENT ADVOCATE				1 1.01 2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19 19.01 19.02 19.03
35 36	INPATIENT ROUTINE SERV COST CENTER NURSING FACILITY OTHER LONG TERM CARE	329850 8721		329850 8721	35 36
62 71	ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY				62 71
95	SPECIAL PURPOSE COST CENTERS SUBTOTALS	338571		338571	95
100. 100. 100. 100.	NONREIMBURSABLE COST CENTERS BARBER & BEAUTY DIVOLUNTEERS DZOUTSIDE MEDICAL SERVICES D3RENTAL SPACE D4MISCELLANEOUS NON-ALLOWABLE D5VACANT SPACE CROSS FOOT ADJUSTMENTS	687 4 7416 56207 42758		7416 56207 42758	100 100.01 100.02 100.03 100.04 100.05 101
102 103	NEGATIVE COST CENTER TOTAL	445643		445643	103

WORKSHEET B-1

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	OLD CAP BLDGS & FIXTURES	OLD CAP BLDG & FIXTURES	OLD CAP MOVABLE EQUIPMENT		RECON- CILIATION		MAIN- TENANCE + REPAIRS	
		SQUARE	SQUARE	SQUARE	GROSS			SQUARE	
		FEET 1	FEET 1.01	FEET 2	GROSS SALARIES 5	6A	COST 6	FEET 7	
			1.01	-	Ÿ	•••			
2 3	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS - BLDG & FI OLD CAP REL COSTS-MYBLE EQUIP NEW CAP REL COSTS-BLDG & FIXT	222457	73156	296775					1 1.01 2 3 4
4 5	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS				4949507				5
6	ADMINISTRATIVE & GENERAL	21401	140701-200	21401		-2483876			6
7	MAINTENANCE & REPAIRS	14568 625	4425	18993 625			709426 545039		
9	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	342	7076	7418			231290	7418	9
10	HOUSEKEEPING	2394		2394			623781		
11 12	DIETARY CAFETERIA	8108		8108	434423		1053565	8106	12
14	NURSING ADMINISTRATION	769		769			182069		14
15	CENTRAL SERVICES & SUPPLY	41589		41589	46325		152458	41589	15 16
16 17	PHARMACY MEDICAL RECORDS & LIBRARY	1414		1414	55507		85162	1414	
18 .	SOCIAL SERVICE	10052		10052			118161	10052	
19	RESTORATIVE THERAPY					-	2000		19 19.01
	RECREATION STAFF DEVELOPMENT								19.02
	PATIENT ADVOCATE								19.03
35	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY	87301		87301	3018939		5119053	87301	35
36	OTHER LONG TERM CARE	4372		4372			7742		
	ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINC								62
71	OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY								71
11	SPECIAL PURPOSE COST CENTERS								722
95	SUBTOTALS	19293	11501	204436	4949507	-2483876	8827746	164042	95
100	NONREIMBURSABLE COST CENTERS BARBER & BEAUTY	344	E	344	1		609	344	100
100.01	VOLUNTEERS								100.01
	OUTSIDE MEDICAL SERVICES	3842	,	3842	2		6803	3842	100.02
	RENTAL SPACE MISCELLANEOUS NON-ALLOWABLE	2789					46370	62306	100.04
100.05	VACANT SPACE	2254	3300	2584	7		42223	3	100.05 101
101 102	CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER								102
102	COST TO BE ALLOC PER B PT I	24655	5 2523				2483876		103
104			.03447				. 278344	3 033067	
104 105	UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT II	1.10832	/	. 66234	U		37894	3.933867 31891	105
106	UNIT COST MULT-WS B PT II						.004246	5	106
106	UNIT COST MULT-WS B PT II							,138335	106
107 108	COST TO BE ALLOC PER B PT III UNIT COST MULT-WS B PT III								108
108	UNIT COST MULT-WS B PT III								108

100.04 MISCELLANEOUS NON-ALLOWABLE
100.05 VACANT SPACE
101 CROSS FOOT ADJUSTMENTS
102 NEGATIVE COST CENTER
103 COST TO BE ALLOC PER B PT I
104 UNIT COST MULT-WS B PT I
105 COST TO BE ALLOC PER B PT II
106 UNIT COST MULT-WS B PT II
106 UNIT COST MULT-WS B PT II
107 COST TO BE ALLOC PER B PT II
107 COST TO BE ALLOC PER B PT II

COST TO BE ALLOC PER B PT III UNIT COST MULT-WS B PT III UNIT COST MULT-WS B PT III

106 106 107

108

108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

101 102

108

126804 103 104 4.405364 104

3172 105 106

.110200 106

242503

8.424924

2300

.079906

903

13

.520000

36.120000

722508

83290

7225.080000

832.900000

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	LIBRARY	
		SQUARE FEET 8	POUNDS OF LAUNDRY 9	SQUARE FEET 10	MEALS SERVED 11	MEALS SERVED 12	DIRECT NRSING HRS 14	REQUIS. 15	TIME SPENT 17	
2 3 4 5 6 7 8 9 10 11 12 14 15 16 17	GENERAL SERVICE COST CENTERS OLD CAP REL COSTS-BLDG & FIXT OLD CAP REL COSTS - BLDG & FI OLD CAP REL COSTS - WBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE		36892		86650 54		28784	100	28784	1 1.01 2 3 4 5 6 7 8 9 10 11 12 14 15 16 17
19.02	SOCIAL SERVICE RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT PATIENT ADVOCATE	10032		10032						19 19.01 19.02 19.03
	INPATIENT ROUTINE SERV COST C		62614	87301	8660	1	7 28784	100	28784	35
35 36	NURSING FACILITY OTHER LONG TERM CARE	87301 4372		4372		•				36
62	ANCILLARY SERVICE COST CENTER OUTPATIENT SERVICE COST CENTE OBSERVATION BEDS (NON-DISTING	ERS								62
71	OTHER REIMBURSABLE COST CENTE HOME HEALTH AGENCY	CRS								71
95	SPECIAL PURPOSE COST CENTERS SUBTOTALS	163417	9950	153605	8665	8 1	7 2878	100	28784	95
100 100.01 100.02	NONREIMBURSABLE COST CENTERS BARBER & BEAUTY 1 VOLUNTEERS 2 OUTSIDE MEDICAL SERVICES	344		344	i		8			100 100.01 100.02 100.03
100.04	RENTAL SPACE MISCELLANEOUS NON-ALLOWABLE VACANT SPACE	3842 6114 2584	1	278	9					100.04

