

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

WORKSHEET S
 PARTS I & II

| | | | | | | | | |
|---|---|--------------|---|----------------|---|-------------------------|---|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | I | PROVIDER NO: | I | PERIOD | I | INTERMEDIARY USE ONLY | I | DATE RECEIVED: |
| COST REPORT CERTIFICATION | I | 16-0080 | I | FROM 7/ 1/2007 | I | --AUDITED --DESK REVIEW | I | / / |
| AND SETTLEMENT SUMMARY | I | | I | TO 6/30/2008 | I | --INITIAL --REOPENED | I | INTERMEDIARY NO: |
| | | | I | | I | --FINAL 1-MCR CODE | I | |
| | | | | | I | 00 - # OF REOPENINGS | I | |

ELECTRONICALLY FILED COST REPORT DATE: 1/16/2009 TIME 14:52

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
 MERCY MEDICAL CENTER 16-0080
 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
 DATE: 1/16/2009 TIME 14:52

nUsI8jDx2YeEGIHlAgtxNIeeI4aPS0
 tBfdf0AtIa8QJJ0ZKzvzng8IfAcks
 uKps1jhzTC0meI1V

PI ENCRYPTION INFORMATION
 DATE: 1/16/2009 TIME 14:52

fwIXLwa5YlDKUGe6Zre2rVXVbfhxf0
 zG93K09.wokcGv2WnEtz.EArNwt1lw
 s6GU8efnbp0:1N5.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

| | TITLE V | A | TITLE XVIII | B | TITLE XIX | |
|-------|--------------------|---|----------------|--------|--------------|---|
| | 1 | 2 | | 3 | 4 | |
| 1 | HOSPITAL | 0 | 1,244,421 | 25,321 | | 0 |
| 2 | SUBPROVIDER | 0 | 16,202 | 0 | | 0 |
| 2 .01 | SUBPROVIDER II | 0 | 20,719 | 0 | | 0 |
| 5 | HOSPITAL-BASED SNF | 0 | 955 | 0 | | 0 |
| 7 | HOSPITAL-BASED HHA | 0 | 0 | 0 | | 0 |
| 100 | TOTAL | 0 | 1,282,297 | 25,321 | | 0 |

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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 THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
 (42 USC 1395g).

FORM APPROVED
 OMB NO. 0938-0050

WORKSHEET S
 PARTS I & II

| | | | | | | | | |
|---|---|--------------|---|----------------|---|-------------------------|---|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | I | PROVIDER NO: | I | PERIOD | I | INTERMEDIARY USE ONLY | I | DATE RECEIVED: |
| COST REPORT CERTIFICATION | I | 16-0080 | I | FROM 7/ 1/2007 | I | --AUDITED --DESK REVIEW | I | / / |
| AND SETTLEMENT SUMMARY | I | | I | TO 6/30/2008 | I | --INITIAL --REOPENED | I | INTERMEDIARY NO: |
| | | | | | | --FINAL 1-MCR CODE | | |
| | | | | | | 00 - # OF REOPENINGS | | |

ELECTRONICALLY FILED COST REPORT DATE: 1/16/2009 TIME 14:42

PART I - CERTIFICATION

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 MERCY MEDICAL CENTER 16-0080
 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

| | TITLE V | A | TITLE XVIII | B | TITLE XIX | |
|-------|--------------------|---|-------------|---|-----------|---|
| | 1 | 2 | 2 | 3 | 4 | |
| 1 | HOSPITAL | 0 | 1,244,421 | | 25,321 | 0 |
| 2 | SUBPROVIDER | 0 | 16,202 | | 0 | 0 |
| 2 .01 | SUBPROVIDER II | 0 | 20,719 | | 0 | 0 |
| 5 | HOSPITAL-BASED SNF | 0 | 955 | | 0 | 0 |
| 7 | HOSPITAL-BASED HHA | 0 | 0 | | 0 | 0 |
| 100 | TOTAL | 0 | 1,282,297 | | 25,321 | 0 |

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 1410 NORTH FORTH STREET P.O. BOX:
 1.01 CITY: CLINTON STATE: IA ZIP CODE: 52732- COUNTY: CLINTON

| COMPONENT 0 | COMPONENT NAME 1 | PROVIDER NO. 2 | NPI NUMBER 2.01 | DATE CERTIFIED 3 | PAYMENT SYSTEM (P,T,O OR N) | | |
|----------------|---------------------|-------------------|--------------------|------------------------|--------------------------------|-------|-----|
| | | | | | V | XVIII | XIX |
| 02.00 | HOSPITAL | 16-0080 | | 7/ 1/1966 | N | P | O |
| 03.00 | SUBPROVIDER | 16-S080 | | 7/ 1/1991 | N | T | N |
| 03.01 | SUBPROVIDER 2 | 16-T080 | | 7/ 1/2006 | N | P | N |
| 06.00 | HOSPITAL-BASED SNF | 16-5119 | | 4/ 1/1983 | N | P | N |
| 09.00 | HOSPITAL-BASED HHA | 16-7154 | | 7/ 1/1998 | N | O | O |
| 12.00 | HOSP-BASED HOSPICE | 16-1527 | | 7/ 1/1998 | | | |
| 16.00 | RENAL DIALYSIS | 16-2313 | | 7/ 1/1991 | | | |

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2007 TO: 6/30/2008 1 2
 18 TYPE OF CONTROL 1

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER 4
 20.01 SUBPROVIDER II 5

OTHER INFORMATION

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

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

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

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

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

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

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

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

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

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

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

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

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

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

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

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

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION IN COL. 3. / /

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

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

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

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. N

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 I 16-0080 I FROM 7/ 1/2007 I WORKSHEET S-2
 I I TO 6/30/2008 I

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS) N N

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 1

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: 7/ 1/2007 ENDING: 6/30/2008

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

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

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

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 1 2 3 4

 100 0.8682 0.8566

28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0.00 2 9916 99916

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

| | | |
|-------------------|-------|-----|
| 28.03 STAFFING | % | Y/N |
| 28.04 RECRUITMENT | 0.00% | |
| 28.05 RETENTION | 0.00% | |
| 28.06 TRAINING | 0.00% | |
| 28.07 | 0.00% | |
| 28.08 | 0.00% | |
| 28.09 | 0.00% | |
| 28.10 | 0.00% | |
| 28.11 | 0.00% | |
| 28.12 | 0.00% | |
| 28.13 | 0.00% | |
| 28.14 | 0.00% | |
| 28.15 | 0.00% | |
| 28.16 | 0.00% | |
| 28.17 | 0.00% | |
| 28.18 | 0.00% | |
| 28.19 | 0.00% | |
| 28.20 | 0.00% | |

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N

30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) N

30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N

30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N

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

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N

33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 N

34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N

35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

| | | | |
|---|---|-------|-----|
| 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) | V | XVIII | XIX |
| 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS) | 1 | 2 | 3 |
| | N | Y | N |
| | N | N | N |

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

TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER. IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y 902022

40.01 NAME: TRINITY HEALTH SYSTEMS FI/CONTRACTOR NAME FI/CONTRACTOR #
 40.02 STREET: 34605 12 MILE ROAD P.O. BOX:
 40.03 CITY: FARMINGTON HILLS STATE: MI ZIP CODE: 48331-

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? N
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCMP DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

| | PART A | PART B | OUTPATIENT ASC | OUTPATIENT RADIOLOGY | OUTPATIENT DIAGNOSTIC |
|---------------------|--------|--------|----------------|----------------------|-----------------------|
| | 1 | 2 | 3 | 4 | 5 |
| 47.00 HOSPITAL | N | N | N | N | N |
| 48.00 SUBPROVIDER | N | N | N | N | N |
| 48.01 SUBPROVIDER 2 | N | N | N | N | N |
| 49.00 SNF | N | N | | | |
| 50.00 HHA | N | N | | | |

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

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

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

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.

| | DATE | Y OR N | LIMIT | Y OR N | FEE |
|--|------|--------|-------|--------|-----|
| | 0 | 1 | 2 | 3 | 4 |
| 56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE. | | N | 0.00 | | 0 |
| 56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. | | | 0.00 | | 0 |
| 56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. | | | 0.00 | | 0 |

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. Y Y

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(ii)(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). N

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

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

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). N N 0

MULTICAMPUS

61.00 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.

| NAME | COUNTY | STATE | ZIP CODE | CBSA | FTE/CAMPUS |
|-------|--------|-------|----------|------|------------|
| 62.00 | | | | | 0.00 |
| 62.01 | | | | | 0.00 |
| 62.02 | | | | | 0.00 |
| 62.03 | | | | | 0.00 |
| 62.04 | | | | | 0.00 |
| 62.05 | | | | | 0.00 |
| 62.06 | | | | | 0.00 |
| 62.07 | | | | | 0.00 |
| 62.08 | | | | | 0.00 |
| 62.09 | | | | | 0.00 |

| COMPONENT | NO. OF BEDS 1 | BED DAYS AVAILABLE 2 | CAH N/A 2.01 | TITLE V 3 | I/P DAYS / TITLE XVIII 4 | O/P VISITS / NOT LTCH N/A 4.01 | TRIPS TITLE XIX 5 | TOTAL TITLE XIX 5 |
|-----------------------------------|------------------|-------------------------|-----------------|--------------|-----------------------------|-----------------------------------|-------------------------|-------------------------|
| 1 ADULTS & PEDIATRICS | 122 | 44,652 | | | 12,570 | | | 3,400 |
| 2 HMO | | | | | | | | |
| 2 01 HMO - (IRF PPS SUBPROVIDER) | | | | | | | | |
| 3 ADULTS & PED-SB SNF | | | | | | | | |
| 4 ADULTS & PED-SB NF | | | | | | | | |
| 5 TOTAL ADULTS AND PEDS | 122 | 44,652 | | | 12,570 | | | 3,400 |
| 6 INTENSIVE CARE UNIT | 10 | 3,660 | | | 1,009 | | | 276 |
| 11 NURSERY | | | | | | | | 451 |
| 12 TOTAL | 132 | 48,312 | | | 13,579 | | | 4,127 |
| 13 RPCH VISITS | | | | | | | | |
| 14 SUBPROVIDER | 14 | 5,124 | | | 757 | | | 788 |
| 14 01 ACUTE REHAB UNIT | 12 | 4,392 | | | 1,173 | | | 8 |
| 15 SKILLED NURSING FACILITY | 97 | 35,502 | | | 4,723 | | | 13,799 |
| 18 HOME HEALTH AGENCY | | | | | 3,420 | | | |
| 21 HOSPICE | | | | | | | | |
| 25 TOTAL | 255 | | | | | | | |
| 26 OBSERVATION BED DAYS | | | | | | | | 321 |
| 26 01 OBSERVATION BED DAYS-SUB I | | | | | | | | |
| 26 02 OBSERVATION BED DAYS-SUB II | | | | | | | | |
| 27 AMBULANCE TRIPS | | | | | | | | |
| 28 EMPLOYEE DISCOUNT DAYS | | | | | | | | |
| 28 01 EMP DISCOUNT DAYS -IRF | | | | | | | | |

