

# Hospital Statement of Cost

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

**General Information**                      **AMENDED PRELIMINARY**

Name of Hospital: Provena Covenant Medical Center		Medicare Provider Number: 14-0113
Street: 1400 West Park Street		Medicaid Provider Number: 21001
City: Urbana	State: Illinois	Zip: 61801
Period Covered by Statement:	From: 01/01/2009	To: 12/31/2009

**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 type="checkbox"/> Medicaid Hospital	<input checked="" type="checkbox"/> Medicaid Sub II Psychiatric	<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 Covenant Medical Center 21001 for the cost report beginning 01/01/2009 and ending 12/31/2009 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

Medicare Provider Number:	14-0113	Medicaid Provider Number:	21001
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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	120	44,390		21,392	48.19%		7,755	3.22
2.	Rehabilitation Unit	25	9,125		4,547	49.83%		411	11.06
3.	Psychiatric Unit	30	10,950		4,145	37.85%		1,503	2.76
4.	Sub III								
5.	Intensive Care Unit	15	5,475		3,565	65.11%			
6.	Coronary Care Unit								
7.	Neonatal ICU								
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	21	7,665		2,340	30.53%			
22.	<b>Total</b>	<b>211</b>	<b>77,605</b>		<b>35,989</b>	<b>46.37%</b>		<b>9,669</b>	<b>3.48</b>
23.	Observation Bed Days				3,224				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Rehabilitation Unit								
3.	Psychiatric Unit				1,354			314	4.31
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Neonatal ICU								
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								
22.	<b>Total</b>				<b>1,354</b>	<b>3.76%</b>		<b>314</b>	<b>4.31</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

Medicare Provider Number:	14-0113	Medicaid Provider Number:	21001
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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	10,447,854	51,674,929	0.202184	810		164	
2.	Recovery Room	1,386,213	10,211,642	0.135748	5,373		729	
3.	Delivery and Labor Room	3,559,419	5,245,902	0.678514				
4.	Anesthesiology	1,157,566	25,542,253	0.045320	20,713		939	
5.	Radiology - Diagnostic	3,215,407	16,050,539	0.200330	7,014		1,405	
6.	Radiology - Therapeutic	1,550,025	2,399,695	0.645926				
7.	Nuclear Medicine	1,007,965	5,193,461	0.194083	8,136		1,579	
8.	Laboratory	7,056,897	63,524,977	0.111089	403,973		44,877	
9.	Blood							
10.	Blood - Administration	1,360,870	2,553,678	0.532906				
11.	Intravenous Therapy	480,198	1,505,388	0.318986	882		281	
12.	Respiratory Therapy	3,554,914	29,464,734	0.120650	18,784		2,266	
13.	Physical Therapy	2,357,586	8,472,250	0.278272	1,005		280	
14.	Occupational Therapy	991,378	4,327,615	0.229082	278		64	
15.	Speech Pathology	235,263	702,641	0.334827				
16.	EKG	291,728	1,697,904	0.171817	17,118		2,941	
17.	EEG	205,860	598,515	0.343951	2,844		978	
18.	Med. / Surg. Supplies	19,342,264	65,111,231	0.297065	11,243		3,340	
19.	Drugs Charged to Patients	8,203,167	70,519,388	0.116325	274,869		31,974	
20.	Renal Dialysis	378,084	735,834	0.513817				
21.	Ambulance	6,034,619	8,198,910	0.736027				
22.	CT Scan	2,283,567	27,475,696	0.083112	12,348		1,026	
23.	Mammography	372,681	916,692	0.406550				
24.	MRI	1,237,442	9,203,464	0.134454	9,447		1,270	
25.	Ultrasound	925,594	5,185,534	0.178495	5,773		1,030	
26.	Oncology	354,436	1,032,257	0.343360				
27.	Gastrointestinal Svs	2,192,763	14,945,265	0.146720				
28.	Other Cardiology	973,049	6,654,208	0.146231	6,262		916	
29.	Cardiopulmonary	1,035,596	1,740,789	0.594900				
30.	Cardiac Cath Lab	3,423,397	32,352,827	0.105814	22		2	
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	8,473,340	48,573,134	0.174445	1,584		276	
45.	Observation	2,881,966	6,443,211	0.447287				
46.	<b>Total</b>				<b>808,478</b>		<b>96,337</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