941391

10087

.064356

6.006144

1449679

20585

.237543

16.728738

25847

699206

3507

2.746357

.013775

345221

7646

3.469349

.076840

### WORKSHEET B-1

### COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION

SOCIAL SERVICE

TIME SPENT 18

	18		
1 1.01 2 3 4 5 6 7 7 8 9 10 11 12 14 15 16 17 18 19 19.01 19.02	RESTORATIVE THERAPY RECREATION STAFF DEVELOPMENT PATIENT ADVOCATE	784	1 1,01 2 3 4 5 6 7 8 9 10 11 12 14 15 16 17 18 19 19.01 19.02 19.03
35	INPATIENT ROUTINE SERV COST CENTERS NURSING FACILITY 28	784	35 36
36	OTHER LONG TERM CARE		30
62	ANCILLARY SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	2784	62 71 95
100.02 100.03 100.04	NONREIMBURSABLE COST CENTERS BARBER & BEAUTY VOLUNTEERS OUTSIDE MEDICAL SERVICES RENTAL SPACE MISCELLANEOUS NON-ALLOWABLE VACANT SPACE CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT I UNIT COST MULT-WS B PT I COST TO BE ALLOC PER B PT II ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II  ONTO TO BE ALLOC PER B PT II	8573 8050 0477 1402	100 100.01 100.02 100.03 100.05 101 102 103 104 104 105 106 106 107 108

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (5/1999) VERSION: 2008.05 11/30/2010 12:17

WORKSHEET C PART I

COMPUTATION	OF.	KATTO OF	COST	10	CHARGES

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART 1, COL 27)	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS	0.00000					35
35	NURSING FACILITY	10688454					36
36	OTHER LONG TERM CARE	65362					30
	ANCILLARY SERVICE COST CENTERS						
	OUTPATIENT SERVICE COST CENTERS						62
62	OBSERVATION BEDS (NON-DISTI						0.2
	OTHER REIMBURSABLE COST CENTERS						101
101	SUBTOTAL	10753816					101
102	LESS OBSERVATION BEDS						102
103	TOTAL	10753816					103

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C PART I (CONT)

			CHARGES		COST OR OTHER	TEFRA INPATIENT	PPS INPATIENT
	COST CENTER DESCRIPTION	INPATIENT 6	OUTPATIENT 7	TOTAL 8	RATIO 9	RATIO 10	RATIO 11
	INPATIENT ROUTINE SERV COST C	ENTERS					35
35	NURSING FACILITY	11381275		11381275			36
36	OTHER LONG TERM CARE						-
	ANCILLARY SERVICE COST CENTER						
	OUTPATIENT SERVICE COST CENTE	CRS					62
62	OBSERVATION BEDS (NON-DISTI	B Dobodia					# E
	OTHER REIMBURSABLE COST CENTE	ERS		11381275			101
101	SUBTOTAL	11381275		11301213			102
102	LESS OBSERVATION BEDS			11381275			103
103	TOTAL.			11301273			- 1- 5:

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### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART I

	(	) TITLE	TANI-V	1	)	TITLE	XVIII-PAR	A T		(XX) T	TLE XIX-I	TAN		
PART I - ALL PR	OVIDER COMPON	ENTS					HOSPITAL (OTHER)	SUB	I	SUB II	ŞUB III	SUB IV	NF (OTHER) (50-95901	
	INPATIENT	DAYS					(50-95901 1	1		1	1	1	1	
1 INPATIENT D	YS (INCLUDING	PRIVATI	E ROOM DAYS	AND SWING-E	BED	DAYS							28784	1
EXCLUDING NO 2 INPATIENT DA	EWBORN)												28784	2
BED AND NEW! 3 PRIVATE ROOM 4 SEMI-PRIVATE 5 TOTAL SWING	BORN DAYS) M DAYS (EXCLUD E ROOM DAYS (E	ING SWI	NG-BED PRIVA G SWING-BED	TE ROOM DAY	YS) OM	DAYS)							28784	3 4 5
ROOM DAYS) '	THROUGH DECEMB	ER 31 0	F THE COST R	EPORTING P	CRI	QD								6
6 TOTAL SWING- ROOM DAYS)	AFTER DECEMBER	31 OF	THE COST REP	ORTING PER	IOU	)								7
7 TOTAL SWING	-BED NF-TYPE I THROUGH DECEME	NPATIEN ER 31 O	T DAYS (INCL F THE COST R	PRIVATE EPORTING P	ERI	OD								8
8 TOTAL SWING	-BED NF-TYPE I	NPATIEN	T DAYS (INCL	PRIVATE										
9 INPATIENT D	AFTER DECEMBER AYS INCLUDING	PRIVATE	ROOM DAYS A	PPLICABLE	TO	THE							28353	9
PROGRAM (EX 10 SWING-BED S	CLUDING SWING-	BED AND	NEWBORN DAY	S)										10
ONLY (INCLU COST REPORT	DING PRIVATE F	ENT DAY	S) THROUGH D	TO TITLE	VVX	III								11
COST REPORT 12 SWING-BED N	ING PERIOD													12
ONLY (INCLU	DING PRIVATE I	ROOM DAY	'S) THROUGH I	ECEMBER 31	O.	FTHE								13
13 SWING-BED N ONLY (INCLU COST REPORT	DING PRIVATE	ENT DAYS	S APPLICABLE (S) AFTER DEC	EMBER 31 C	F	THE	•							
14 MEDICALLY N	ECESSARY PRIVI	ATE ROOM	DAYS APPLIC	ABLE TO TH	E									14
PROGRAM (EX 15 TOTAL NURSE	CLUDING SWING- RY DAYS	-BED DAY	(8)											15 16
16 TITLE V OR		AYS												10

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### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART I (CONT)

[ ] TITLE V-INPT [ ] TIT	LE XVIII-PART A	i.	(XX) TIT	LE XIX-IN	PT		
PART I - ALL PROVIDER COMPONENTS	HOSPITAL SU (OTHER) (50-95901	BI	SUB II	SUB III		NF (OTHER) (50-95901	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
10 MEDICALD RATE FOR SWING-BED NE SERVICES APPLICABLE TO							19
SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD 20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO							20
SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST						10688454	21 22
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							23
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							24
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							25
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							26
26 TOTAL SWING-BED COST 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST				i.	82	10688454	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES							28
(EXCLUDING SWING-BED CHARGES) 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29 30
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							31
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32 33
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE 34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34 35
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL						10688454	36 37
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL						10000424	37
THE FULL THE WOOL OVER SECTION.							

