

# Hospital Statement of Cost

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

**General Information** AMENDED PRELIMINARY as of 06/29/2010

Name of Hospital: Provena United Samaritans Medical Center		Medicare Provider Number: 14-0093	
Street: 812 North Logan Avenue		Medicaid Provider Number: 4001	
City: Danville	State: Illinois	Zip: 61832	
Period Covered by Statement:	From: 01-01-2008	To: 12-31-2008	

**Type of Control**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" 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)) Provena United Samaritans M 4001 for the cost report beginning 01-01-2008 and ending 12-31-2008 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

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

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: 14-0093	Medicaid Provider Number: 4001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-2008 To: 12-31-2008

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	162	59,292	2,058	24,711	41.68%		7,957	3.43
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	12	4,392		2,617	59.59%			
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	17	6,205		1,352	21.79%			
22.	<b>Total</b>	<b>191</b>	<b>69,889</b>	<b>2,058</b>	<b>28,680</b>	<b>41.04%</b>		<b>7,957</b>	<b>3.43</b>
23.	Observation Bed Days				3,959				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,101			2,191	2.05
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				382				
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				1,039				
22.	<b>Total</b>				<b>5,522</b>	<b>19.25%</b>		<b>2,191</b>	<b>2.05</b>

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

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

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number:	14-0093	Medicaid Provider Number:	4001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-2008 To: 12-31-2008

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	4,259,400	15,352,355	0.277443	1,421,755		394,456	
2.	Recovery Room	992,460	2,277,758	0.435718	328,111		142,964	
3.	Delivery and Labor Room	3,030,783	4,953,017	0.611906	2,361,694		1,445,135	
4.	Anesthesiology	422,442	3,900,142	0.108315	772,615		83,686	
5.	Radiology - Diagnostic	3,316,805	12,641,898	0.262366	464,235		121,799	
6.	Radiology - Therapeutic	1,694,683	8,576,197	0.197603	3,945		780	
7.	Nuclear Medicine	767,849	4,552,993	0.168647	166,488		28,078	
8.	Laboratory	7,483,060	53,516,656	0.139827	4,863,571		680,059	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,992,619	7,091,131	0.281002	581,693		163,457	
13.	Physical Therapy	710,056	1,690,049	0.420139	40,571		17,045	
14.	Occupational Therapy	520,568	1,099,190	0.473592	24,787		11,739	
15.	Speech Pathology	94,739	302,433	0.313256	27,041		8,471	
16.	EKG	305,141	3,606,236	0.084615	152,199		12,878	
17.	EEG							
18.	Med. / Surg. Supplies	6,601,377	31,897,622	0.206955	2,907,362		601,693	
19.	Drugs Charged to Patients	14,520,720	71,392,868	0.203392	6,317,799		1,284,990	
20.	Renal Dialysis	273,939	554,669	0.493878	91,217		45,050	
21.	Ambulance							
22.	CT Scan	2,155,105	35,655,978	0.060442	1,371,367		82,888	
23.	Ultrasound	994,054	5,740,392	0.173168	293,896		50,893	
24.	Cardiopulmonary	1,933,908	10,025,817	0.192893	309,510		59,702	
25.	Outpatient Psych	6,358	24,952	0.254809				
26.	Wound Care Center	450,979	881,016	0.511885	12,801		6,553	
27.	Endoscopy	2,552,366	4,381,755	0.582499	180,971		105,415	
28.	MRI	2,043,292	13,837,726	0.147661	196,763		29,054	
29.	Mammography	631,171	1,344,723	0.469369	1,560		732	
30.	Oncology	1,370,896	3,852,838	0.355815				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic							
44.	Emergency	7,596,508	50,720,541	0.149772	37,280		5,584	
45.	Observation	3,082,557	5,301,271	0.581475	10,330		6,007	
46.	<b>Total</b>				<b>22,939,561</b>		<b>5,389,108</b>	

\* 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**

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: 14-0093	Medicaid Provider Number: 4001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-2008 To: 12-31-2008

**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)	22,322,963			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	28,670			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	778.62			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,101			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,193,121			
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)	3,193,121			