| COMPONENT | TITLE XIX OBSERVATION BEDS ADMITTED 5.01 | I/P DAYS / NOT ADMITTED 5.02 | O/P VISITS / TOTAL ALL PATS 6 | / TRIPS / TOTAL OBSERVATION BEDS ADMITTED 6.01 | DISCHARGES / TITLE XVIII 6.02 | INTERNS & RES. FTES / TOTAL 7 | LESS I&R REPL NON-PHYS ANES 8 |
|-----------------------------------|---|---------------------------------|----------------------------------|---|----------------------------------|----------------------------------|----------------------------------|
| 1 ADULTS & PEDIATRICS | | | 20,741 | | | | |
| 2 HMO | | | | | | | |
| 2 01 HMO - (IRF PPS SUBPROVIDER) | | | | | | | |
| 3 ADULTS & PED-SB SNF | | | | | | | |
| 4 ADULTS & PED-SB NF | | | | | | | |
| 5 TOTAL ADULTS AND PEDS | | | 20,741 | | | | |
| 6 INTENSIVE CARE UNIT | | | 1,466 | | | | |
| 11 NURSERY | | | 1,279 | | | | |
| 12 TOTAL | | | 23,486 | | | | |
| 13 RPCH VISITS | | | | | | | |
| 14 SUBPROVIDER | | | 2,282 | | | | |
| 14 01 ACUTE REHAB UNIT | | | 1,646 | | | | |
| 15 SKILLED NURSING FACILITY | | | 22,244 | | | | |
| 18 HOME HEALTH AGENCY | | | 19,578 | | | | |
| 21 HOSPICE | | | | | | | |
| 25 TOTAL | | | | | | | |
| 26 OBSERVATION BED DAYS | | 321 | 419 | | 419 | | |
| 26 01 OBSERVATION BED DAYS-SUB I | | | | | | | |
| 26 02 OBSERVATION BED DAYS-SUB II | | | | | | | |
| 27 AMBULANCE TRIPS | | | | | | | |
| 28 EMPLOYEE DISCOUNT DAYS | | | 261 | | | | |
| 28 01 EMP DISCOUNT DAYS -IRF | | | | | | | |

| COMPONENT | I & R FTES NET 9 | --- FULL TIME EMPLOYEES ON PAYROLL 10 | EQUIV NONPAID WORKERS 11 | TITLE V 12 | DISCHARGES TITLE XVIII 13 | TITLE XIX 14 | TOTAL ALL PATIENTS 15 |
|-----------------------------------|---------------------|--|-----------------------------|---------------|------------------------------|-----------------|--------------------------|
| 1 ADULTS & PEDIATRICS | | | | | 2,831 | 1,087 | 5,480 |
| 2 HMO | | | | | | | |
| 2 01 HMO - (IRF PPS SUBPROVIDER) | | | | | | | |
| 3 ADULTS & PED-SB SNF | | | | | | | |
| 4 ADULTS & PED-SB NF | | | | | | | |
| 5 TOTAL ADULTS AND PEDS | | | | | | | |
| 6 INTENSIVE CARE UNIT | | | | | | | |
| 11 NURSERY | | | | | | | |
| 12 TOTAL | | 627.96 | | | 2,831 | 1,087 | 5,480 |
| 13 RPCH VISITS | | | | | | | |
| 14 SUBPROVIDER | | 16.36 | | | 119 | 174 | 502 |
| 14 01 ACUTE REHAB UNIT | | 10.44 | | | 102 | 1 | 144 |
| 15 SKILLED NURSING FACILITY | | 63.73 | | | | | |
| 18 HOME HEALTH AGENCY | | 35.08 | | | | | |
| 21 HOSPICE | | 8.64 | | | | | |
| 25 TOTAL | | 762.21 | | | | | |
| 26 OBSERVATION BED DAYS | | | | | | | |
| 26 01 OBSERVATION BED DAYS-SUB I | | | | | | | |
| 26 02 OBSERVATION BED DAYS-SUB II | | | | | | | |
| 27 AMBULANCE TRIPS | | | | | | | |
| 28 EMPLOYEE DISCOUNT DAYS | | | | | | | |
| 28 01 EMP DISCOUNT DAYS -IRF | | | | | | | |

HOSPITAL WAGE INDEX INFORMATION

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 I 16-0080 I FROM 7/ 1/2007 I WORKSHEET S-3
 I I TO 6/30/2008 I PARTS II & III

| PART II - WAGE DATA | AMOUNT REPORTED 1 | RECLASS OF SALARIES 2 | ADJUSTED SALARIES 3 | PAID HOURS RELATED TO SALARY 4 | AVERAGE HOURLY WAGE 5 | DATA SOURCE 6 |
|--|----------------------|--------------------------|------------------------|-----------------------------------|--------------------------|------------------|
| SALARIES | | | | | | |
| 1 TOTAL SALARY | 36,214,877 | | 36,214,877 | 1,714,179.00 | 21.13 | |
| 2 NON-PHYSICIAN ANESTHETIST PART A | | | | | | |
| 3 NON-PHYSICIAN ANESTHETIST PART B | | | | | | |
| 4 PHYSICIAN - PART A | | | | | | |
| 4.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS) | | | | | | |
| 5 PHYSICIAN - PART B | | | | | | |
| 5.01 NON-PHYSICIAN - PART B | | | | | | |
| 6 INTERNS & RESIDENTS (APPRVD) | | | | | | |
| 6.01 CONTRACT SERVICES, I&R | | | | | | |
| 7 HOME OFFICE PERSONNEL | | | | | | |
| 8 SNF | 2,201,299 | | 2,201,299 | 134,684.00 | 16.34 | |
| 8.01 EXCLUDED AREA SALARIES | 6,216,363 | | 6,216,363 | 309,963.00 | 20.06 | |
| OTHER WAGES & RELATED COSTS | | | | | | |
| 9 CONTRACT LABOR: | 392,303 | | 392,303 | 4,402.54 | 89.11 | |
| 9.01 PHARMACY SERVICES UNDER CONTRACT | | | | | | |
| 9.02 LABORATORY SERVICES UNDER CONTRACT | | | | | | |
| 9.03 MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT | | | | | | |
| 10 CONTRACT LABOR: PHYS PART A | 412,763 | | 412,763 | 3,761.00 | 109.75 | |
| 10.01 TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS) | | | | | | |
| 11 HOME OFFICE SALARIES & WAGE RELATED COSTS | 2,802,810 | | 2,802,810 | 58,091.00 | 48.25 | |
| 12 HOME OFFICE: PHYS PART A | | | | | | |
| 12.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS) | | | | | | |
| WAGE RELATED COSTS | | | | | | |
| 13 WAGE-RELATED COSTS (CORE) | 6,829,911 | | 6,829,911 | | | CMS 339 |
| 14 WAGE-RELATED COSTS (OTHER) | | | | | | CMS 339 |
| 15 EXCLUDED AREAS | 2,068,260 | | 2,068,260 | | | CMS 339 |
| 16 NON-PHYS ANESTHETIST PART A | | | | | | CMS 339 |
| 17 NON-PHYS ANESTHETIST PART B | | | | | | CMS 339 |
| 18 PHYSICIAN PART A | | | | | | CMS 339 |
| 18.01 PART A TEACHING PHYSICIANS | | | | | | CMS 339 |
| 19 PHYSICIAN PART B | | | | | | CMS 339 |
| 19.01 WAGE-RELATD COSTS (RHC/FQHC) | | | | | | CMS 339 |
| 20 INTERNS & RESIDENTS (APPRVD) | | | | | | CMS 339 |
| OVERHEAD COSTS - DIRECT SALARIES | | | | | | |
| 21 EMPLOYEE BENEFITS | 537,034 | | 537,034 | 43,242.00 | 12.42 | |
| 22 ADMINISTRATIVE & GENERAL | 5,082,109 | | 5,082,109 | 206,108.00 | 24.66 | |
| 22.01 A & G UNDER CONTRACT | 522,905 | | 522,905 | 3,767.72 | 138.79 | |
| 23 MAINTENANCE & REPAIRS | 387,585 | | 387,585 | 22,525.00 | 17.21 | |
| 24 OPERATION OF PLANT | | | | | | |
| 25 LAUNDRY & LINEN SERVICE | 91,625 | | 91,625 | 8,446.00 | 10.85 | |
| 26 HOUSEKEEPING | 688,189 | | 688,189 | 57,566.00 | 11.95 | |
| 26.01 HOUSEKEEPING UNDER CONTRACT | | | | | | |
| 27 DIETARY | 1,326,450 | | 1,326,450 | 97,675.00 | 13.58 | |
| 27.01 DIETARY UNDER CONTRACT | | | | | | |
| 28 CAFETERIA | | | | | | |
| 29 MAINTENANCE OF PERSONNEL | | | | | | |
| 30 NURSING ADMINISTRATION | 1,115,788 | | 1,115,788 | 30,240.00 | 36.90 | |
| 31 CENTRAL SERVICE AND SUPPLY | 122,092 | | 122,092 | 9,408.00 | 12.98 | |
| 32 PHARMACY | | | | | | |
| 33 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY | 813,805 | | 813,805 | 41,331.00 | 19.69 | |
| 34 SOCIAL SERVICE | 425,638 | | 425,638 | 17,229.00 | 24.70 | |
| 35 OTHER GENERAL SERVICE | | | | | | |
| PART III - HOSPITAL WAGE INDEX SUMMARY | | | | | | |
| 1 NET SALARIES | 36,737,782 | | 36,737,782 | 1,717,946.72 | 21.38 | |
| 2 EXCLUDED AREA SALARIES | 8,417,662 | | 8,417,662 | 444,647.00 | 18.93 | |
| 3 SUBTOTAL SALARIES | 28,320,120 | | 28,320,120 | 1,273,299.72 | 22.24 | |
| 4 SUBTOTAL OTHER WAGES & RELATED COSTS | 3,607,876 | | 3,607,876 | 66,254.54 | 54.45 | |
| 5 SUBTOTAL WAGE-RELATED COSTS | 6,829,911 | | 6,829,911 | | 24.12 | |
| 6 TOTAL | 38,757,907 | | 38,757,907 | 1,339,554.26 | 28.93 | |
| 7 NET SALARIES | | | | | | |
| 8 EXCLUDED AREA SALARIES | | | | | | |
| 9 SUBTOTAL SALARIES | | | | | | |
| 10 SUBTOTAL OTHER WAGES & RELATED COSTS | | | | | | |
| 11 SUBTOTAL WAGE-RELATED COSTS | | | | | | |
| 12 TOTAL | | | | | | |
| 13 TOTAL OVERHEAD COSTS | 11,113,220 | | 11,113,220 | 537,537.72 | 20.67 | |

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
I 16-0080 I FROM 7/ 1/2007 I WORKSHEET S-4
I HHA NO: I TO 6/30/2008 I
I 16-7154 I
COUNTY: CLINTON

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

| | TITLE V 1 | TITLE XVIII 2 | TITLE XIX 3 | OTHER 4 |
|-----------------------------|-----------------|---------------------|-------------------|------------|
| 1 HOME HEALTH AIDE HOURS | 0 | 12,534 | 5,521 | 2,431 |
| 2 UNDUPLICATED CENSUS COUNT | | | | |

TOTAL
5

| | |
|-----------------------------|--------|
| 1 HOME HEALTH AIDE HOURS | 20,486 |
| 2 UNDUPLICATED CENSUS COUNT | |

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00

HHA NO. OF FTE EMPLOYEES (2080 HRS)

| | STAFF 1 | CONTRACT 2 | TOTAL 3 |
|--|------------|---------------|------------|
| 3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S) | | | |
| 4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S) | .78 | | .78 |
| 5 OTHER ADMINISTRATIVE PERSONEL | 12.07 | | 12.07 |
| 6 DIRECTING NURSING SERVICE | | | |
| 7 NURSING SUPERVISOR | 1.28 | | 1.28 |
| 8 PHYSICAL THERAPY SERVICE | | | |
| 9 PHYSICAL THERAPY SUPERVISOR | | | |
| 10 OCCUPATIONAL THERAPY SERVICE | | | |
| 11 OCCUPATIONAL THERAPY SUPERVISOR | | | |
| 12 SPEECH PATHOLOGY SERVICE | | | |
| 13 SPEECH PATHOLOGY SUPERVISOR | | | |
| 14 MEDICAL SOCIAL SERVICE | | | |
| 15 MEDICAL SOCIAL SERVICE SUPERVISOR | | | |
| 16 HOME HEALTH AIDE | 7.35 | .98 | 8.33 |
| 17 HOME HEALTH AIDE SUPERVISOR | 1.15 | | 1.15 |
| 18 OTHER | 12.47 | | 12.47 |