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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#### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART II

	[ ] TITLE V-INPT [ ] TITLE XVI	III-PART A		(XX) TITLE	XIX-INPT		PART II
PART		HOSPITAL SUB (OTHER) (50-95901	s r	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 1		1	1	1	
38 39 40 41	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST						38 39 40 41
		TOTAL I/P COS 1	ST	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLES V AND XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						42
43 44 45 46 47	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						43 44 45 46 47
		HOSPITAL S	SUB	I SUB I	I SUB II	II SUB IV	
		(50-95901 1	1	1	1.	1	
48 49	PROGRAM INPATIENT ANCILLARY SERVICE COST TOTAL PROGRAM INPATIENT COSTS						48 49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 53	TOTAL PROGRAM EXCLUDABLE COST TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						52 53

# KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PART II (CONT)

	[ ] TITLE V-INPT	(	) TITLE	XVIII-PART	A	(XX) TITLE	XIX-INPT			
PART II - HOSPITAL AND SU	BPROVIDERS ONLY			HOSPITAL (OTHER) (50-95901		I SUB II	SUB III	SUB IV	8	
54 PROGRAM DISCHARGES 55 TARGET AMOUNT PER D	UNT AND LIMITATION COMPUTAT) ISCHARGE ADJUSTED INPATIENT OPERATING		AND	1	1	1	1	1		54 55 56 57
TARGET AMOUNT 58 BONUS PAYMENT	THE 54 OR LINE 55 FROM THE	COST R	ÉPORTING	3						58 58.01
DEDIAN ENDING 1996	UPDATED & COMPOUNDED BY THE	e there	IEI DHON	ET						58.02
REPORT UPDATED BY T	THE MARKET BASKET IS LESS THAN THE LOWER OF L	INES 5	5, 58.0	1						58.03
COSTS ARE LESS THAN 58.04 RELIEF PAYMENT 59 ALLOWABLE INPATIENT 59.01 ALLOWABLE INPATIENT 59.02 PROGRAM DISCHARGES 59.03 PROGRAM DISCHARGES 59.04 PROGRAM DISCHARGES 59.05 REDUCED INPAT COST 59.06 REDUCED INPAT COST	COST PLUS INCENTIVE PAYMENT COST PER DISCHARGE (LTCH OF PRIOR TO JULY 1 AFTER JULY 1 (SEE INSTRUCTIONS) PER DISCHARGE FOR DISCHARGE PER DISCHARGE (SEE INSTR.) COST PLUS INCENTIVE PAYMENT	PRIOR TO LICH (SEE	TO JULY ER JULY ONLY) INSTR.)	1 1						58.04 59.01 59.02 59.03 59.04 59.05 59.06 59.07 59.08
	PROGRAM INPATIENT ROUTIN	ie swii	NG BED C	OST						60
60 MEDICARE SWING-BED	SNF INPATIENT ROUTINE COSTS COST REPORTING PERIOD	5 THRO	UGH							61
61 MEDICARE SWING-BED	SNF INPATIENT ROUTINE COSTS	S AFTE	R							1000
62 TOTAL MEDICARE SWII	COST REPORTING PERIOD NG-BED SNF INPATIENT ROUTINE NG-BED NF INPATIENT ROUTINE	COSTS	S THROUGH	I						62 63
DECEMBED 31 OF THE	COST REPORTING PERIOD NG-BED NF INPATIENT ROUTINE									64
DECEMBED 31 OF THE	COST REPORTING PERIOD IX SWING-BED NF INPATIENT RO									65

### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (11/98)

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#### COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III 6 IV

( ) TITLE V-INPT	[ ] TITLE >	(XX) A TRACTION	TITLE XIX-INPT	
PART III - SKILLED NURSING FACILITY, NURSING FACILIT	Y AND ICF/MR ONI	NF (OTHER) (50-95901		941
66 SHF/NF/ICF/MR ROUTINE SERVICE COST 67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST 68 PROGRAM ROUTINE SERVICE COST 69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE 70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE C 71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTI 72 PER DIEM CAPITAL RELATED COSTS 73 PROGRAM CAPITAL RELATED COSTS 74 INPATIENT ROUTINE SERVICE COST 75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COS 76 TOTAL PGM ROUTINE SERVICE COST FOR COMPARISON TO 77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATIO 78 INPATIENT ROUTINE SERVICE COST LIMITATION 79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	TO PROGRAM COSTS NE SERV COSTS STS COST LIMIT	1 10688454 371.33 10528319 10528319 329850 11.46 324925 10203394 400.00 11341200 10528319	3 · 2	66 67 68 69 70 71 72 73 74 75 76 77
80 PROGRAM INPATIENT ANCILLARY SERVICES 81 UTILIZATION REVIEWPHYSICIAN COMPENSATION 82 TOTAL PROGRAM INPATIENT OPERATING COSTS		10528319		80 81 82

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1 PARTS III & IV

[ ] TITLE V-INPT

[ ] TITLE XVIII-PART A

(XX) TITLE XIX-INPT

HOSPITAL SUB I SUB II SUB III SUB IV (OTHER) (50-95901 1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 85 OBSERVATION BED COST

83 84 85

#### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/1999)

(XX) TITLE XIX

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### WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