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	4,398,173	2,617	1,680.62	382	641,997
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	706,916	1,352	522.87	1,039	543,262
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					5,389,108
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>9,767,488</b>

**Hospital Statement of Cost**  
**Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**  
 AMENDED PRELIMINARY as of 06/29/2010

<b>Medicare Provider Number:</b> 14-0093	<b>Medicaid Provider Number:</b> 4001
<b>Program:</b> Medicaid-Hospital	<b>Period Covered by Statement:</b> From: 01-01-2008 To: 12-31-2008

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)
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(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

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number:	14-0093	Medicaid Provider Number:	4001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-2008 To: 12-31-2008

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.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	2,786,318	3,900,142	0.714415	772,615		551,968	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	14,269	7,091,131	0.002012	581,693		1,170	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	136,363	3,606,236	0.037813	152,199		5,755	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	Ultrasound							
24.	Cardiopulmonary	231,018	10,025,817	0.023042	309,510		7,132	
25.	Outpatient Psych							
26.	Wound Care Center							
27.	Endoscopy							
28.	MRI	855	13,837,726	0.000062	196,763		12	
29.	Mammography							
30.	Oncology	44,964	3,852,838	0.011670				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency	417,149	50,720,541	0.008224	37,280		307	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>566,344</b>	

\* 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**

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: <b>14-0093</b>	Medicaid Provider Number: <b>4001</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>01-01-2008</b> To: <b>12-31-2008</b>

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)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
47.	Adults and Pediatrics							
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>						<b>566,344</b>	
69.	<b>Total (Lines 67-68)</b>						<b>566,344</b>	

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

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: 14-0093	Medicaid Provider Number: 4001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-2008 To: 12-31-2008

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	9,767,488	
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)	566,344	
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)		
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>10,333,832</b>	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	22,939,561	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,648,127	
	B. Sub I		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	2,083,367	
	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	1,129,871	
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>30,800,926</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		20,467,094
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

**Hospital Statement of Cost / Computation of Allowable Cost**

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: 14-0093	Medicaid Provider Number: 4001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-2008 To: 12-31-2008

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)	10,333,832	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	10,333,832	
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	<b>10,333,832</b>	

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>		

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: 14-0093	Medicaid Provider Number: 4001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-2008 To: 12-31-2008

**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)	20,467,094
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
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)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

**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		
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

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

BHF Supplement No. 1

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: 14-0093	Medicaid Provider Number: 4001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-2008 To: 12-31-2008

**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)

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number:	14-0093	Medicaid Provider Number:	4001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-2008 To: 12-31-2008

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)
	<b>Inpatient Ancillary Centers</b>	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
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.	CT Scan							
23.	Ultrasound							
24.	Cardiopulmonary							
25.	Outpatient Psych							
26.	Wound Care Center							
27.	Endoscopy							
28.	MRI							
29.	Mammography							
30.	Oncology							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	<b>Ancillary Total</b>							

\* 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)

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number:	14-0093	Medicaid Provider Number:	4001
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01-01-2008 To: 12-31-2008

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							
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>							
69.	<b>Total (Lines 67-68)</b>							

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

AMENDED PRELIMINARY as of 06/29/2010

Medicare Provider Number: 14-0093	Medicaid Provider Number: 4001
Program: Medicaid-Hospital	Period Covered by Statement: From: 01-01-2008 To: 12-31-2008

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,420	63	4,483
Newborn Days	1,011	28	1,039
Total Inpatient Revenue	32,767,228	(1,966,302)	30,800,926
Ancillary Revenue	25,629,012	(2,689,451)	22,939,561
Routine Revenue	7,138,216	723,149	7,861,365
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

Laboratory costs and charges include Blood-Administration from W/S C.  
 Cardiopulmonary costs include Cardiac Cath Lab and Cardiology from W/S C.  
 Filed OHF Supplement No. 2 charges for Respiratory Therapy, EKG and Cardiopulmonary are greater than the filed W/S C charges.

Per letter, Psych Unit closed on 12/31/2004.

Amended due to revised Cost Report submitted by Anne Little, Regional Reimbursement Director..

It appears the revised cost report correctly includes Title 19 as well as incorrectly includes Non-Medicaid Title 21 and No Federal Match data.