HOME HEALTH AGENCY MSA CODES

| | | |
|--|---|-------|
| 19 HOW MANY MSAS IN COL. 1 OR CBSAS IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD? | 0 | 3 |
| 20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE). | | 50031 |
| 20.01 | | 99914 |
| 20.02 | | 99916 |

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON OR AFTER OCTOBER 1, 2000

| | FULL EPISODES | | LUPA EPISODES 3 | PEP ONLY EPISODES 4 |
|--|--------------------------|-----------------------|-----------------------|---------------------------|
| | WITHOUT OUTLIERS 1 | WITH OUTLIERS 2 | | |
| 21 SKILLED NURSING VISITS | 1,960 | 0 | 68 | 10 |
| 22 SKILLED NURSING VISIT CHARGES | 215,600 | 0 | 7,480 | 1,100 |
| 23 PHYSICAL THERAPY VISITS | 983 | 0 | 4 | 1 |
| 24 PHYSICAL THERAPY VISIT CHARGES | 122,875 | 0 | 500 | 125 |
| 25 OCCUPATIONAL THERAPY VISITS | 0 | 0 | 0 | 0 |
| 26 OCCUPATIONAL THERAPY VISIT CHARGES | 0 | 0 | 0 | 0 |
| 27 SPEECH PATHOLOGY VISITS | 6 | 0 | 0 | 0 |
| 28 SPEECH PATHOLOGY VISIT CHARGES | 750 | 0 | 0 | 0 |
| 29 MEDICAL SOCIAL SERVICE VISITS | 29 | 0 | 0 | 1 |
| 30 MEDICAL SOCIAL SERVICE VISIT CHARGES | 4,495 | 0 | 0 | 155 |
| 31 HOME HEALTH AIDE VISITS | 291 | 0 | 2 | 5 |
| 32 HOME HEALTH AIDE VISIT CHARGES | 17,460 | 0 | 120 | 300 |
| 33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31) | 3,269 | 0 | 74 | 17 |
| 34 OTHER CHARGES | 0 | 0 | 0 | 0 |
| 35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34) | 361,180 | 0 | 8,100 | 1,680 |
| 36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER) | 231 | 0 | 30 | 2 |
| 37 TOTAL NUMBER OF OUTLIER EPISODES | 0 | 0 | 0 | 0 |
| 38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES | 4,447 | 0 | 33 | 0 |

HOSPITAL-BASED HOME HEALTH AGENCY
 STATISTICAL DATA
 HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
 OR AFTER OCTOBER 1, 2000

| | SCIC WITHIN A PEP 5 | SCIC ONLY EPISODES 6 | TOTAL (COLS. 1-6) 7 |
|--|---------------------------|----------------------------|---------------------------|
| 21 SKILLED NURSING VISITS | 0 | 41 | 2,079 |
| 22 SKILLED NURSING VISIT CHARGES | 0 | 4,510 | 228,690 |
| 23 PHYSICAL THERAPY VISITS | 0 | 18 | 1,006 |
| 24 PHYSICAL THERAPY VISIT CHARGES | 0 | 2,250 | 125,750 |
| 25 OCCUPATIONAL THERAPY VISITS | 0 | 0 | 0 |
| 26 OCCUPATIONAL THERAPY VISIT CHARGES | 0 | 0 | 0 |
| 27 SPEECH PATHOLOGY VISITS | 0 | 0 | 6 |
| 28 SPEECH PATHOLOGY VISIT CHARGES | 0 | 0 | 750 |
| 29 MEDICAL SOCIAL SERVICE VISITS | 0 | 1 | 31 |
| 30 MEDICAL SOCIAL SERVICE VISIT CHARGES | 0 | 155 | 4,805 |
| 31 HOME HEALTH AIDE VISITS | 0 | 0 | 298 |
| 32 HOME HEALTH AIDE VISIT CHARGES | 0 | 0 | 17,880 |
| 33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31) | 0 | 60 | 3,420 |
| 34 OTHER CHARGES | 0 | 0 | 0 |
| 35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34) | 0 | 6,915 | 377,875 |
| 36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER) | 0 | 3 | 266 |
| 37 TOTAL NUMBER OF OUTLIER EPISODES | 0 | 0 | 0 |
| 38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES | 0 | 57 | 4,537 |

HOSPITAL RENAL DIALYSIS DEPARTMENT
 STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 I 16-0080 I FROM 7/ 1/2007 I
 I SATELLITE NO: I TO 6/30/2008 I WORKSHEET S-5
 I I I

| DESCRIPTION | ----- OUTPATIENT ----- | | ----- TRAINING ----- | | ----- HOME ----- | |
|---|------------------------|----------------|------------------------|-------------------|------------------------|-------------------|
| | REGULAR 1 | HIGH FLUX 2 | HEMO- DIALYSIS 3 | CAPD CCPD 4 | HEMO- DIALYSIS 5 | CAPD CCPD 6 |
| 1 NUMBER OF PATIENTS IN PROGRAM AT END OF COST REPORTING PERIOD | 65 | | | | | |
| 2 NUMBER OF TIMES PER WEEK PATIENT RECEIVES DIALYSIS | 3.00 | | | | | |
| 3 AVERAGE PATIENT DIALYSIS TIME INCLUDING SETUP | 4.50 | | | | | |
| 4 CAPD EXCHANGES PER DAY | | | | | | |
| 5 NUMBER OF DAYS IN YEAR DIALYSIS FURNISHED | 312 | | | | | |
| 6 NUMBER OF STATIONS | 13 | | | | | |
| 7 TREATMENT CAPACITY PER DAY PER STATION | 3 | | | | | |
| 8 UTILIZATION (SEE INSTRUCTIONS) | | | | | | |
| 9 AVERAGE TIMES DIALYZERS RE-USED | | | | | | |
| 10 PERCENTAGE OF PATIENTS RE-USING DIALYZERS | | | | | | |
| TRANSPLANT INFORMATION | | | | | | |
| 11 NUMBER OF PATIENTS ON TRANSPLANT LIST | 6 | | | | | |
| 12 NUMBER OF PATIENTS TRANSPLANTED DURING THE COST REPORTING PERIOD | 1 | | | | | |
| EPOIETIN | | | | | | |
| 13 NET COSTS OF EPOIETIN FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER | | | | | | |
| 13 . 1 EPOIETIN AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM | | | | | | |
| 14 NUMBER OF EPO UNITS FURNISHED RELATING TO THE RENAL DIALYSIS DEPARTMENT | | | | | | |
| 14 . 1 NUMBER OF EPO UNITS FURNISHED RELATING TO THE HOME DIALYSIS DEPARTMENT | | | | | | |
| PHYSICIAN PAYMENT METHOD (ENTER "X" IF METHOD(S) IS APPLICABLE) | | | | | | |
| 15 MCP [X] INITIAL METHOD [] | | | | | | |
| ARANESP | | | | | | |
| 16 NET COSTS OF ARANESP FURNISHED TO ALL MAINTENANCE DIALYSIS PATIENTS BY THE PROVIDER | | | | | | |
| 17 ARANESP AMOUNT FROM WORKSHEET A FOR HOME DIALYSIS PROGRAM | | | | | | |
| 18 NUMBER OF ARANESP UNITS FURNISHED RELATING TO RENAL DIALYSIS DEPARTMENT | | | | | | |
| 19 NUMBER OF ARANESP UNITS FURNISHED RELATING TO HOME DIALYSIS DEPARTMENT | | | | | | |

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
I 16-0080 I FROM 7/ 1/2007 I WORKSHEET S-7
I TO 6/30/2008 I

| GROUP(1) | M3PI REVENUE CODE | SERVICES PRIOR TO 10/1 RATE | 10/1 DAYS 3.01 | SERVICES ON/AFTER 10/1 RATE | 10/1 DAYS 4.01 | SRVCS 4/1/01 TO 9/30/01 RATE | 4.02 | DAYS 4.03 |
|----------|-------------------|-----------------------------|----------------|-----------------------------|----------------|------------------------------|------|-----------|
| 1 | RUC | | 110 | | | | | |
| 2 | RUB | | 70 | | | | | |
| 3 | RUA | | 32 | | | | | |
| 3 .01 | RUX | | 15 | | | | | |
| 3 .02 | RUL | | 199 | | | | | |
| 4 | RVC | | 203 | | | | | |
| 5 | RVB | | 392 | | | | | |
| 6 | RVA | | 237 | | | | | |
| 6 .01 | RVX | | 195 | | | | | |
| 6 .02 | RVL | | 972 | | | | | |
| 7 | RHC | | 179 | | | | | |
| 8 | RHB | | 141 | | | | | |
| 9 | RHA | | 154 | | | | | |
| 9 .01 | RHX | | | | | | | |
| 9 .02 | RHL | | | | | | | |
| 10 | RMC | | 63 | | | | | |
| 11 | RMB | | 46 | | | | | |
| 12 | RMA | | 16 | | | | | |
| 12 .01 | RMX | | 539 | | | | | |
| 12 .02 | RML | | 930 | | | | | |
| 13 | RLB | | | | | | | |
| 14 | RLA | | | | | | | |
| 14 .01 | RLX | | | | | | | |
| 15 | SE3 | | 3 | | | | | |
| 16 | SE2 | | 139 | | | | | |
| 17 | SE1 | | 26 | | | | | |
| 18 | SSC | | | | | | | |
| 19 | SSB | | 11 | | | | | |
| 20 | SSA | | 48 | | | | | |
| 21 | CC2 | | | | | | | |
| 22 | CC1 | | | | | | | |
| 23 | CB2 | | | | | | | |
| 24 | CB1 | | | | | | | |
| 25 | CA2 | | | | | | | |
| 26 | CA1 | | | | | | | |
| 27 | IB2 | | | | | | | |
| 28 | IB1 | | | | | | | |
| 29 | IA2 | | | | | | | |
| 30 | IA1 | | | | | | | |
| 31 | BB2 | | | | | | | |
| 32 | BB1 | | | | | | | |
| 33 | BA2 | | | | | | | |
| 34 | BA1 | | | | | | | |
| 35 | PE2 | | | | | | | |
| 36 | PE1 | | 3 | | | | | |
| 37 | PD2 | | | | | | | |
| 38 | PD1 | | | | | | | |
| 39 | PC2 | | | | | | | |
| 40 | PC1 | | | | | | | |
| 41 | PB2 | | | | | | | |
| 42 | PB1 | | | | | | | |
| 43 | PA2 | | | | | | | |
| 44 | PA1 | | | | | | | |
| 45 | Default | | | | | | | |
| 46 | TOTAL | | 4,723 | | | | | |

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:
 Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8682
 Wage Index Factor (after 10/01): 0.8566
 SNF Facility Specific Rate : 0.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 9916
 SNF CBSA Code : 99916