( ) TITLE V

		HOSPITAL (50-95901) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (50-95901) (OTHER)	
1 2 3 4	COMPUTATION OF NET COST OF COVERED SERVICES INPATIENT HOSPITAL/SNE/NF SERVICES MEDICAL AND OTHER SERVICES INTERNS AND RESIDENTS ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O	1	1	1	1	1	1 10528319	1 2 3 4
5 6 7 8	COST OF TEACHING PHYSICIANS SUBTOTAL INPATIENT PRIMARY PAYER PAYMENTS OUTPATIENT PRIMARY PAYER PAYMENTS						10528319	6 7 8 9
9 10 11 12 13 14 15 16	SUBTOTAL  COMPUTATION OF LESSER OF COST OR CHARGES ROUTINE SERVICE CHARGES ANCILLARY SERVICE CHARGES INTERNS AND RESIDENTS SERVICE CHARGES ORGAN ACQUISITION CHARGES, NET OF REVENUE TEACHING PHYSICIANS INCENTIVE FROM TARGET AMOUNT COMPUTATION TOTAL REASONABLE CHARGES						11217375	10 11 12 13 14 15
17 18	CUSTOMARY CHARGES AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN							17 18
19 20 21 22 23	ACCORDANCE WITH 42 CFR 413.13(E) RATIO OF LINE 17 TO LINE 18 TOTAL CUSTOMARY CHARGES EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES COST OF COVERED SERVICES						11217375 689056 10528319	21 22
24 25 26 27 28 29 30 31 32 33	PROSPECTIVE PAYMENT AMOUNT OTHER THAN OUTLIER PAYMENTS OUTLIER PAYMENTS PROGRAM CAPITAL PAYMENTS CAPITAL EXCEPTION PAYMENTS ROUTINE SERVICE OTHER PASS THROUGH COSTS ANCILLARY SERVICE OTHER PASS THROUGH COSTS SUBTOTAL CUSTOMARY CHARGES (TITLE XIX PPS COVERED LESSER OF LINES 30 OR 31 DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						10528319 10528319	31

( ) TITLE XVIII

### KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/1999)

(XX) TITLE XIX

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WORKSHEET E-3 PART III

# CALCULATION OF REIMBURSEMENT SETTLEMENT PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

[ ] TITLE V

	( ) 11100 4	( )			36192560.6			
		HOSPITAL (50-95901) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (50-95901) (OTHER)	
		1	1	1	1	1	1	
34 35 36 37 38 38.01 38.02 39 40 41 42 43 44	COMPUTATION OF REIMBURSEMENT SETTLEMENT EXCESS OF REASONABLE COST SUBTOTAL COINSURANCE SUM OF AMOUNTS FROM WKST E, PARTS C, D AND E, REIMBURSABLE BAD DEBTS REDUCED REIMBURSABLE BAD DEBTS REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) UTILIZATION REVIEW SUBTOTAL INPATIENT ROUTINE SERVICE COST MEDICARE INPATIENT ROUTINE CHARGES AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM	1		•	•			34 35 36 37 38 38.01 38.02 39 40 41 42 43 44
45 46 47 48 49 50 51 52 53	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) RATIO OF LINE 43 TO LINE 44 TOTAL CUSTOMARY CHARGES EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION OTHER ADJUSTMENTS AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS SUBTOTAL INDIRECT MEDICAL EDUCATION ADJUSTMENT DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		ı				10528319	53 54 55
55 56 57 57,01	TOTAL AMOUNT PAYABLE TO THE PROVIDER SEQUESTRATION ADJUSTMENT INTERIM PAYMENTS TENTATIVE SETTLEMENT (FOR FI USE ONLY) BALANCE DUE PROVIDER/PROGRAM					a	9293870 1234449	56 57 57.01 58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2							59

[ ] TITLE XVIII

WORKSHEET G

#### BALANCE SHEET

**	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
1 2	CURRENT ASSETS CASH ON HAND AND IN BANKS TEMPORARY INVESTMENTS	43977				1 2 3
3 4 5 6	NOTES RECEIVABLE ACCOUNTS RECEIVABLE OTHER RECEIVABLES ALLOWANCE FOR UNCOLLECTIBLE	866848				4 5
7 8	NOTES & ACCOUNTS RECEIVABLE INVENTORY PREPAID EXPENSES	109504				6 7 8
9 10 11	OTHER CURRENT ASSETS DUE FROM OTHER FUNDS TOTAL CURRENT ASSETS	1020329				9 10 11
	FIXED ASSETS					
12 12.01	ACCUMULATED DEPRECIATION	457400				12 12.01
13	LAND IMPROVEMENTS	295805				13
13.01	ACCUMULATED DEPRECIATION BUILDINGS	-223951 4519128				13.01 14
14.01 15	ACCUMULATED DEPRECIATION LEASEHOLD IMPROVEMENTS ACCUMULATED AMORTIZATION	-2773031		140		14.01 15 15.01
16	FIXED EQUIPMENT	2558752				16
16.01 17	ACCUMULATED DEPRECIATION AUTOMOBILES AND TRUCKS	-1000659 61480				16.01 17
17.01	ACCUMULATED DEPRECIATION	-52605				17.01
18 01	MAJOR MOVABLE EQUIPMENT ACCUMULATED DEPRECIATION	3522764 -2906593				18 18.01
19	MINOR EQUIPMENT DEPRECIABLE	-2900333				19
19.01 20	ACCUMULATED DEPRECIATION					19.01 20
21	MINOR EQUIPMENT-NONDEPRECIABLE TOTAL FIXED ASSETS	4458490				21
	OTHER RECETE					
22	OTHER ASSETS INVESTMENTS					22
23	DEPOSITS ON LEASES					23 24
24 25	DUE FROM OWNERS/OFFICERS OTHER ASSETS					25
26	TOTAL OTHER ASSETS					26
27	TOTAL ASSETS	5478819				27
	LIABILITIES AND FUND BALANCES	GENERAL	SPECIFIC	ENDOWMENT	PLANT	
		FUND	PURPOSE	FUND	FUND	
			FUND	FUND 3	4 4	
•	CURRENT LIABILITIES	1				20
28 29	ACCOUNTS PAYABLE	1 262282	FUND			28 29
29 30	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE	1	FUND			29 30
29 30 31	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (SHORT TERM)	1 262282 271125	FUND			29 30 31
29 30 31 32 33	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOAMS PAYABLE (SHORT TERM) DEFERRED INCOME ACCELERATED PAYMENTS	1 262282 271125 307256	FUND			29 30 31 32 33
29 30 31 32 33 34	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (SHORT TERM) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS	1 262282 271125	FUND			29 30 31 32 33
29 30 31 32 33	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOAMS PAYABLE (SHORT TERM) DEFERRED INCOME ACCELERATED PAYMENTS	1 262282 271125 307256	FUND			29 30 31 32 33
29 30 31 32 33 34 35	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (SHORT TERM) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES	1 262282 271125 307256	FUND			29 30 31 32 33 34 35
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29 30 31 32 33 34 35 36 37 38 39	ACCOUNTS PAYABLE SALARIES, WAGES & FEES PAYABLE PAYROLL TAXES PAYABLE NOTES & LOANS PAYABLE (SHORT TERM) DEFERRED INCOME ACCELERATED PAYMENTS DUE TO OTHER FUNDS OTHER CURRENT LIABILITIES TOTAL CURRENT LIABILITIES LONG-TERM LIABILITIES MORTGAGE PAYABLE NOTES PAYABLE UNSECURED LOANS LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66	1 262282 271125 307256	FUND			29 30 31 32 33 34 35 36 37 38 39 40
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# KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2008.05 11/30/2010 12:17

