

Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information PRELIMINARY

Name of Hospital: Provident Hospital of Cook County		Medicare Provider Number: 14-0300	
Street: 500 East 51st Street		Medicaid Provider Number: 3049	
City: Chicago	State: Illinois	Zip: 60615	
Period Covered by Statement:	From: 12-01-2007	To: 11-30-2008	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Provident Hospital of Cook Cc 3049 for the cost report beginning 12-01-2007 and ending 11-30-2008 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.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12-01-2007 To: 11-30-2008

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	100	36,600		18,329	50.08%		5,214	4.00
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	19	6,954		2,508	36.07%			
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	10	3,660		1,263	34.51%			
22.	Total	129	47,214		22,100	46.81%		5,214	4.00
23.	Observation Bed Days								

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,154			1,797	3.90
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				862				
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				434				
22.	Total				7,450	33.71%		1,797	3.90

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	7,753	58,379

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	9,020,597	1,986,827	4.540203	91,855	16,725	417,040	75,935
2.	Recovery Room							
3.	Delivery and Labor Room	6,285,708	1,228,128	5.118121	785,790		4,021,768	
4.	Anesthesiology							
5.	Radiology - Diagnostic	6,286,324	10,268,033	0.612223	1,025,456	1,324,606	627,808	810,954
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	139,057	145,217	0.957581	20,358	7,358	19,494	7,046
8.	Laboratory	4,656,506	17,140,601	0.271665	3,398,731	1,693,138	923,316	459,966
9.	Blood							
10.	Blood - Administration	944,599	472,306	1.999972	175,409	29,775	350,813	59,549
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,951,008	2,157,082	0.904466	819,127	19,343	740,873	17,495
13.	Physical Therapy	409,640	1,238,534	0.330746	50,045	134,830	16,552	44,594
14.	Occupational Therapy	82,961	73,660	1.126269	12,380	2,610	13,943	2,940
15.	Speech Pathology	29,442	32,452	0.907248		1,624		1,473
16.	EKG	452,242	1,083,828	0.417264	228,924	48,617	95,522	20,286
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	6,999,173	10,913,235	0.641347	3,649,069	100,787	2,340,319	64,639
20.	Renal Dialysis	2,767	281,246	0.009838	129,000	375	1,269	4
21.	Ambulance							
22.	Other							
23.	Other							
24.	Other							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	2,385,125	2,995,073	0.796350	155	960,573	123	764,952
44.	Emergency	10,432,136	9,263,595	1.126143	507,715	1,496,320	571,760	1,685,070
45.	Observation							
46.	Total				10,894,014	5,836,681	10,140,600	4,014,903

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Sub I	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	22,653,859			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	18,329			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,235.96			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,154			
3.	Program general inpatient routine cost (Line 1c X Line 2)	7,606,098			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	7,606,098			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	6,687,762	2,508	2,666.57	862	2,298,583
9.	Coronary Care Unit					
10.	Other					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	1,872,942	1,263	1,482.93	434	643,592
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					10,140,600
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					20,688,873

**Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program
PRELIMINARY**

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Sub I						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Lines 60-63)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12-01-2007 To: 11-30-2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	2,527,256	1,986,827	1.272006	91,855	16,725	116,840	21,274
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	658,754	10,268,033	0.064156	1,025,456	1,324,606	65,789	84,981
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	136,286	17,140,601	0.007951	3,398,731	1,693,138	27,023	13,462
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	116,668	1,238,534	0.094198	50,045	134,830	4,714	12,701
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	583,536	1,083,828	0.538403	228,924	48,617	123,253	26,176
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Other							
23.	Other							
24.	Other							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	2,734,860	9,263,595	0.295227	507,715	1,496,320	149,891	441,754
45.	Observation							
46.	Ancillary Total						487,510	600,348

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	8,681,899	18,329	473.67	6,154		2,914,965	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,327,826	2,508	529.44	862		456,377	
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						3,371,342	
68.	Ancillary Total (from line 46)						487,510	600,348
69.	Total (Lines 67-68)						3,858,852	600,348

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		4,014,903
2.	Inpatient Operating Services (BHF Page 4, Line 25)	20,688,873	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)	3,858,852	600,348
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	778,399	375,910
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	25,326,124	4,991,161
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	84.00%	16.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	10,894,014	5,836,681
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	5,075,304	
	B. Sub I		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	2,480,956	
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	630,810	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	19,081,084	5,836,681
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		(5,399,520)
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)	(4,535,597)	(863,923)

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	25,326,124	4,991,161
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)	(4,535,597)	(863,923)
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	20,790,527	4,127,238
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	20,790,527	4,127,238

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	23,636,368
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		12/01/20(to 11/30/2005 (1)	12/01/20(to 11/30/2006 (2)	12/01/20(to 11/30/2007 (3)		
		1.	Carry Over - Beginning of Current Period	3,915,929		
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)			5,399,520	5,399,520	
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)	3,915,929	7,443,367	12,277,072	5,399,520	29,035,888

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			1.	Cost Report Period ended 11/30/2005		100.00%
2.	Cost Report Period ended 11/30/2006		100.00%			
3.	Cost Report Period ended 11/30/2007		80.00%		20.00%	
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Sub I	Sub II Sub II	Sub III Sub III
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

Part C. Program Cost

	General Service	Sub I Sub I	Sub II Sub II	Sub III Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Sub I	Sub II Sub II	Sub III Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12-01-2007 To: 11-30-2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	183,150	1,986,827	0.092182	91,855	16,725	8,467	1,542
2.	Recovery Room							
3.	Delivery and Labor Room	135,589	1,228,128	0.110403	785,790		86,754	
4.	Anesthesiology							
5.	Radiology - Diagnostic	22,946	10,268,033	0.002235	1,025,456	1,324,606	2,292	2,960
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Other							
23.	Other							
24.	Other							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	276,602	2,995,073	0.092352	155	960,573	14	88,711
44.	Emergency	1,750,148	9,263,595	0.188928	507,715	1,496,320	95,922	282,697
45.	Observation							
46.	Ancillary Total						193,449	375,910

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	1,401,369	18,329	76.46	6,154		470,535	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	176,058	2,508	70.20	862		60,512	
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	156,867	1,263	124.20	434		53,903	
67.	Routine Total (lines 47-66)						584,950	
68.	Ancillary Total (from line 46)						193,449	375,910
69.	Total (Lines 67-68)						778,399	375,910

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12-01-2007 To: 11-30-2008

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,016		7,016
Newborn Days	434		434
Total Inpatient Revenue	19,081,084		19,081,084
Ancillary Revenue	10,894,014		10,894,014
Routine Revenue	8,187,070		8,187,070
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	3,516	4,237	7,753
Total Outpatient Revenue	5,836,681		5,836,681
Outpatient Received and Receivable			

Notes:

Filed OHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.
Adjusted Discharges on BHF Page 2 to agree with W/S S-3.
GME Costs were added as filed W/S B, Pt 1, Col 26.