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
I 16-0080 I FROM 7/ 1/2007 I WORKSHEET S-7
I TO 6/30/2008 I

| | GROUP(1) | M3PI REVENUE CODE | HIGH COST(2) | | TOTAL |
|----|----------|----------------------|--------------|-----------------------|-------|
| | | | RUGs | SWING BED SNF DAYS | |
| | 1 | 2 | 4.05 | 4.06 | 5 |
| 1 | RUC | | | | |
| 2 | RUB | | | | |
| 3 | RUA | | | | |
| 3 | .01 RUX | | | | |
| 3 | .02 RUL | | | | |
| 4 | RVC | | | | |
| 5 | RVB | | | | |
| 6 | RVA | | | | |
| 6 | .01 RVX | | | | |
| 6 | .02 RVL | | | | |
| 7 | RHC | | | | |
| 8 | RHB | | | | |
| 9 | RHA | | | | |
| 9 | .01 RHX | | | | |
| 9 | .02 RHL | | | | |
| 10 | RMC | | | | |
| 11 | RMB | | | | |
| 12 | RMA | | | | |
| 12 | .01 RMX | | | | |
| 12 | .02 RML | | | | |
| 13 | RLB | | | | |
| 14 | RLA | | | | |
| 14 | .01 RLX | | | | |
| 15 | SE3 | | | | |
| 16 | SE2 | | | | |
| 17 | SE1 | | | | |
| 18 | SSC | | | | |
| 19 | SSB | | | | |
| 20 | SSA | | | | |
| 21 | CC2 | | | | |
| 22 | CC1 | | | | |
| 23 | CB2 | | | | |
| 24 | CB1 | | | | |
| 25 | CA2 | | | | |
| 26 | CA1 | | | | |
| 27 | IB2 | | | | |
| 28 | IB1 | | | | |
| 29 | IA2 | | | | |
| 30 | IA1 | | | | |
| 31 | BB2 | | | | |
| 32 | BB1 | | | | |
| 33 | BA2 | | | | |
| 34 | BA1 | | | | |
| 35 | PE2 | | | | |
| 36 | PE1 | | | | |
| 37 | PD2 | | | | |
| 38 | PD1 | | | | |
| 39 | PC2 | | | | |
| 40 | PC1 | | | | |
| 41 | PB2 | | | | |
| 42 | PB1 | | | | |
| 43 | PA2 | | | | |
| 44 | PA1 | | | | |
| 45 | Default | | | | |
| 46 | TOTAL | | | | |

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

Worksheet S-2 reference data:
 Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8682
 Wage Index Factor (after 10/01) : 0.8566
 SNF Facility Specific Rate : 0.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 9916
 SNF CBSA Code : 99916

HOSPICE 1

PART I - ENROLLMENT DAYS

| | TITLE XVIII UNDUPLICATED MEDICARE DAYS 1 | TITLE XIX UNDUPLICATED MEDICAID DAYS 2 | TITLE XVIII UNDUPLICATED SNF DAYS 3 | TITLE XIX UNDUPLICATED NF DAYS 4 |
|--------------------------|---|---|--|---|
| 1 CONTINUOUS HOME CARE | | | | |
| 2 ROUTINE HOME CARE | 5,816 | | | |
| 3 INPATIENT RESPITE CARE | | | | |
| 4 GENERAL INPATIENT CARE | 17 | | | |
| 5 TOTAL HOSPICE DAYS | 5,833 | | | |

PART I - ENROLLMENT DAYS (CONTINUED)

| | OTHER UNDUPLICATED DAYS 5 | TOTAL UNDUPLICATED DAYS 6 |
|--------------------------|------------------------------------|------------------------------------|
| 1 CONTINUOUS HOME CARE | | |
| 2 ROUTINE HOME CARE | 6,495 | 12,311 |
| 3 INPATIENT RESPITE CARE | 3 | 3 |
| 4 GENERAL INPATIENT CARE | 4,031 | 4,048 |
| 5 TOTAL HOSPICE DAYS | 10,529 | 16,362 |

PART II - CENSUS DATA

| | TITLE XVIII 1 | TITLE XIX 2 | TITLE XVIII SNF 3 | TITLE XIX NF 4 |
|---|------------------|----------------|-------------------------|----------------------|
| 6 NUMBER OF PATIENTS RECEIVING HOSPICE CARE | | | | |
| 7 TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE | | | | |
| 8 AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6) | | | | |
| 9 UNDUPLICATED CENSUS COUNT | | | | |

PART II - CENSUS DATA (CONTINUED)

| | OTHER 5 | TOTAL 6 |
|---|------------|------------|
| 6 NUMBER OF PATIENTS RECEIVING HOSPICE CARE | | |
| 7 TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE | | |
| 8 AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6) | | |
| 9 UNDUPLICATED CENSUS COUNT | | |

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 I 16-0080 I FROM 7/ 1/2007 I WORKSHEET S-10
 I I TO 6/30/2008 I
 I I I

DESCRIPTION

| | | |
|--------------------------------|---|------------|
| UNCOMPENSATED CARE INFORMATION | | |
| 1 | DO YOU HAVE A WRITTEN CHARITY CARE POLICY? | |
| 2 | ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04 | |
| 2.01 | IS IT AT THE TIME OF ADMISSION? | |
| 2.02 | IS IT AT THE TIME OF FIRST BILLING? | |
| 2.03 | IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE? | |
| 2.04 | | |
| 3 | ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS? | |
| 4 | ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA? | |
| 5 | ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY? | |
| 6 | ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA? | |
| 7 | ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA? | |
| 8 | DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01 | |
| 8.01 | DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES? | |
| 9 | IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04 | |
| 9.01 | IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY? | |
| 9.02 | IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT? | |
| 9.03 | IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION? | |
| 9.04 | IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT? | |
| 10 | IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF? | |
| 11 | IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04 | |
| 11.01 | IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL? | |
| 11.02 | IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL? | |
| 11.03 | IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL? | |
| 11.04 | IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL? | |
| 12 | ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE? | |
| 13 | IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES? | |
| 14 | IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02 | |
| 14.01 | DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE? | |
| 14.02 | WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING? | |
| 15 | DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS? | |
| 16 | ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE? | |
| UNCOMPENSATED CARE REVENUES | | |
| 17 | REVENUE FROM UNCOMPENSATED CARE | 4,739,280 |
| 17.01 | GROSS MEDICAID REVENUES | 11,640,413 |
| 18 | REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS | |
| 19 | REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS) | |
| 20 | RESTRICTED GRANTS | |
| 21 | NON-RESTRICTED GRANTS | |
| 22 | TOTAL GROSS UNCOMPENSATED CARE REVENUES | 16,379,693 |
| UNCOMPENSATED CARE COST | | |
| 23 | TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS | |
| 24 | COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103) | .387322 |
| 25 | TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24) | |
| 26 | TOTAL SCHIP CHARGES FROM YOUR RECORDS | |
| 27 | TOTAL SCHIP COST, (LINE 24 * LINE 26) | |
| 28 | TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS | 11,640,413 |
| 29 | TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28) | 4,508,588 |
| 30 | OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS | 4,739,280 |
| 31 | UNCOMPENSATED CARE COST (LINE 24 * LINE 30) | 1,835,627 |

HOSPITAL UNCOMPENSATED CARE DATA

IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)
I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
I 16-0080 I FROM 7/ 1/2007 I WORKSHEET S-10
I I TO 6/30/2008 I
I I I

DESCRIPTION

32 TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL 4,508,588
(SUM OF LINES 25, 27, AND 29)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 I 16-0080 I FROM 7/ 1/2007 I WORKSHEET A
 I TO 6/30/2008 I

| COST CENTER | COST CENTER DESCRIPTION | SALARIES | OTHER | TOTAL | RECLASS-IFICATIONS | RECLASSIFIED TRIAL BALANCE |
|-------------|---|------------|------------|------------|--------------------|----------------------------|
| | | 1 | 2 | 3 | 4 | 5 |
| 3 | 0300 GENERAL SERVICE COST CNTR | | | | | |
| | NEW CAP REL COSTS-BLDG & FIXT | | 4,714,824 | 4,714,824 | -858,865 | 3,855,959 |
| 3.01 | 0301 NEW CAP SOUTH 1970 BUILDING | | | | 492,691 | 492,691 |
| 3.02 | 0302 NEW CAP BLUFF BUILDING | | | | 73,924 | 73,924 |
| 3.03 | 0303 NEW CAP REL COSTS-RAD ONCOLOGY BLDG | | | | 154,655 | 154,655 |
| 4 | 0400 NEW CAP REL COSTS-MVBLE EQUIP | | | | | |
| 5 | 0500 EMPLOYEE BENEFITS | 537,034 | 4,740,517 | 5,277,551 | 8,369 | 5,285,920 |
| 6.02 | 0620 INFORMATION SYSTEMS | 1,157,332 | 4,259,296 | 5,416,628 | -29,898 | 5,386,730 |
| 6.03 | 0630 PURCHASING, RECEIVING AND STORES | 399,046 | 188,019 | 587,065 | -371 | 586,694 |
| 6.04 | 0640 ADMITTING | 443,643 | 62,536 | 506,179 | -394 | 505,785 |
| 6.05 | 0650 CASHIERING/ACCOUNTS RECEIVABLE | 341,578 | 364,967 | 706,545 | -1,114 | 705,431 |
| 6.06 | 0660 OTHER ADMINISTRATIVE AND GENERAL | 2,740,510 | 6,967,712 | 9,708,222 | 11,489 | 9,719,711 |
| 7 | 0700 MAINTENANCE & REPAIRS | 387,585 | 1,522,751 | 1,910,336 | -116 | 1,910,220 |
| 8 | 0800 OPERATION OF PLANT | | 1,673,679 | 1,673,679 | | 1,673,679 |
| 9 | 0900 LAUNDRY & LINEN SERVICE | 91,625 | 80,290 | 171,915 | 315,754 | 487,669 |
| 10 | 1000 HOUSEKEEPING | 688,189 | 212,717 | 900,906 | -160 | 900,746 |
| 11 | 1100 DIETARY | 1,326,450 | 947,770 | 2,274,220 | 131,449 | 2,405,669 |
| 12 | 1200 CAFETERIA | | | | | |
| 14 | 1400 NURSING ADMINISTRATION | 1,115,788 | 144,646 | 1,260,434 | -1,436 | 1,258,998 |
| 15 | 1500 CENTRAL SERVICES & SUPPLY | 122,092 | 78,475 | 200,567 | -8,372 | 192,195 |
| 17 | 1700 MEDICAL RECORDS & LIBRARY | 813,805 | 269,159 | 1,082,964 | -3,733 | 1,079,231 |
| 18 | 1800 SOCIAL SERVICE | 425,638 | 39,449 | 465,087 | -932 | 464,155 |
| | INPAT ROUTINE SRVC CNTRS | | | | | |
| 25 | 2500 ADULTS & PEDIATRICS | 5,865,304 | 1,232,030 | 7,097,334 | -131,445 | 6,965,889 |
| 26 | 2600 INTENSIVE CARE UNIT | 812,188 | 242,681 | 1,054,869 | -20,300 | 1,034,569 |
| 31 | 3100 SUBPROVIDER | 819,207 | 160,110 | 979,317 | -13,513 | 965,804 |
| 31.01 | 3101 ACUTE REHAB UNIT | 509,750 | 401,469 | 911,219 | -1,769 | 909,450 |
| 33 | 3300 NURSERY | 404,605 | 91,074 | 495,679 | -1,656 | 494,023 |
| 34 | 3400 SKILLED NURSING FACILITY | 2,201,299 | 743,760 | 2,945,059 | -78,349 | 2,866,710 |
| | ANCILLARY SRVC COST CNTRS | | | | | |
| 37 | 3700 OPERATING ROOM | 1,478,817 | 2,627,317 | 4,106,134 | -23,473 | 4,082,661 |
| 39 | 3900 DELIVERY ROOM & LABOR ROOM | 246,471 | 87,277 | 333,748 | -6,285 | 327,463 |
| 41 | 4100 RADIOLOGY-DIAGNOSTIC | 1,581,654 | 2,053,099 | 3,634,753 | -14,197 | 3,620,556 |
| 44 | 4400 LABORATORY | 1,417,880 | 1,806,021 | 3,223,901 | -1,088 | 3,222,813 |
| 49 | 4900 RESPIRATORY THERAPY | 881,897 | 195,890 | 1,077,787 | -194 | 1,077,593 |
| 50 | 5000 PHYSICAL THERAPY | 871,902 | 327,333 | 1,199,235 | -3,910 | 1,195,325 |
| 52 | 5200 SPEECH PATHOLOGY | 83,758 | 43,282 | 127,040 | -32 | 127,008 |
| 53 | 5300 ELECTROCARDIOLOGY | 415,508 | 321,576 | 737,084 | -3,028 | 734,056 |
| 55 | 5500 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | | | |
| 56 | 5600 DRUGS CHARGED TO PATIENTS | 950,473 | 3,412,545 | 4,363,018 | -817 | 4,362,201 |
| 57 | 5700 RENAL DIALYSIS | 590,054 | 342,576 | 932,630 | -3,730 | 928,900 |
| 59 | 3120 SPECIAL PROCEDURES | 439,709 | 2,099,033 | 2,538,742 | -1,649 | 2,537,093 |
| 59.02 | 3950 PARTIAL HOSPITALIZATION | | 5 | 5 | | 5 |
| | OUTPAT SERVICE COST CNTRS | | | | | |
| 61 | 6100 EMERGENCY | 1,166,680 | 3,209,269 | 4,375,949 | -28,458 | 4,347,491 |
| 62 | 6200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | |
| | OTHER REIMBURS COST CNTRS | | | | | |
| 71 | 7100 HOME HEALTH AGENCY | 1,492,587 | 945,455 | 2,438,042 | -1,214 | 2,436,828 |
| | SPEC PURPOSE COST CENTERS | | | | | |
| 88 | 8800 INTEREST EXPENSE | | | | | |
| 90 | 9000 OTHER CAPITAL RELATED COSTS | | | | | |
| 93 | 9300 HOSPICE | 423,263 | 610,268 | 1,033,531 | -647 | 1,032,884 |
| 95 | 9500 SUBTOTALS | 33,243,321 | 47,218,877 | 80,462,198 | -52,814 | 80,409,384 |
| | NONREIMBURS COST CENTERS | | | | | |
| 96 | 9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN | | | | | |
| 98 | 9800 PHYSICIANS' PRIVATE OFFICES | 22,394 | 213,435 | 235,829 | -7 | 235,822 |
| 100 | 7950 OTHER NON-REIMBURSABLE | | | | | |
| 100.01 | 7951 RESPITE | | | | | |
| 100.02 | 7952 LIFELINE | 41,324 | 25,589 | 66,913 | | 66,913 |
| 100.03 | 7953 OUTREACH | 58,732 | 7,096 | 65,828 | | 65,828 |
| 100.04 | 7954 ENT | 391,280 | 212,616 | 603,896 | | 603,896 |
| 100.05 | 7955 GASTRO CLINIC | 480,069 | 109,993 | 590,062 | | 590,062 |
| 100.09 | 7959 SENIOR SERVICES | 15,083 | 45,010 | 60,093 | -2,862 | 57,231 |
| 100.11 | 7961 GUEST MEALS | | | | | |
| 100.12 | 7962 OTHER | 7,229 | 7,593 | 14,822 | -1,676 | 13,146 |
| 100.13 | 7963 RURAL OUTREACH | 59,051 | 10,709 | 69,760 | -1,292 | 68,468 |
| 100.16 | 7966 WYNDREST NURSING HOME | 1,896,394 | 673,828 | 2,570,222 | 58,651 | 2,628,873 |
| 101 | TOTAL | 36,214,877 | 48,524,746 | 84,739,623 | -0- | 84,739,623 |