WORKSHEET G-1

#### STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND	SPECIFIC PURPOSE 2	FUND ENDOWMENT	FUND PLANT FUND	
		_				
1	FUND BALANCES AT BEGINNING OF PERIOD	3283540			1	
2	NET INCOME (LOSS)	-1944135			2	
3	TOTAL	1339405			3	
4	ADDITIONS (CREDIT ADJUSTMENTS)	3254774			4	
5					5	
6					6	
7					7	
8					8	
9					9	
10	TOTAL ADDITIONS	3254774			10	
11	SUBTOTAL	4594179			11	
12	DEDUCTIONS (DEBIT ADJUSTMENTS)				12	
13					13	
14					14	
15	5				15	
16					16	
17					17	
18	TOTAL DEDUCTIONS				18	
	FUND BALANCE AT END OF PERIOD	4594179			19	
13	PER BALANCE SHEET					

# KPMG LLP COMPU-MAX MICRO SYSTEM VERSION: 2008.05 IN LIEU OF FORM CMS-2552-96 (9/96) 11/30/2010 12:17

### STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2 PARTS I & II

### PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
1 2 4 5	GENERAL INPATIENT ROUTINE CARE SERVICES HOSPITAL SUBPROVIDER I SWING BED - SNF SWING BED - NF SKILLED NURSING FACILITY	1	2	3	1 2 4 5
7	NURSING FACILITY	11381275		11381275	6 7
8	OTHER LONG TERM CARE	11001110		11301273	8
9	TOTAL GENERAL INPATIENT CARE SERVICES	11381275		11381275	9
10 11 12 13 14 15 16 17 18 19 20 21	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE TOTAL INPATIENT ROUTINE CARE SERVICES ANCILLARY SERVICES OUTPATIENT SERVICES HOME HEALTH AGENCY AMBULANCE CORF	11381275		11381275	10 11 12 13 14 15 16 17 18 19 20
22 23 24	ASC HOSPICE				21 22 23 24
25	TOTAL PATIENT REVENUES	11381275		11381275	25
	PART II - OPERATING	EXPENSES			
26	ADDINATIO DUDINATA	1		2	Navian.
26 27 28 29 30 31 32	OPERATING EXPENSES ADD (SPECIFY)			10240844	26 27 28 29 30 31 32
33 34 35 36 37 38 39	TOTAL ADDITIONS DEDUCT (SPECIFY)  TOTAL DEDUCTIONS				32 33 34 35 36 37 38 39
40	TOTAL OPERATING EXPENSES			10240844	40

WORKSHEET G-3

KPMG LLP COMPU-MAX MICRO SYSTEM IN LIEU OF FORM CMS-2552-96 (9/96)

PROVIDER NO. 5095901 WITHROW HOSPITAL PERIOD FROM 07/01/2009 TO 06/30/2010

STATEMENT OF REVENUES AND EXPENSES

#### DESCRIPTION

2 LESS 3 NET 4 LESS	AL PATIENT REVENUES S - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS PATIENT REVENUES S - TOTAL OPERATING EXPENSES INCOME FROM SERVICE TO PATIENTS	11381275 3156246 8225029 10240844 -2015815	1 2 3 4 5
7 . INCC 8 REVE 9 REVE 10 PURC 11 REB# 12 PAR# 13 REVE 14 REVE 15 REVE 16 REV 17 REVE 18 REVE 19 TUI' 20 REVI	TRIBUTIONS, DONATIONS, BEQUESTS, ETC.  OME FROM INVESTMENTS ENUE FROM TELEPHONE AND TELEGRAPH SERVICE ENUE FROM TELEVISION AND RADIO SERVICE CHASE DISCOUNTS ATES AND REFUNDS OF EXPENSES KING LOT RECEIPTS ENUE FROM LAUNDRY AND LINEN SERVICE ENUE FROM LAUNDRY AND LINEN SERVICE ENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS ENUE FROM RENTAL OF LIVING QUARTERS 'FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS 'ENUE FROM SALE OF DEUGS TO OTHER THAN PATIENTS 'ENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS TION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) TENUE FROM GITTS, FLOMER, COFFEE SHOPS, CANTEEN	168	6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21
22 REN	ITAL OF VENDING MACHINES ITAL OF HOSPITAL SPACE VERNMENTAL APPROPRIATIONS	71230	22
24 MISC 25 TOTA 26 TOTA 27 28 29	CCELLANEOUS PAL OTHER INCOME PAL	282 71680 -1944135	24 25 26 27 28 29 30
	TAL OTHER EXPENSES T INCOME (OR LOSS) FOR THE PERIOD	-1944135	31



# STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin Governor Bureau for Behavioral Health and Health Facilities 350 Capitol Street, Room 350 Charleston, West Virginia 25301 Telephone: (304) 558-0627 Fax: (304) 558-2230 Michael J. Lewis, M.D., Ph.D. Cabinet Secretary

### MEMORANDUM

To:

Vickie Jones, Commissioner

Bureau for Behavioral Health and Health Facilities

From:

Jennifer Jarrell, Accountant IV

Bureau for Behavioral Health and Health Facilities

Date:

June 17, 2011

Subj:

Medicaid Rates for Fiscal Year Ending 2012

Attached is the rate schedule for the state owned health care facilities for fiscal year ending June 30, 2012. The enhanced FMAP ends June 30, 2011 and the rate goes back to .7324 on July 1, 2011. The rate then changes to .7262 beginning October 1, 2011. These changes are detailed on the attached rate schedule.

