

Hospital Statement of Cost

BHF Page 1

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: 12/01/2009	To: 11/30/2010	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
☐ Church	☐ Individual	☐ State	☐ Township
☐ Corporation	☐ Partnership	☐ City	☐ Hospital District
☐ Other (Specify) _____	☐ Corporation	☐ County	☐ Other (Specify) _____

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify) _____

Health Care Program

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

☐ Medicaid Hospital	☐ Medicaid Sub II	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I	☐ Medicaid Sub III	☐ 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 12/01/2009 and ending 11/30/2010 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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2009 To: 11/30/2010

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	94	34,310		13,361	38.94%		4,036	3.84
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	15	5,475		2,154	39.34%			
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		803	21.94%			
22.	Total	119	43,445		16,318	37.56%		4,036	3.84
23.	Observation Bed Days				808				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,445			969	4.06
2.	Sub I								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				486				
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				519				
22.	Total				4,450	27.27%		969	4.06

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	6,317	99,674

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2009 To: 11/30/2010

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	3,807,037	2,112,497	1.802150	63,244	124,305	113,975	224,016
2.	Recovery Room	1,540,886	206,310	7.468790	4,715	18,120	35,215	135,334
3.	Delivery and Labor Room	6,335,199	792,720	7.991723				
4.	Anesthesiology	3,557,685	508,292	6.999294	26,813	28,354	187,672	198,458
5.	Radiology - Diagnostic	5,744,075	6,342,537	0.905643	352,790	487,955	319,502	441,913
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	150,678	557,761	0.270148	36,659	15,776	9,903	4,262
8.	Laboratory	5,475,277	8,051,201	0.680057	854,632	360,344	581,198	245,054
9.	Blood							
10.	Blood - Administration	962,206	416,859	2.308229	104,954	18,244	242,258	42,111
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,538,431	1,589,470	1.597030	413,924	34,105	661,049	54,467
13.	Physical Therapy	602,353	1,152,580	0.522613	11,587	43,504	6,056	22,736
14.	Occupational Therapy	47,980	99,555	0.481945	1,207	175	582	84
15.	Speech Pathology	16,040	191	83.979058				
16.	EKG	850,836	413,592	2.057187	56,892	43,086	117,037	88,636
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	10,600,660	9,401,965	1.127494	2,603,660	184,417	2,935,611	207,929
20.	Renal Dialysis	66,644	194,866	0.341999	58,125		19,879	
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	8,480,451	5,593,584	1.516103	857	2,113	1,299	3,204
44.	Emergency	15,561,113	8,026,068	1.938821		1,201,504		2,329,501
45.	Observation							
46.	Total				4,590,059	2,562,002	5,231,236	3,997,705

* 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

BHF Page 4

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2009 To: 11/30/2010

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)	24,047,061			
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	14,169			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,697.16			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,445			
3.	Program general inpatient routine cost (Line 1c X Line 2)	5,846,716			
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)	5,846,716			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1) (A)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	5,977,746	2,154	2,775.18	486	1,348,737
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	283,625	803	353.21	519	183,316
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					5,231,236
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					12,610,005

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: 12/01/2009 To: 11/30/2010

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)	
		(1)	(2)	(3)	(4)	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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2009 To: 11/30/2010

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	2,583,745	2,112,497	1.223076	63,244	124,305	77,352	152,034
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,177,966	6,342,537	0.185725	352,790	487,955	65,522	90,625
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	164,118	8,051,201	0.020384	854,632	360,344	17,421	7,345
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	359,582	413,592	0.869412	56,892	43,086	49,463	37,459
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	2,768,014	8,026,068	0.344878		1,201,504		414,372
45.	Observation							
46.	Ancillary Total						209,758	701,835

* 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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2009 To: 11/30/2010

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	11,124,143	14,169	785.10	3,445		2,704,670	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	1,570,236	2,154	728.99	486		354,289	
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)						3,058,959	
68.	Ancillary Total (from line 46)						209,758	701,835
69.	Total (Lines 67-68)						3,268,717	701,835

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2009 To: 11/30/2010

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			3,997,705
2. Inpatient Operating Services (BHF Page 4, Line 25)		12,610,005	
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)		3,268,717	701,835
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)		176,597	99,090
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		16,055,319	4,798,630
8. Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)		77.00%	23.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		4,590,059	2,562,002
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		3,186,000	
B. Sub I			
C. Sub II			
D. Sub III			
E. Intensive Care Unit			
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			
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		7,776,059	2,562,002
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)			(10,515,888)
15. Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		(8,097,234)	(2,418,654)

Hospital Statement of Cost / Computation of Allowable Cost

BHF Page 8

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2009 To: 11/30/2010

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)	16,055,319	4,798,630
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)	(8,097,234)	(2,418,654)
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	7,958,085	2,379,976
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)	7,958,085	2,379,976

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

BHF Page 9

PRELIMINARY

Medicare Provider Number:	14-0300	Medicaid Provider Number:	3049
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 12/01/2009 To: 11/30/2010

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)
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	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
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)				10,515,888	10,515,888
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)				10,515,888	10,515,888

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	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(2A)		(3A)	
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: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2009 To: 11/30/2010

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

1. Gross Routine Revenues	Adults and Pediatrics	Sub I Sub I	Sub II Sub II	Sub III Sub III
(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: 12/01/2009 To: 11/30/2010

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	66,197	2,112,497	0.031336	63,244	124,305	1,982	3,895
2.	Recovery Room							
3.	Delivery and Labor Room	49,006	792,720	0.061820				
4.	Anesthesiology	8,294	508,292	0.016317	26,813	28,354	438	463
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.	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	99,973	5,593,584	0.017873	857	2,113	15	38
44.	Emergency	632,559	8,026,068	0.078813		1,201,504		94,694
45.	Observation							
46.	Ancillary Total						2,435	99,090

* 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: 12/01/2009 To: 11/30/2010

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	506,501	14,169	35.75	3,445		123,159	
48.	Sub I							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	63,633	2,154	29.54	486		14,356	
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	56,697	803	70.61	519		36,647	
67.	Routine Total (lines 47-66)						174,162	
68.	Ancillary Total (from line 46)						2,435	99,090
69.	Total (Lines 67-68)						176,597	99,090

PRELIMINARY

Medicare Provider Number: 14-0300	Medicaid Provider Number: 3049
Program: Medicaid-Hospital	Period Covered by Statement: From: 12/01/2009 To: 11/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,931		3,931
Newborn Days	519		519
Total Inpatient Revenue	7,776,059		7,776,059
Ancillary Revenue	4,590,059		4,590,059
Routine Revenue	3,186,000		3,186,000
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	6,317		6,317
Total Outpatient Revenue	2,562,002		2,562,002
Outpatient Received and Receivable			

Notes:

[illegible]