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 I 16-0080 I FROM 7/ 1/2007 I WORKSHEET A
 I I TO 6/30/2008 I

| COST CENTER | COST CENTER DESCRIPTION | ADJUSTMENTS | NET EXPENSES FOR ALLOC |
|-------------|---|-------------|------------------------|
| | | 6 | 7 |
| | GENERAL SERVICE COST CNTR | | |
| 3 | 0300 NEW CAP REL COSTS-BLDG & FIXT | -534,589 | 3,321,370 |
| 3.01 | 0301 NEW CAP SOUTH 1970 BUILDING | | 492,691 |
| 3.02 | 0302 NEW CAP BLUFF BUILDING | | 73,924 |
| 3.03 | 0303 NEW CAP REL COSTS-RAD ONCOLOGY BLDG | | 154,655 |
| 4 | 0400 NEW CAP REL COSTS-MVBLE EQUIP | | |
| 5 | 0500 EMPLOYEE BENEFITS | -188,511 | 5,097,409 |
| 6.02 | 0620 INFORMATION SYSTEMS | -689,850 | 4,696,880 |
| 6.03 | 0630 PURCHASING, RECEIVING AND STORES | | 586,694 |
| 6.04 | 0640 ADMITTING | | 505,785 |
| 6.05 | 0650 CASHIERING/ACCOUNTS RECEIVABLE | | 705,431 |
| 6.06 | 0660 OTHER ADMINISTRATIVE AND GENERAL | -3,944,365 | 5,775,346 |
| 7 | 0700 MAINTENANCE & REPAIRS | | 1,910,220 |
| 8 | 0800 OPERATION OF PLANT | -17,732 | 1,655,947 |
| 9 | 0900 LAUNDRY & LINEN SERVICE | -51,902 | 435,767 |
| 10 | 1000 HOUSEKEEPING | | 900,746 |
| 11 | 1100 DIETARY | -395,430 | 2,010,239 |
| 12 | 1200 CAFETERIA | | |
| 14 | 1400 NURSING ADMINISTRATION | -10,883 | 1,248,115 |
| 15 | 1500 CENTRAL SERVICES & SUPPLY | | 192,195 |
| 17 | 1700 MEDICAL RECORDS & LIBRARY | -35,494 | 1,043,737 |
| 18 | 1800 SOCIAL SERVICE | | 464,155 |
| | INPAT ROUTINE SRVC CNTRS | | |
| 25 | 2500 ADULTS & PEDIATRICS | -19 | 6,965,870 |
| 26 | 2600 INTENSIVE CARE UNIT | | 1,034,569 |
| 31 | 3100 SUBPROVIDER | -31,673 | 934,131 |
| 31.01 | 3101 ACUTE REHAB UNIT | | 909,450 |
| 33 | 3300 NURSERY | | 494,023 |
| 34 | 3400 SKILLED NURSING FACILITY | -1,134 | 2,865,576 |
| | ANCILLARY SRVC COST CNTRS | | |
| 37 | 3700 OPERATING ROOM | -22,240 | 4,060,421 |
| 39 | 3900 DELIVERY ROOM & LABOR ROOM | -3,320 | 324,143 |
| 41 | 4100 RADIOLOGY-DIAGNOSTIC | -11,200 | 3,609,356 |
| 44 | 4400 LABORATORY | -14,665 | 3,208,148 |
| 49 | 4900 RESPIRATORY THERAPY | | 1,077,593 |
| 50 | 5000 PHYSICAL THERAPY | -450 | 1,194,875 |
| 52 | 5200 SPEECH PATHOLOGY | | 127,008 |
| 53 | 5300 ELECTROCARDIOLOGY | | 734,056 |
| 55 | 5500 MEDICAL SUPPLIES CHARGED TO PATIENTS | | |
| 56 | 5600 DRUGS CHARGED TO PATIENTS | -259,050 | 4,103,151 |
| 57 | 5700 RENAL DIALYSIS | -1,500 | 927,400 |
| 59 | 3120 SPECIAL PROCEDURES | -27,337 | 2,509,756 |
| 59.02 | 3950 PARTIAL HOSPITALIZATION | | 5 |
| | OUTPAT SERVICE COST CNTRS | | |
| 61 | 6100 EMERGENCY | -2,549,151 | 1,798,340 |
| 62 | 6200 OBSERVATION BEDS (NON-DISTINCT PART) | | |
| | OTHER REIMBURS COST CNTRS | | |
| 71 | 7100 HOME HEALTH AGENCY | -85,118 | 2,351,710 |
| | SPEC PURPOSE COST CENTERS | | |
| 88 | 8800 INTEREST EXPENSE | | -0- |
| 90 | 9000 OTHER CAPITAL RELATED COSTS | | -0- |
| 93 | 9300 HOSPICE | 981 | 1,033,865 |
| 95 | SUBTOTALS | -8,874,632 | 71,534,752 |
| | NONREIMBURS COST CENTERS | | |
| 96 | 9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN | | |
| 98 | 9800 PHYSICIANS' PRIVATE OFFICES | | 235,822 |
| 100 | 7950 OTHER NON-REIMBURSABLE | | |
| 100.01 | 7951 RESPITE | | |
| 100.02 | 7952 LIFELINE | | 66,913 |
| 100.03 | 7953 OUTREACH | | 65,828 |
| 100.04 | 7954 ENT | | 603,896 |
| 100.05 | 7955 GASTRO CLINIC | | 590,062 |
| 100.09 | 7959 SENIOR SERVICES | | 57,231 |
| 100.11 | 7961 GUEST MEALS | | |
| 100.12 | 7962 OTHER | | 13,146 |
| 100.13 | 7963 RURAL OUTREACH | | 68,468 |
| 100.16 | 7966 WYNDREST NURSING HOME | | 2,628,873 |
| 101 | TOTAL | -8,874,632 | 75,864,991 |

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 I 16-0080 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET
 I I TO 6/30/2008 I