If you have any questions, do not hesitate to contact me at 356-4803 or email me at Jennifer.L.Jarrell@wv.gov.

#### Attachment

cc:

Debra Cook

Craig Richards

Nancy Atkins, Commissioner for BMS

Nora McQuain, BMS Tina Bailes, BMS Kelly Johnson, BMS Betty Jo Scarberry, BCF

Sue Buster, BCF Anita M. Hayes, BCF Terri J. Cook, BCF

Tammy Pritt-Jones, BCF

Maria Carr, Hopemont
Betsy Strawser, Hopemont
Linda Dailey, Lakin Hospital
Carol Staats, Lakin Hospital
Carol Merrill, Manchin Health Care
Linda Pruitte, Manchin Health Care
Angela Booker, Withrow Hospital
Carla Parent, Withrow Hospital
Walt Garrett, Welch Community
Johnny Brant, Welch Community

DEPARTMENT OF HEALTH & HUMAN RESOURCES Long Term Care Facilities Fiscal Year 2012 Medicaid Interim Rates As of July 1, 2011

		and American Control of	
GROSS CHARGE	MEDICAID INTERIM	MEDICAID CONTRACTUAL	FFP RATE PAYMENT
RATE	RATE	ALLOWANCE	
RATES - July 1, 2	011 to Septembe	r 30, 2011	(0.7324)
\$250.00	\$225.00	\$25.00	\$164.79
\$450.00	\$275.00	\$175.00	\$201.41
\$215.00	\$190.00	\$25.00	\$139.16
\$450.00	\$360.00	\$90.00	\$263.66
\$205.00	\$180.00	\$25.00	\$131.83
RATES - October	1, 2011 to June 3	30, 2012	(0.7262)
\$250.00	\$225.00	\$25.00	\$163.40
\$450.00	\$275.00	\$175.00	\$199.71
\$215.00	\$190.00	\$25.00	\$137.98
\$450.00	\$360.00	\$90.00	\$261.43
\$205.00	\$180.00	\$25.00	\$130.72
	CHARGE RATE  RATES - July 1, 2  \$250.00 \$450.00 \$215.00 \$450.00 \$205.00  RATES - October  \$250.00 \$450.00 \$450.00 \$450.00 \$450.00	CHARGE RATE  RATES - July 1, 2011 to Septembe  \$250.00 \$225.00 \$450.00 \$190.00 \$450.00 \$275.00 \$215.00 \$190.00 \$450.00 \$360.00	CHARGE RATE RATE ALLOWANCE  RATES - July 1, 2011 to September 30, 2011  \$250.00 \$225.00 \$25.00 \$25.00 \$450.00 \$175.00 \$190.00 \$25.00 \$450.00 \$180.00 \$25.00  RATES - October 1, 2011 to June 30, 2012  \$250.00 \$225.00 \$25.

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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

PURCHASE ORDER NO BHS90044

PAGE 1

BLANKET RELEASE

CORRECT PURCHASE ORDER NUMBER MUST APPEAR ON ALL PACKAGES, INVOICES, AND SHIPPING PAPERS, QUESTIONS CONCERNING THIS PUR-CHASE ORDER SHOULD BE DIRECTED TO THE BUYER AS NOTED BELOW.

CHANGE ORDER ....

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

HEALTH AND HUMAN RESOURCES BBH/HF **ROOM 350** 350 CAPITOL STREET CHARLESTON, WV

25301-3702

BOOKE

\*709041713 304-346-0441 ARNETT & FOSTER PLLC PO BOX 2629

CHARLESTON WV 25329

HEALTH AND HUMAN RESOURCES BBH/HF ROOM 350 350 CAPITOL STREET CHARLESTON, WV

25301-3702

304-558-3672

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QUANTITY H18881 DESTINATION PREPAID UOP VENDOR ITEM NO LINE UNITPRICE AMOUNT DELIVERY DATE CATINO ITEM NUMBER CONTRACT THE VENDOR, ARNETT & FOSTER, P.L. L.C., AGREES TO ENTER WITH THE AGENCY, WV DEPARTMENT OF HEALTH AND HUMAN INTO A CONTRACT TO PROVIDE ACCOUNTING RESOURCES, SERVICES FOR BBH/HF ROOM 350, 350 CAPITOL STREET, CHARLESTON, WV 25301-3702 PER THE SPECIFICATIONS, TERMS AND CONDITIONS, BID REQUIREMENTS, ADDENDUM NO. 1 DATED 10/1/2008, ADDENDUM NO. 2 DATED 10/8/2008, AND THE VENDOR'S BID DATED 10/21/2008 INCORPORATED HEREIN BY REFERENCE AND MADE A PART OF HEREOF. PURCHASING DIVISION CERTIFIED ENCUMBERED 6 2008 Beverly Tolo 0001 72,500.00000 YR 11/01/2008 946 - 10ACCOUNTING SERVICES CONTRACT TO OBTAIN THE SERVICES OF A CERTIFIED PUBLIC ACCOUNTING FIRM WITH HEALTHCARE FINANCIAL MANAGEMENT EXPERIENCE TO PROVIDE TECHNICAL ASSISTANCE F APPROVAL AS TO FORM IS REQUIRED BY ATTORNEY GENERAL, CHECK HERE 72,500.00

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Department of Administration
Purchasing Division
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Charleston, WV 25305-0130

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HEALTH AND HUMAN RESOURCES
BBH/HF
ROOM 350
350 CAPITOL STREET
CHARLESTON, WV

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\*709041713 304-346-0441 ARNETT & FOSTER PLLC PO BOX 2629

CHARLESTON WV 25329

HEALTH AND HUMAN RESOURCES BBH/HF ROOM 350 350 CAPITOL STREET CHARLESTON, WV

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HEALTH AND HUMAN RESOURCES BBH/HF ROOM 350 350 CAPITOL STREET

CHARLESTON, WV

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\*709041713 304-346-0441 ARNETT & FOSTER PLLC PO BOX 2629

CHARLESTON WV 25329

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BBH/HF ROOM 350 350 CAPITOL STREET CHARLESTON, WV

HEALTH AND HUMAN RESOURCES

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### BID SCHEDULE SHEET

The price(s) quoted in the vendor's Quotation will not be subject to any increase and will be considered firm for the life of the contract. Unit costs shall be firm and include all costs in the bid response. Bidder is to provide an all-inclusive price for each service/tasks to be provided as requested in Section 2.2.

