

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: Union Hospital, Inc.		Medicare Provider Number: 15-0023	
Street: 1606 No. 7th St.		Medicaid Provider Number: 20003	
City: Terre Haute	State: Indiana	Zip: 47804	
Period Covered by Statement:	From: 09/01/08	To: 08/31/09	

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 checked="" type="checkbox"/> Corporation XXXX XXXX	<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 XXXX XXXX	<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 type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I XXXX XXXX Rehabilitation Unit	<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)) Union Hospital, Inc. 20003 for the cost report beginning 09/01/08 and ending 08/31/09 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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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	213	77,745		54,611	70.24%		14,832	4.56
2.	Rehabilitation Unit	22	8,030		5,712	71.13%		502	11.38
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	32	11,680		9,659	82.70%			
6.	Coronary Care Unit								
7.	Intensive Nursery	13	4,745		3,323	70.03%			
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	32	11,680		2,688	23.01%			
22.	Total	312	113,880		75,993	66.73%		15,334	4.78
23.	Observation Bed Days				7,176				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Rehabilitation Unit				146				
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Intensive Nursery								
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.	Total				146	0.19%			

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

PRELIMINARY

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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	26,152,507	105,264,251	0.248446	6,804		1,690	
2.	Recovery Room	3,698,694	8,866,665	0.417146	1,326		553	
3.	Delivery and Labor Room	3,720,578	9,818,275	0.378944				
4.	Anesthesiology							
5.	Radiology - Diagnostic	16,884,054	45,424,675	0.371693	4,066		1,511	
6.	Radiology - Therapeutic	7,818,314	20,160,204	0.387809				
7.	Nuclear Medicine							
8.	Laboratory	8,198,914	60,310,575	0.135945	11,454		1,557	
9.	Blood							
10.	Blood - Administration	2,511,680	3,632,071	0.691528	1,660		1,148	
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,926,642	10,197,994	0.385041	3,542		1,364	
13.	Physical Therapy	2,690,851	6,186,440	0.434960	50,273		21,867	
14.	Occupational Therapy	2,053,164	5,008,302	0.409952	49,016		20,094	
15.	Speech Pathology	978,962	2,243,682	0.436319	12,621		5,507	
16.	EKG	2,238,083	12,630,207	0.177201	913		162	
17.	EEG	1,038,551	2,596,557	0.399972				
18.	Med. / Surg. Supplies	1,778,572	5,477,358	0.324713	4,662		1,514	
19.	Drugs Charged to Patients	61,599,258	207,536,721	0.296811	71,439		21,204	
20.	Renal Dialysis	895,857	2,448,796	0.365836				
21.	Ambulance							
22.	Cardiac Surgery	3,750,908	8,632,319	0.434519				
23.	WVSC	21,082,015	61,773,941	0.341277				
24.	OP Treatment Room	3,998,523	4,845,718	0.825166				
25.	Cat Scan	3,903,685	47,070,780	0.082932	4,937		409	
26.	Cardiac Cath Lab	31,821,103	85,306,818	0.373019				
27.	Psych Servs.	746,992	1,129,730	0.661213				
28.	OP Physical Therapy	2,285,257	3,665,630	0.623428				
29.	Radioisotope	2,201,038	7,788,073	0.282617				
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	16,972,545	13,031,472	1.302427				
44.	Emergency	8,849,219	46,045,102	0.192186				
45.	Observation	4,533,294	4,240,852	1.068958				
46.	Total				222,713		78,580	

* 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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Rehabilitation Uni	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)	39,002,665	5,025,043		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	61,787	5,712		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	631.24	879.73		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		146		
3.	Program general inpatient routine cost (Line 1c X Line 2)		128,441		
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)		128,441		

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	12,445,939	9,659	1,288.53		
9.	Coronary Care Unit					
10.	Intensive Nursery	2,763,691	3,323	831.69		
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	1,468,840	2,688	546.44		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					78,580
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					207,021

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

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Intensive Nursery						
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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 09/01/08 To: 08/31/09

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	5,095,454	105,264,251	0.048406	6,804		329	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	7,033,276	45,424,675	0.154834	4,066		630	
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	70,150	12,630,207	0.005554	913		5	
17.	EEG	924,928	2,596,557	0.356213				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery	1,887,132	8,632,319	0.218612				
23.	WVSC							
24.	OP Treatment Room							
25.	Cat Scan							
26.	Cardiac Cath Lab							
27.	Psych Servs.							
28.	OP Physical Therapy							
29.	Radioisotope							
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	2,306,413	13,031,472	0.176988				
44.	Emergency							
45.	Observation							
46.	Ancillary Total						964	

* 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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Nursery							
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)							
68.	Ancillary Total (from line 46)						964	
69.	Total (Lines 67-68)						964	

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

PRELIMINARY

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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)	207,021	
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)	964	
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)	352	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	208,337	
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)	222,713	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Rehabilitation Unit	118,048	
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Intensive Nursery		
	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.	Total Charges for Patient Services (Sum of Lines 9 through 11)	340,761	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		132,424
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

PRELIMINARY

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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)	208,337	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	208,337	
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)	208,337	

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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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)	132,424
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

PRELIMINARY

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 09/01/08 To: 08/31/09

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 Ur	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 Rehabilitation Ur	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 Rehabilitation Ur	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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 09/01/08 To: 08/31/09

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	59,937	105,264,251	0.000569	6,804		4	
2.	Recovery Room							
3.	Delivery and Labor Room	359,622	9,818,275	0.036628				
4.	Anesthesiology							
5.	Radiology - Diagnostic	86,576	45,424,675	0.001906	4,066		8	
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.	Cardiac Surgery							
23.	WVSC							
24.	OP Treatment Room							
25.	Cat Scan							
26.	Cardiac Cath Lab							
27.	Psych Servs.	66,597	1,129,730	0.058949				
28.	OP Physical Therapy	13,319	3,665,630	0.003633				
29.	Radioisotope							
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	1,395,198	13,031,472	0.107064				
44.	Emergency							
45.	Observation							
46.	Ancillary Total						12	

* 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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 09/01/08 To: 08/31/09

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	1,182,095	61,787	19.13				
48.	Rehabilitation Unit	13,319	5,712	2.33	146		340	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	83,246	9,659	8.62				
52.	Coronary Care Unit							
53.	Intensive Nursery	73,256	3,323	22.05				
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)						340	
68.	Ancillary Total (from line 46)						12	
69.	Total (Lines 67-68)						352	