| LINE NO. | COST CENTER DESCRIPTION | CMS CODE | STANDARD LABEL FOR NON-STANDARD CODES |
|----------|--------------------------------------|----------|---------------------------------------|
| | GENERAL SERVICE COST | | |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 0300 | |
| 3.01 | NEW CAP SOUTH 1970 BUILDING | 0301 | NEW CAP REL COSTS-BLDG & FIXT |
| 3.02 | NEW CAP BLUFF BUILDING | 0302 | NEW CAP REL COSTS-BLDG & FIXT |
| 3.03 | NEW CAP REL COSTS-RAD ONCOLOGY BLDG | 0303 | NEW CAP REL COSTS-BLDG & FIXT |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | 0400 | |
| 5 | EMPLOYEE BENEFITS | 0500 | |
| 6.02 | INFORMATION SYSTEMS | 0620 | DATA PROCESSING |
| 6.03 | PURCHASING, RECEIVING AND STORES | 0630 | PURCHASING, RECEIVING AND STORES |
| 6.04 | ADMITTING | 0640 | ADMITTING |
| 6.05 | CASHIERING/ACCOUNTS RECEIVABLE | 0650 | CASHIERING/ACCOUNTS RECEIVABLE |
| 6.06 | OTHER ADMINISTRATIVE AND GENERAL | 0660 | OTHER ADMINISTRATIVE AND GENERAL |
| 7 | MAINTENANCE & REPAIRS | 0700 | |
| 8 | OPERATION OF PLANT | 0800 | |
| 9 | LAUNDRY & LINEN SERVICE | 0900 | |
| 10 | HOUSEKEEPING | 1000 | |
| 11 | DIETARY | 1100 | |
| 12 | CAFETERIA | 1200 | |
| 14 | NURSING ADMINISTRATION | 1400 | |
| 15 | CENTRAL SERVICES & SUPPLY | 1500 | |
| 17 | MEDICAL RECORDS & LIBRARY | 1700 | |
| 18 | SOCIAL SERVICE | 1800 | |
| | INPAT ROUTINE SRVC C | | |
| 25 | ADULTS & PEDIATRICS | 2500 | |
| 26 | INTENSIVE CARE UNIT | 2600 | |
| 31 | SUBPROVIDER | 3100 | |
| 31.01 | ACUTE REHAB UNIT | 3101 | SUBPROVIDER ##### |
| 33 | NURSERY | 3300 | |
| 34 | SKILLED NURSING FACILITY | 3400 | |
| | ANCILLARY SRVC COST | | |
| 37 | OPERATING ROOM | 3700 | |
| 39 | DELIVERY ROOM & LABOR ROOM | 3900 | |
| 41 | RADIOLOGY-DIAGNOSTIC | 4100 | |
| 44 | LABORATORY | 4400 | |
| 49 | RESPIRATORY THERAPY | 4900 | |
| 50 | PHYSICAL THERAPY | 5000 | |
| 52 | SPEECH PATHOLOGY | 5200 | |
| 53 | ELECTROCARDIOLOGY | 5300 | |
| 55 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 5500 | |
| 56 | DRUGS CHARGED TO PATIENTS | 5600 | |
| 57 | RENAL DIALYSIS | 5700 | |
| 59 | SPECIAL PROCEDURES | 3120 | CARDIAC CATHETERIZATION LABORATORY |
| 59.02 | PARTIAL HOSPITALIZATION | 3950 | OTHER ANCILLARY SERVICE COST CENTERS |
| | OUTPAT SERVICE COST | | |
| 61 | EMERGENCY | 6100 | |
| 62 | OBSERVATION BEDS (NON-DISTINCT PART) | 6200 | |
| | OTHER REIMBURS COST | | |
| 71 | HOME HEALTH AGENCY | 7100 | |
| | SPEC PURPOSE COST CE | | |
| 88 | INTEREST EXPENSE | 8800 | |
| 90 | OTHER CAPITAL RELATED COSTS | 9000 | |
| 93 | HOSPICE | 9300 | |
| 95 | SUBTOTALS | 0000 | |
| | NONREIMBURS COST CEN | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 9600 | |
| 98 | PHYSICIANS' PRIVATE OFFICES | 9800 | |
| 100 | OTHER NON-REIMBURSABLE | 7950 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.01 | RESPIRE | 7951 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.02 | LIFELINE | 7952 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.03 | OUTREACH | 7953 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.04 | ENT | 7954 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.05 | GASTRO CLINIC | 7955 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.09 | SENIOR SERVICES | 7959 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.11 | GUEST MEALS | 7961 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.12 | OTHER | 7962 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.13 | RURAL OUTREACH | 7963 | OTHER NONREIMBURSABLE COST CENTERS |
| 100.16 | WYNDREST NURSING HOME | 7966 | OTHER NONREIMBURSABLE COST CENTERS |
| 101 | TOTAL | 0000 | |

RECLASSIFICATIONS

| | | |
|------------------------|---|-------------------------------------|
| PROVIDER NO: 160080 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 1/16/2009 WORKSHEET A-6 |
|------------------------|---|-------------------------------------|

| EXPLANATION OF RECLASSIFICATION | | INCREASE | | |
|---------------------------------|---------------------------|------------------------------------|--------|---------|
| CODE (1) | COST CENTER | LINE NO | SALARY | OTHER |
| 1 | LAUNDRY EXPENSE | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |
| 15 | | | | |
| 16 | | | | |
| 17 | | | | |
| 18 | | | | |
| 19 | | | | |
| 20 | | | | |
| 21 | | | | |
| 22 | DEPRECIATION TO WYNDCREST | B WYNDREST NURSING HOME | 100.16 | 107,595 |
| 23 | DEPRECIATION TO CHILDCARE | C EMPLOYEE BENEFITS | 5 | 30,000 |
| 24 | DIETARY EXPENSE | D DIETARY | 11 | 135,333 |
| 25 | | | | |
| 26 | | | | |
| 27 | | | | |
| 28 | | | | |
| 29 | | | | |
| 30 | | | | |
| 31 | | | | |
| 32 | | | | |
| 33 | | | | |
| 34 | | | | |
| 35 | | | | |
| 1 | DIETARY EXPENSE | D | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | PRINTING TRANSFERS | E OTHER ADMINISTRATIVE AND GENERAL | 6.06 | 47,797 |
| 15 | | | | |
| 16 | | | | |
| 17 | | | | |
| 18 | | | | |
| 19 | | | | |
| 20 | | | | |
| 21 | | | | |
| 22 | | | | |
| 23 | | | | |
| 24 | | | | |
| 25 | | | | |
| 26 | | | | |
| 27 | | | | |
| 28 | | | | |
| 29 | | | | |
| 30 | | | | |
| 31 | | | | |
| 32 | | | | |
| 33 | | | | |
| 34 | | | | |
| 35 | | | | |
| 1 | PRINTING TRANSFERS | E | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |

RECLASSIFICATIONS

| | | |
|------------------------|---|--|
| PROVIDER NO: 160080 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 1/16/2009 WORKSHEET A-6 CONTD |
|------------------------|---|--|

| EXPLANATION OF RECLASSIFICATION | INCREASE | | | | |
|---------------------------------|------------------|-------------------------------------|-----------------|-------------|------------|
| | CODE (1) 1 | COST CENTER 2 | LINE NO 3 | SALARY 4 | OTHER 5 |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |
| 13 | | | | | |
| 14 | | | | | |
| 15 | | | | | |
| 16 | | | | | |
| 17 DEPRECIATION EXPENSE | F | NEW CAP SOUTH 1970 BUILDING | 3.01 | | 492,691 |
| 18 | | NEW CAP BLUFF BUILDING | 3.02 | | 73,924 |
| 19 | | NEW CAP REL COSTS-RAD ONCOLOGY BLDG | 3.03 | | 154,655 |
| 36 TOTAL RECLASSIFICATIONS | | | | | 1,357,836 |

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

| | | |
|------------------------|---|-------------------------------------|
| PROVIDER NO: 160080 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 1/16/2009 WORKSHEET A-6 |
|------------------------|---|-------------------------------------|

| EXPLANATION OF RECLASSIFICATION | CODE (1) | COST CENTER 6 | DECREASE | | SALARY 8 | OTHER 9 | A-7 REF 10 |
|---------------------------------|-------------|------------------|-----------------|--------|-------------|------------|------------------|
| | | | LINE NO 7 | | | | |
| 1 LAUNDRY EXPENSE | A | | | 11 | | 251 | |
| 2 | | | | 14 | | 44 | |
| 3 | | | | 15 | | 8,236 | |
| 4 | | | | 25 | | 97,632 | |
| 5 | | | | 26 | | 14,152 | |
| 6 | | | | 31 | | 6,060 | |
| 7 | | | | 33 | | 1,597 | |
| 8 | | | | 37 | | 21,861 | |
| 9 | | | | 39 | | 6,181 | |
| 10 | | | | 41 | | 13,556 | |
| 11 | | | | 44 | | 210 | |
| 12 | | | | 49 | | 96 | |
| 13 | | | | 50 | | 1,836 | |
| 14 | | | | 53 | | 1,848 | |
| 15 | | | | 56 | | 231 | |
| 16 | | | | 57 | | 2,631 | |
| 17 | | | | 59 | | 1,472 | |
| 18 | | | | 61 | | 26,159 | |
| 19 | | | | 34 | | 63,074 | |
| 20 | | | | 100.16 | | 48,475 | |
| 21 | | | | 31.01 | | 239 | |
| 22 DEPRECIATION TO WYNDCREST | B | | | 3 | | 107,595 | 9 |
| 23 DEPRECIATION TO CHILDCARE | C | | | 3 | | 30,000 | 9 |
| 24 DIETARY EXPENSE | D | | | 5 | | 19,758 | |
| 25 | | | | 6.02 | | 12,185 | |
| 26 | | | | 6.06 | | 36,308 | |
| 27 | | | | 14 | | 959 | |
| 28 | | | | 18 | | 430 | |
| 29 | | | | 25 | | 30,726 | |
| 30 | | | | 26 | | 5,686 | |
| 31 | | | | 31 | | 7,102 | |
| 32 | | | | 31.01 | | 1,488 | |
| 33 | | | | 37 | | 855 | |
| 34 | | | | 41 | | 139 | |
| 35 | | | | 44 | | 27 | |
| 1 DIETARY EXPENSE | D | | | 49 | | 26 | |
| 2 | | | | 50 | | 94 | |
| 3 | | | | 53 | | 507 | |
| 4 | | | | 57 | | 593 | |
| 5 | | | | 59 | | 65 | |
| 6 | | | | 61 | | 1,850 | |
| 7 | | | | 71 | | 667 | |
| 8 | | | | 93 | | 160 | |
| 9 | | | | 100.09 | | 583 | |
| 10 | | | | 34 | | 13,524 | |
| 11 | | | | 100.12 | | 731 | |
| 12 | | | | 100.13 | | 686 | |
| 13 | | | | 17 | | 184 | |
| 14 PRINTING TRANSFERS | E | | | 5 | | 1,873 | |
| 15 | | | | 6.02 | | 17,713 | |
| 16 | | | | 6.03 | | 371 | |
| 17 | | | | 6.04 | | 394 | |
| 18 | | | | 6.05 | | 1,114 | |
| 19 | | | | 7 | | 116 | |
| 20 | | | | 10 | | 160 | |
| 21 | | | | 11 | | 3,633 | |
| 22 | | | | 14 | | 433 | |
| 23 | | | | 15 | | 136 | |
| 24 | | | | 17 | | 3,549 | |
| 25 | | | | 18 | | 502 | |
| 26 | | | | 25 | | 3,087 | |
| 27 | | | | 26 | | 462 | |
| 28 | | | | 31 | | 351 | |
| 29 | | | | 31.01 | | 42 | |
| 30 | | | | 33 | | 59 | |
| 31 | | | | 37 | | 757 | |
| 32 | | | | 39 | | 104 | |
| 33 | | | | 41 | | 502 | |
| 34 | | | | 44 | | 851 | |
| 35 | | | | 49 | | 72 | |
| 1 PRINTING TRANSFERS | E | | | 50 | | 1,980 | |
| 2 | | | | 52 | | 32 | |
| 3 | | | | 53 | | 673 | |
| 4 | | | | 56 | | 586 | |
| 5 | | | | 57 | | 506 | |
| 6 | | | | 59 | | 112 | |

RECLASSIFICATIONS

| | | |
|------------------------|---|--|
| PROVIDER NO: 160080 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 1/16/2009 WORKSHEET A-6 CONTD |
|------------------------|---|--|

| EXPLANATION OF RECLASSIFICATION | DECREASE | | | | | A-7 REF 10 |
|---------------------------------|-------------|-------------------------------|------------|--------|-----------|------------------|
| | CODE (1) | COST CENTER | LINE NO | SALARY | OTHER | |
| | 1 | 6 | 7 | 8 | 9 | |
| 7 | | EMERGENCY | 61 | | 449 | |
| 8 | | HOME HEALTH AGENCY | 71 | | 547 | |
| 9 | | HOSPICE | 93 | | 487 | |
| 10 | | SENIOR SERVICES | 100.09 | | 2,279 | |
| 11 | | SKILLED NURSING FACILITY | 34 | | 1,751 | |
| 12 | | OTHER | 100.12 | | 945 | |
| 13 | | RURAL OUTREACH | 100.13 | | 606 | |
| 14 | | WYNDREST NURSING HOME | 100.16 | | 469 | |
| 15 | | LAUNDRY & LINEN SERVICE | 9 | | 87 | |
| 16 | | PHYSICIANS' PRIVATE OFFICES | 98 | | 7 | |
| 17 DEPRECIATION EXPENSE | F | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 721,270 | 9 |
| 18 | | | | | | 9 |
| 19 | | | | | | 9 |
| 36 TOTAL RECLASSIFICATIONS | | | | | 1,357,836 | |