Medicare Provider Number: 14-0113	Medicaid Provider Number: 21001
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Unit	Sub II Psychiatric Unit	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	21,972,804	5,258,324	3,699,922	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	24,616	4,547	4,145	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	892.62	1,156.44	892.62	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,354	
3.	Program general inpatient routine cost (Line 1c X Line 2)			1,208,607	
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)			1,208,607	

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	6,850,382	3,565	1,921.57		
9.	Coronary Care Unit					
10.	Neonatal ICU					
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	1,833,080	2,340	783.37		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					96,337
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>1,304,944</b>

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

<b>Medicare Provider Number:</b>	14-0113	<b>Medicaid Provider Number:</b>	21001
<b>Program:</b>	Medicaid-Psychiatric	<b>Period Covered by Statement:</b>	From: 01/01/2009 To: 12/31/2009

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.	Rehabilitation Unit						
4.	Psychiatric Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal ICU						
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.	<b>Total (Sum of Lines 22 and 26)</b>								

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

AMENDED PRELIMINARY

Medicare Provider Number:	14-0113	Medicaid Provider Number:	21001
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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							
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	93,719	1,697,904	0.055197	17,118		945	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	Mammography							
24.	MRI							
25.	Ultrasound							
26.	Oncology							
27.	Gastrointestinal Svs							
28.	Other Cardiology							
29.	Cardiopulmonary							
30.	Cardiac Cath Lab							
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							
45.	Observation							
46.	<b>Ancillary Total</b>						<b>945</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

Medicare Provider Number:	14-0113	Medicaid Provider Number:	21001
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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							
48.	Rehabilitation Unit							
49.	Psychiatric Unit							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU							
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	740,307	2,340	316.37				
67.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>						945	
69.	<b>Total (Lines 67-68)</b>						945	

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

AMENDED PRELIMINARY

Medicare Provider Number: 14-0113	Medicaid Provider Number: 21001
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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)	1,304,944	
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)	945	
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)	63,732	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>1,369,621</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)	808,478	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Rehabilitation Unit		
	C. Psychiatric Unit	1,942,798	
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Neonatal ICU		
	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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>2,751,276</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,381,655
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

Medicare Provider Number: 14-0113	Medicaid Provider Number: 21001
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

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)	1,369,621	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,369,621	
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>1,369,621</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

Medicare Provider Number: 14-0113	Medicaid Provider Number: 21001
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

**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)	1,381,655
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

Medicare Provider Number: 14-0113	Medicaid Provider Number: 21001
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 01/01/2009 To: 12/31/2009

**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 Rehabilitation Unit	Sub II Psychiatric Unit	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 Rehabilitation Unit	Sub II Psychiatric Unit	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 Rehabilitation Unit	Sub II Psychiatric Unit	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

Medicare Provider Number:	14-0113	Medicaid Provider Number:	21001
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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	40,668	51,674,929	0.000787	810		1	
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.	Mammography							
24.	MRI							
25.	Ultrasound							
26.	Oncology							
27.	Gastrointestinal Svs	146,548	14,945,265	0.009806				
28.	Other Cardiology	113,941	6,654,208	0.017123	6,262		107	
29.	Cardiopulmonary							
30.	Cardiac Cath Lab							
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>						<b>108</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

Medicare Provider Number:	14-0113	Medicaid Provider Number:	21001
Program:	Medicaid-Psychiatric	Period Covered by Statement:	From: 01/01/2009 To: 12/31/2009

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	1,156,758	24,616	46.99				
48.	Rehabilitation Unit							
49.	Psychiatric Unit	194,782	4,145	46.99	1,354		63,624	
50.	Sub III							
51.	Intensive Care Unit	179,156	3,565	50.25				
52.	Coronary Care Unit							
53.	Neonatal ICU							
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>						63,624	
68.	<b>Ancillary Total (from line 46)</b>						108	
69.	<b>Total (Lines 67-68)</b>						63,732	