# A. The vendor shall provide technical assistance and in-service training as follows:

1. General accounting/technical assistance for healthcare facilities. 2. Medicare and Medicaid cost accounting and statistical methods for reporting purposes. 3. In-service training - a minimum of three (3) per year, two (2) day sessions or as requested by BHHF, at locations designated by OHF.  B. The vendor will provide technical assistance in compiling the accounting documents necessary to complete the cost reports for:  Facility  1. Hopemont Hospital 2. Lakin Hospital 3. Pinecrest Hospital 4. Total "Task B" 5,000 6,000 6,000 6. The vendor will review the completed cost reports for:  Total "Task B" All-Inclusive Cost." All-Inclusive Cost. Task B"		General Administrative Services	All-Inclusive Cost / Task
healthcare facilities.  Medicare and Medicaid cost accounting and statistical methods for reporting purposes.  In-service training - a minimum of three (3) per year, two (2) day sessions or as requested by BHHF, at locations designated by OHF.  Total "Task A" 9,000  The vendor will provide technical assistance in compiling the accounting documents necessary to complete the cost reports for:  Facility Cost / Task  Hopemont Hospital 2,000  Lakin Hospital 2,000  C. The vendor will review the completed cost reports for:  Facility Total "Task B" 6,000  C. The vendor will review the completed cost reports for:  Facility Cost / Task  All-Inclusive Cost / Task  All-Inclusive Cost / Task  Lakin Hospital 2,500  Lakin Hospital 2,500  John Manchin Sr. Health Care Center  4. Pinecrest Hospital 2,500			
2. Medicare and Medicaid cost accounting and statistical methods for reporting purposes. 3. In-service training - a minimum of three (3) per year, two (2) day sessions or as requested by BHHF, at locations designated by OHF.  B. The vendor will provide technical assistance in compiling the accounting documents necessary to complete the cost reports for:  Facility  1. Hopemont Hospital 2. Lakin Hospital 3. Pinecrest Hospital 4. Total "Task B"  Cost / Task  Cost / Task  All-Inclusive Cost / Task  All-Inclusive Cost / Task  Cost / Task  Lakin Hospital 3. Pinecrest Hospital 4. Hopemont Hospital 5. Lakin Hospital 6.000  C. The vendor will review the completed cost reports for: Facility  All-Inclusive Cost / Task  Cost / Task  John Manchin Sr. Health Care Center  4. Pinecrest Hospital	1.	hootthcare facilities	2,000
1. Hopemont Hospital 2. Lakin Hospital 3. Pinecrest Hospital 4. Hopemont Hospital 4. Lakin Hospital 5,000  C. The vendor will review the completed cost reports for: Facility 5,000  All-Inclusive Cost / Task B"  All-Inclusive B,000  All-Inclusive Cost / Task B"  All-Inclusive	2.	Medicare and Medicaid cost accounting and	2,000
BHHF, at locations designated by OHF.  Total "Task A" 9,000  The vendor will provide technical assistance in compiling the accounting documents necessary to complete the cost reports for:  Facility  All-Inclusive Cost / Task  1. Hopemont Hospital 2,000 2,000 2,000 2,000 2,000 2,000 3. Pinecrest Hospital  Total "Task B" 6,000  C. The vendor will review the completed cost reports for: Facility  All-Inclusive Cost / Task Cost / Task  1. Hopemont Hospital 2,500 2,500 2,500 3. John Manchin Sr. Health Care Center 4. Pinecrest Hospital	3.	In-service training - a minimum of three (3) per year, two (2) day sessions or as requested by	5,000
All-Inclusive Facility  All-Inclusive Cost / Task  1. Hopemont Hospital 2. Lakin Hospital 3. Pinecrest Hospital  Total "Task B"  6,000  C. The vendor will review the completed cost reports for: Facility  1. Hopemont Hospital 2,500  2,500  2,000  4. Pinecrest Hospital 2,000  4. Pinecrest Hospital 2,500  2,500		11 1! decidented by limit	9,000
All-Inclusive Cost / Task  1. Hopemont Hospital 2. Lakin Hospital 3. Pinecrest Hospital  Cost / Task B"  Total "Task B"  All-Inclusive 6,000  All-Inclusive 7			B
All-Inclusive Facility  All-Inclusive Cost / Task  1. Hopemont Hospital 2. Lakin Hospital 3. Pinecrest Hospital  Total "Task B"  All-Inclusive 6,000  Total "Task B"  All-Inclusive 6,000  All-Inclusive Cost / Task  1. Hopemont Hospital 2,500  1. Lakin Hospital 2,500  2,500  2,500  4. Pinecrest Hospital		www.ide technical assistance in compiling the account	ing documents
Total "Task B"   2,000	В.	The vendor will provide technical assistance in sometimes and the complete the cost reports for:	All I
1. Hopemont Hospital       2,000         2. Lakin Hospital       8,000         3. Pinecrest Hospital       Total "Task B"       6,000         C. The vendor will review the completed cost reports for:			
1. Hopemont Hospital       2,000         2. Lakin Hospital       8,000         3. Pinecrest Hospital       6,000         Total "Task B"         6,000         All-Inclusive Cost / Task         1. Hopemont Hospital       2,500         2. Lakin Hospital       2,500         3. John Manchin Sr. Health Care Center       2,500         4. Pinecrest Hospital       2,500		Facility	CUSL/ Task
2. Lakin Hospital  3. Pinecrest Hospital  Total "Task B"  6,000  C. The vendor will review the completed cost reports for: Facility  1. Hopemont Hospital 2,500  2,500  2,500  2,500  3. John Manchin Sr. Health Care Center  4. Pinecrest Hospital		Hopemont Hospital	2,000
2,000  The vendor will review the completed cost reports for: Facility  All-Inclusive Cost / Task  1. Hopemont Hospital 2,500  2,500  2,500  3. John Manchin Sr. Health Care Center  4. Pinecrest Hospital	1.		2,000
C. The vendor will review the completed cost reports for:  Facility  All-Inclusive Cost / Task  1. Hopemont Hospital  2,500  2,500  2,500  3. John Manchin Sr. Health Care Center  4. Pinecrest Hospital	2.	Lakin Hospital	2,000
C. The vendor will review the completed cost reports for:  Facility  All-Inclusive Cost / Task  1. Hopemont Hospital  2,500  2,500  2,500  3. John Manchin Sr. Health Care Center  4. Pinecrest Hospital	3.	Pinecrest Hospital	
Facility Cost / Task  1. Hopemont Hospital  2,500  2,500  2. Lakin Hospital  3. John Manchin Sr. Health Care Center  4. Pinecrest Hospital		Total "Task B"	6,000
Facility Cost / Task  1. Hopemont Hospital  2,500  2,500  2. Lakin Hospital  3. John Manchin Sr. Health Care Center  4. Pinecrest Hospital	8		
Facility Cost / Task  1. Hopemont Hospital  2,500  2,500  2. Lakin Hospital  3. John Manchin Sr. Health Care Center  4. Pinecrest Hospital			
Facility       Cost / Task         1. Hopemont Hospital       2,500         2. Lakin Hospital       2,500         3. John Manchin Sr. Health Care Center       2,500         4. Pinecrest Hospital       2,500	C.	The vendor will review the completed cost reports for:	All-Inclusive
<ol> <li>Hopemont Hospital</li> <li>Lakin Hospital</li> <li>John Manchin Sr. Health Care Center</li> <li>Pinecrest Hospital</li> </ol>			Cost / Task
2. Lakin Hospital 2,500  3. John Manchin Sr. Health Care Center 4. Pinecrest Hospital			2,500
3. John Manchin Sr. Health Care Center  2,500  4. Pinecrest Hospital	1.		2,500
John Manchin Sr. Health Care Center      Pinecrest Hospital	2.	Lakin Hospital	2 500
4. Pinecrest Hospital	3.	John Manchin Sr. Health Care Center	2,300
	4	Pinecrest Hospital	2,500
			10,000