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

| | | |
|------------------------|---|--|
| PROVIDER NO: 160080 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 1/16/2009 WORKSHEET A-6 NOT A CMS WORKSHEET |
|------------------------|---|--|

RECLASS CODE: A
EXPLANATION : LAUNDRY EXPENSE

| ----- INCREASE ----- | | | | ----- DECREASE ----- | | | |
|------------------------------------|-------------------------|------|---------|----------------------------|--------|--------|---------|
| LINE | COST CENTER | LINE | AMOUNT | COST CENTER | LINE | AMOUNT | |
| 1.00 | LAUNDRY & LINEN SERVICE | 9 | 315,841 | DIETARY | 11 | 251 | |
| 2.00 | | | 0 | NURSING ADMINISTRATION | 14 | 44 | |
| 3.00 | | | 0 | CENTRAL SERVICES & SUPPLY | 15 | 8,236 | |
| 5.00 | | | 0 | ADULTS & PEDIATRICS | 25 | 97,632 | |
| 6.00 | | | 0 | INTENSIVE CARE UNIT | 26 | 14,152 | |
| 7.00 | | | 0 | SUBPROVIDER | 31 | 6,060 | |
| 8.00 | | | 0 | NURSERY | 33 | 1,597 | |
| 9.00 | | | 0 | OPERATING ROOM | 37 | 21,861 | |
| 10.00 | | | 0 | DELIVERY ROOM & LABOR ROOM | 39 | 6,181 | |
| 11.00 | | | 0 | RADIOLOGY-DIAGNOSTIC | 41 | 13,556 | |
| 12.00 | | | 0 | LABORATORY | 44 | 210 | |
| 13.00 | | | 0 | RESPIRATORY THERAPY | 49 | 96 | |
| 14.00 | | | 0 | PHYSICAL THERAPY | 50 | 1,836 | |
| 15.00 | | | 0 | ELECTROCARDIOLOGY | 53 | 1,848 | |
| 16.00 | | | 0 | DRUGS CHARGED TO PATIENTS | 56 | 231 | |
| 17.00 | | | 0 | RENAL DIALYSIS | 57 | 2,631 | |
| 18.00 | | | 0 | SPECIAL PROCEDURES | 59 | 1,472 | |
| 19.00 | | | 0 | EMERGENCY | 61 | 26,159 | |
| 20.00 | | | 0 | SKILLED NURSING FACILITY | 34 | 63,074 | |
| 21.00 | | | 0 | WYNDREST NURSING HOME | 100.16 | 48,475 | |
| 22.00 | | | 0 | ACUTE REHAB UNIT | 31.01 | 239 | |
| TOTAL RECLASSIFICATIONS FOR CODE A | | | 315,841 | | | | 315,841 |

RECLASS CODE: B
EXPLANATION : DEPRECIATION TO WYNDCREST

| ----- INCREASE ----- | | | | ----- DECREASE ----- | | | |
|------------------------------------|-----------------------|--------|---------|-------------------------------|------|---------|---------|
| LINE | COST CENTER | LINE | AMOUNT | COST CENTER | LINE | AMOUNT | |
| 1.00 | WYNDREST NURSING HOME | 100.16 | 107,595 | NEW CAP REL COSTS-BLDG & FIXT | 3 | 107,595 | |
| TOTAL RECLASSIFICATIONS FOR CODE B | | | 107,595 | | | | 107,595 |

RECLASS CODE: C
EXPLANATION : DEPRECIATION TO CHILDCARE

| ----- INCREASE ----- | | | | ----- DECREASE ----- | | | |
|------------------------------------|-------------------|------|--------|-------------------------------|------|--------|--------|
| LINE | COST CENTER | LINE | AMOUNT | COST CENTER | LINE | AMOUNT | |
| 1.00 | EMPLOYEE BENEFITS | 5 | 30,000 | NEW CAP REL COSTS-BLDG & FIXT | 3 | 30,000 | |
| TOTAL RECLASSIFICATIONS FOR CODE C | | | 30,000 | | | | 30,000 |

RECLASS CODE: D
EXPLANATION : DIETARY EXPENSE

| ----- INCREASE ----- | | | | ----- DECREASE ----- | | | |
|------------------------------------|-------------|------|---------|--------------------------------|--------|--------|---------|
| LINE | COST CENTER | LINE | AMOUNT | COST CENTER | LINE | AMOUNT | |
| 1.00 | DIETARY | 11 | 135,333 | EMPLOYEE BENEFITS | 5 | 19,758 | |
| 2.00 | | | 0 | INFORMATION SYSTEMS | 6.02 | 12,185 | |
| 3.00 | | | 0 | OTHER ADMINISTRATIVE AND GENER | 6.06 | 36,308 | |
| 5.00 | | | 0 | NURSING ADMINISTRATION | 14 | 959 | |
| 6.00 | | | 0 | SOCIAL SERVICE | 18 | 430 | |
| 7.00 | | | 0 | ADULTS & PEDIATRICS | 25 | 30,726 | |
| 8.00 | | | 0 | INTENSIVE CARE UNIT | 26 | 5,686 | |
| 9.00 | | | 0 | SUBPROVIDER | 31 | 7,102 | |
| 10.00 | | | 0 | ACUTE REHAB UNIT | 31.01 | 1,488 | |
| 11.00 | | | 0 | OPERATING ROOM | 37 | 855 | |
| 12.00 | | | 0 | RADIOLOGY-DIAGNOSTIC | 41 | 139 | |
| 13.00 | | | 0 | LABORATORY | 44 | 27 | |
| 14.00 | | | 0 | RESPIRATORY THERAPY | 49 | 26 | |
| 15.00 | | | 0 | PHYSICAL THERAPY | 50 | 94 | |
| 16.00 | | | 0 | ELECTROCARDIOLOGY | 53 | 507 | |
| 17.00 | | | 0 | RENAL DIALYSIS | 57 | 593 | |
| 18.00 | | | 0 | SPECIAL PROCEDURES | 59 | 65 | |
| 19.00 | | | 0 | EMERGENCY | 61 | 1,850 | |
| 20.00 | | | 0 | HOME HEALTH AGENCY | 71 | 667 | |
| 21.00 | | | 0 | HOSPICE | 93 | 160 | |
| 22.00 | | | 0 | SENIOR SERVICES | 100.09 | 583 | |
| 23.00 | | | 0 | SKILLED NURSING FACILITY | 34 | 13,524 | |
| 24.00 | | | 0 | OTHER | 100.12 | 731 | |
| 25.00 | | | 0 | RURAL OUTREACH | 100.13 | 686 | |
| 26.00 | | | 0 | MEDICAL RECORDS & LIBRARY | 17 | 184 | |
| TOTAL RECLASSIFICATIONS FOR CODE D | | | 135,333 | | | | 135,333 |

RECLASS CODE: E
EXPLANATION : PRINTING TRANSFERS

| ----- INCREASE ----- | | | | ----- DECREASE ----- | | | |
|----------------------|--------------------------------|------|--------|----------------------|------|--------|--|
| LINE | COST CENTER | LINE | AMOUNT | COST CENTER | LINE | AMOUNT | |
| 1.00 | OTHER ADMINISTRATIVE AND GENER | 6.06 | 47,797 | EMPLOYEE BENEFITS | 5 | 1,873 | |

RECLASSIFICATIONS

| | | |
|--------------|----------------|---------------------|
| PROVIDER NO: | PERIOD: | PREPARED |
| 160080 | FROM 7/ 1/2007 | 1/16/2009 |
| | TO 6/30/2008 | WORKSHEET A-6 |
| | | NOT A CMS WORKSHEET |

RECLASS CODE: E
EXPLANATION : PRINTING TRANSFERS

| ----- INCREASE ----- | | | | ----- DECREASE ----- | | | |
|------------------------------------|-------------|------|--------|--------------------------------|--------|--------|--------|
| LINE | COST CENTER | LINE | AMOUNT | COST CENTER | LINE | AMOUNT | |
| 2.00 | | | 0 | INFORMATION SYSTEMS | 6.02 | 17,713 | |
| 3.00 | | | 0 | PURCHASING, RECEIVING AND STOR | 6.03 | 371 | |
| 4.00 | | | 0 | ADMITTING | 6.04 | 394 | |
| 5.00 | | | 0 | CASHIERING/ACCOUNTS RECEIVABLE | 6.05 | 1,114 | |
| 6.00 | | | 0 | MAINTENANCE & REPAIRS | 7 | 116 | |
| 7.00 | | | 0 | HOUSEKEEPING | 10 | 160 | |
| 8.00 | | | 0 | DIETARY | 11 | 3,633 | |
| 9.00 | | | 0 | NURSING ADMINISTRATION | 14 | 433 | |
| 10.00 | | | 0 | CENTRAL SERVICES & SUPPLY | 15 | 136 | |
| 11.00 | | | 0 | MEDICAL RECORDS & LIBRARY | 17 | 3,549 | |
| 12.00 | | | 0 | SOCIAL SERVICE | 18 | 502 | |
| 13.00 | | | 0 | ADULTS & PEDIATRICS | 25 | 3,087 | |
| 14.00 | | | 0 | INTENSIVE CARE UNIT | 26 | 462 | |
| 15.00 | | | 0 | SUBPROVIDER | 31 | 351 | |
| 16.00 | | | 0 | ACUTE REHAB UNIT | 31.01 | 42 | |
| 17.00 | | | 0 | NURSERY | 33 | 59 | |
| 18.00 | | | 0 | OPERATING ROOM | 37 | 757 | |
| 19.00 | | | 0 | DELIVERY ROOM & LABOR ROOM | 39 | 104 | |
| 20.00 | | | 0 | RADIOLOGY-DIAGNOSTIC | 41 | 502 | |
| 21.00 | | | 0 | LABORATORY | 44 | 851 | |
| 22.00 | | | 0 | RESPIRATORY THERAPY | 49 | 72 | |
| 23.00 | | | 0 | PHYSICAL THERAPY | 50 | 1,980 | |
| 24.00 | | | 0 | SPEECH PATHOLOGY | 52 | 32 | |
| 25.00 | | | 0 | ELECTROCARDIOLOGY | 53 | 673 | |
| 26.00 | | | 0 | DRUGS CHARGED TO PATIENTS | 56 | 586 | |
| 27.00 | | | 0 | RENAL DIALYSIS | 57 | 506 | |
| 28.00 | | | 0 | SPECIAL PROCEDURES | 59 | 112 | |
| 30.00 | | | 0 | EMERGENCY | 61 | 449 | |
| 31.00 | | | 0 | HOME HEALTH AGENCY | 71 | 547 | |
| 32.00 | | | 0 | HOSPICE | 93 | 487 | |
| 33.00 | | | 0 | SENIOR SERVICES | 100.09 | 2,279 | |
| 34.00 | | | 0 | SKILLED NURSING FACILITY | 34 | 1,751 | |
| 35.00 | | | 0 | OTHER | 100.12 | 945 | |
| 36.00 | | | 0 | RURAL OUTREACH | 100.13 | 606 | |
| 37.00 | | | 0 | WYNDREST NURSING HOME | 100.16 | 469 | |
| 38.00 | | | 0 | LAUNDRY & LINEN SERVICE | 9 | 87 | |
| 39.00 | | | 0 | PHYSICIANS' PRIVATE OFFICES | 98 | 7 | |
| TOTAL RECLASSIFICATIONS FOR CODE E | | | 47,797 | | | | 47,797 |

RECLASS CODE: F
EXPLANATION : DEPRECIATION EXPENSE

| ----- INCREASE ----- | | | | ----- DECREASE ----- | | | |
|------------------------------------|--------------------------------|------|---------|-------------------------------|------|---------|---------|
| LINE | COST CENTER | LINE | AMOUNT | COST CENTER | LINE | AMOUNT | |
| 1.00 | NEW CAP SOUTH 1970 BUILDING | 3.01 | 492,691 | NEW CAP REL COSTS-BLDG & FIXT | 3 | 721,270 | |
| 2.00 | NEW CAP BLUFF BUILDING | 3.02 | 73,924 | | | 0 | |
| 3.00 | NEW CAP REL COSTS-RAD ONCOLOGY | 3.03 | 154,655 | | | 0 | |
| TOTAL RECLASSIFICATIONS FOR CODE F | | | 721,270 | | | | 721,270 |

Health Financial Systems MCRIF32 FOR MERCY MEDICAL CENTER IN LIEU OF FORM CMS-2552-96(09/1996)
 ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL I PROVIDER NO: I PERIOD: I PREPARED 1/16/2009
 ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE I 16-0080 I FROM 7/ 1/2007 I WORKSHEET A-7
 COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS I I TO 6/30/2008 I PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

| DESCRIPTION | BEGINNING BALANCES 1 | PURCHASES 2 | ACQUISITIONS DONATION 3 | TOTAL 4 | DISPOSALS AND RETIREMENTS 5 | ENDING BALANCE 6 | FULLY DEPRECIATED ASSETS 7 |
|-----------------------|----------------------------|----------------|-------------------------------|------------|--------------------------------------|------------------------|-------------------------------------|
| 1 LAND | 512,212 | | | | | 512,212 | |
| 2 LAND IMPROVEMENTS | 1,951,089 | 70,415 | | 70,415 | | 2,021,504 | |
| 3 BUILDINGS & FIXTURE | 63,840,365 | 1,333,550 | | 1,333,550 | 81,036 | 65,092,879 | |
| 4 BUILDING IMPROVEMEN | | | | | | | |
| 5 FIXED EQUIPMENT | | | | | | | |
| 6 MOVABLE EQUIPMENT | 35,462,848 | 2,763,618 | | 2,763,618 | 583,172 | 37,643,294 | |
| 7 SUBTOTAL | 101,766,514 | 4,167,583 | | 4,167,583 | 664,208 | 105,269,889 | |
| 8 RECONCILING ITEMS | | | | | | | |
| 9 TOTAL | 101,766,514 | 4,167,583 | | 4,167,583 | 664,208 | 105,269,889 | |

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

| * | DESCRIPTION | COMPUTATION OF RATIOS | | | ALLOCATION OF OTHER CAPITAL | | | TOTAL |
|------|----------------------|-----------------------|--|----------------|-----------------------------|----------------|------------|-------|
| | | GROSS ASSETS 1 | CAPITLIZED GROSS ASSETS LEASES 2 | FOR RATIO 3 | RATIO 4 | INSURANCE 5 | TAXES 6 | |
| 3 | NEW CAP REL COSTS-BL | 67,114,382 | | 67,114,382 | .640663 | | | |
| 3 01 | NEW CAP SOUTH 1970 B | | | | | | | |
| 3 02 | NEW CAP BLUFF BUILDI | | | | | | | |
| 3 03 | NEW CAP REL COSTS-RA | | | | | | | |
| 4 | NEW CAP REL COSTS-MV | 37,643,294 | | 37,643,294 | .359337 | | | |
| 5 | TOTAL | 104,757,676 | | 104,757,676 | 1.000000 | | | |

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

| * | DESCRIPTION | DEPRECIATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL | TOTAL (1) |
|------|----------------------|--------------|-------|-----------|-----------|-------|--------------------|-----------|
| | | 9 | 10 | 11 | 12 | 13 | RELATED COST 14 | 15 |
| 3 | NEW CAP REL COSTS-BL | 1,757,017 | | 1,564,353 | | | | 3,321,370 |
| 3 01 | NEW CAP SOUTH 1970 B | 492,691 | | | | | | 492,691 |
| 3 02 | NEW CAP BLUFF BUILDI | 73,924 | | | | | | 73,924 |
| 3 03 | NEW CAP REL COSTS-RA | 154,655 | | | | | | 154,655 |
| 4 | NEW CAP REL COSTS-MV | | | | | | | |
| 5 | TOTAL | 2,478,287 | | 1,564,353 | | | | 4,042,640 |

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

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

| * | DESCRIPTION | DEPRECIATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL | TOTAL (1) |
|------|----------------------|--------------|-------|-----------|-----------|-------|--------------------|-----------|
| | | 9 | 10 | 11 | 12 | 13 | RELATED COST 14 | 15 |
| 3 | NEW CAP REL COSTS-BL | 2,615,882 | | 2,098,942 | | | | 4,714,824 |
| 3 01 | NEW CAP SOUTH 1970 B | | | | | | | |
| 3 02 | NEW CAP BLUFF BUILDI | | | | | | | |
| 3 03 | NEW CAP REL COSTS-RA | | | | | | | |
| 4 | NEW CAP REL COSTS-MV | | | | | | | |
| 5 | TOTAL | 2,615,882 | | 2,098,942 | | | | 4,714,824 |

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO:
I 16-0080
I

I PERIOD: I PREPARED 1/16/2009
I FROM 7/ 1/2007 I WORKSHEET A-8
I TO 6/30/2008 I

| DESCRIPTION (1) | (2) BASIS/CODE | AMOUNT | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | | WKST. A-7 REF. 5 |
|-----------------|-------------------|------------|--|---------|----|---------------------------|
| | | | COST CENTER | LINE NO | | |
| 1 | | | **COST CENTER DELETED** | 1 | | |
| 2 | | | **COST CENTER DELETED** | 2 | | |
| 3 | A | -534,589 | NEW CAP REL COSTS-BLDG & | 3 | 11 | |
| 4 | | | NEW CAP REL COSTS-MVBLE E | 4 | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | A | -2,198 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 10 | A | -17,732 | OPERATION OF PLANT | 8 | | |
| 11 | | | | | | |
| 12 | A-8-2 | -1,796,834 | | | | |
| 13 | | | | | | |
| 14 | A-8-1 | -8,086 | | | | |
| 15 | B | -51,902 | LAUNDRY & LINEN SERVICE | 9 | | |
| 16 | B | -395,430 | DIETARY | 11 | | |
| 17 | | | | | | |
| 18 | | | | | | |
| 19 | | | | | | |
| 20 | B | -32,107 | MEDICAL RECORDS & LIBRARY | 17 | | |
| 21 | | | | | | |
| 22 | | | | | | |
| 23 | | | | | | |
| 24 | | | | | | |
| 25 | A-8-3/A-8-4 | | RESPIRATORY THERAPY | 49 | | |
| 26 | A-8-3/A-8-4 | | PHYSICAL THERAPY | 50 | | |
| 27 | A-8-3 | | | | | |
| 28 | | | **COST CENTER DELETED** | 89 | | |
| 29 | | | **COST CENTER DELETED** | 1 | | |
| 30 | | | **COST CENTER DELETED** | 2 | | |
| 31 | | | NEW CAP REL COSTS-BLDG & | 3 | | |
| 32 | | | NEW CAP REL COSTS-MVBLE E | 4 | | |
| 33 | | | **COST CENTER DELETED** | 20 | | |
| 34 | | | | | | |
| 35 | A-8-4 | | **COST CENTER DELETED** | 51 | | |
| 36 | A-8-4 | | SPEECH PATHOLOGY | 52 | | |
| 37 | B | -259,050 | DRUGS CHARGED TO PATIENTS | 56 | | |
| 38 | B | -450 | PHYSICAL THERAPY | 50 | | |
| 39 | B | -10,883 | NURSING ADMINISTRATION | 14 | | |
| 40 | B | -19,274 | EMPLOYEE BENEFITS | 5 | | |
| 41 | B | -10,399 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 42 | B | -1,339 | RADIOLOGY-DIAGNOSTIC | 41 | | |
| 43 | B | -9,861 | RADIOLOGY-DIAGNOSTIC | 41 | | |
| 44 | B | -9,773 | LABORATORY | 44 | | |
| 45 | B | -465 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 46 | B | -3,320 | DELIVERY ROOM & LABOR ROO | 39 | | |
| 47 | B | -19 | ADULTS & PEDIATRICS | 25 | | |
| 48 | B | -3,595 | HOME HEALTH AGENCY | 71 | | |
| 49 | B | 981 | HOSPICE | 93 | | |
| 49.01 | B | -47,415 | HOME HEALTH AGENCY | 71 | | |
| 49.02 | B | -397 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.03 | B | -342,358 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.04 | | | | | | |
| 49.05 | | | | | | |
| 49.06 | | | | | | |
| 49.07 | B | -3,387 | MEDICAL RECORDS & LIBRARY | 17 | | |
| 49.08 | B | -5,377 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.09 | B | -413 | EMPLOYEE BENEFITS | 5 | | |
| 49.10 | A | -1,055 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.11 | B | -32,862 | EMPLOYEE BENEFITS | 5 | | |
| 49.12 | B | -41 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.13 | B | -294,373 | EMPLOYEE BENEFITS | 5 | | |
| 49.14 | A | -16,319 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.15 | A | -232,689 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.16 | A | -3,833,806 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.17 | A | -841,880 | EMERGENCY | 61 | | |
| 49.18 | A | -34,108 | HOME HEALTH AGENCY | 71 | | |
| 49.19 | A | -21,827 | OTHER ADMINISTRATIVE AND | 6.06 | | |
| 49.20 | | | | | | |
| 50 | | -8,874,632 | | | | |

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

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

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

| LINE NO. | COST CENTER | EXPENSE ITEMS | AMOUNT OF ALLOWABLE COST | AMOUNT | NET* ADJUSTMENTS | WKSHT A-7 COL. REF. | |
|----------|-------------|--------------------------|---------------------------|-----------|------------------|---------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | | |
| 1 | 6 2 | INFORMATION SYSTEMS | TIS FEES | 2,868,587 | 3,558,437 | -689,850 | |
| 2 | 5 | EMPLOYEE BENEFITS | PENSION | 2,054,871 | 1,453,000 | 601,871 | |
| 3 | 5 | EMPLOYEE BENEFITS | WORKER COMP | 67,729 | 350,839 | -283,110 | |
| 4 | 5 | EMPLOYEE BENEFITS | STOP LOSS | 116,333 | 276,683 | -160,350 | |
| 4.01 | 6 6 | OTHER ADMINISTRATIVE AND | MALPRACTICE INSURANCE | 29,723 | 146,441 | -116,718 | |
| 4.02 | 6 6 | OTHER ADMINISTRATIVE AND | OTHER INSURANCE | 202,942 | 192,717 | 10,225 | |
| 4.03 | 6 6 | OTHER ADMINISTRATIVE AND | INTERCOMPANY DEBT COST | 939,358 | 902,396 | 36,962 | |
| 4.04 | 6 6 | OTHER ADMINISTRATIVE AND | TRINITY MANAGEMENT FEES | 2,146,596 | 1,553,712 | 592,884 | |
| 4.05 | 7 | MAINTENANCE & REPAIRS | IC REPAIRS AND MAINTNENAN | 694,479 | 694,479 | | |
| 5 | | TOTALS | | 9,120,618 | 9,128,704 | -8,086 | |

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

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

| SYMBOL (1) | NAME | PERCENTAGE OF OWNERSHIP | RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME | PERCENTAGE OF OWNERSHIP | TYPE OF BUSINESS |
|------------|------|-------------------------|---|-------------------------|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 |
| 1 | B | TRINITY HEALTH | | | |
| | | 100.00 | | 0.00 | |
| 2 | | 0.00 | | 0.00 | |
| 3 | | 0.00 | | 0.00 | |
| 4 | | 0.00 | | 0.00 | |
| 5 | | 0.00 | | 0.00 | |

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.