D. The vendor shall provide technical assistance for maximizing reimbursement from third party payers. The vendor's services will include the following:

D-1: Assisting the Department with modifying and/or updating each facility's routine, professional, and ancillary services fee schedule (except Welch Community Hospital, Mildred Mitchell-Bateman Hospital, and William R. Sharpe, Jr. Hospital). All changes must be made in accordance with Medicare and Medicare principles.

	Facility	8		All-Inclusive Cost / Task
1.	Hopemont Hospital	*	¥	1,200
2.	Lakin Hospital		ii.	1,200
3.	John Manchin Sr. Health Care Center	•		1,200
4.	Pinecrest Hospital	ä		1,200
			Total "Task D-1"	4,800

D-2: Provide technical assistance to update each facility's billing and collections procedures (except Welch Community Hospital, Mildred Mitchell-Bateman Hospital, and William R. Sharpe, Jr. Hospital). All procedures must be in accordance with Medicare and Medicaid principles.

od!	Facility	All-Inclusive Cost / Task
1.	Hopemont Hospital	_1,200
2.	Lakin Hospital	1,200
3.	John Manchin Sr. Health Care Center	_1,200
4.	Pinecrest Hospital	1,200
	Total "Task D-2"	4,800
E.	Provide technical assistance in setting the following LTC facility's Medic	aid rates:
	Facility	All-Inclusive Cost / Task
1.	Facility	All-litolasivo
1. 2:	Facility  Hopemont Hospital	Cost / Task
2:	Facility	Cost / Task
2:	Hopemont Hospital  Lakin Hospital  John Manchin Sr. Health Care Center	Cost / Task  1,250  1,250
2:	Facility  Hopemont Hospital  Lakin Hospital	Cost / Task  1,250  1,250  1,250

F.	Provide technical expertise to maximize the Disproportionate Share Hosp	oital reimbursement All-Inclusive Cost / Task
1.	Welch Community Hospital	6,500
2. 3.	William R. Sharpe, Jr. Hospital  Mildred Mitchell-Bateman Hospital	6,500
Ö.	Total 'Task F'	19,500
	SUB-TOTAL OF A, B, C, D-1, D-2, E & F: \$	60,350

### HOURLY RATE FOR OPTIONAL ADDITIONAL SERVICES THAT MAY BE REQUESTED ANCILLARY TO THE CONTRACT SCOPE OF WORK AND AGENCY REQUIREMENTS

Classification	Maximum Hours	<b>Hourly Rate</b>	<u>Total</u>
Partner/Member	15	295	4,425
Manager	15	215	3,225
Supervisor	15	150	2,250
Staff	15	85	1,275
	15	65	975
Clerical		ated Additional Services	12,150
*	Total Cost for Estim	atou Additional	Section 1

NOT TO EXCEED <b>GRAND</b> TOTAL OF A, B, C, D, E, & F and ESTIMATED ADDITIONAL SERVICES FOR A ONE YEAR PERIOD:	\$ 72ұ500

Basis of Award:

The vendor, who meets all of the mandatory requirements for experience, and submits the lowest bid, will be awarded the contract.

Vendor:	ARNOT & Foster, P.L.L.C.				21/2008
×	14AA	Drinted Name	Jon	Keith	HutchEson
Signatory:	1977	_Pilited Name_			

SHIP

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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

PURCHASE ORDER NO. BHS90044

BLANKET RELEASE

CORRECT PURCHASE ORDER NUMBER MUST APPEAR ON ALL PACKAGES, INVOICES, AND SHIPPING PAPERS. QUESTIONS CONCERNING THIS PURCHASE ORDER SHOULD BE DIRECTED TO THE BUYER AS NOTED BELOW.

CHANGE ORDER

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

HEALTH AND HUMAN RESOURCES レスンローの田 BBH/HF **ROOM 350** 350 CAPITOL STREET T CHARLESTON, WV

25301-3702

VENDOR

304-346-0441 \*709041713 ARNETT & FOSTER PLLC PO BOX 2629

CHARLESTON WV 25329 HEALTH AND HUMAN RESOURCES BBH/HF ROOM 350 350 CAPITOL STREET CHARLESTON, WV

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