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: St. Mary's Medical Center		**Medicare Provider Number:** 15-0100	
Street: 3700 Washington Ave.		**Medicaid Provider Number:** 5038	
City: Evansville	**State:** Indiana	**Zip:** 47714	
Period Covered by Statement:	**From:** 07/01/2009	**To:** 06/30/2010	

Type of Control

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

Type of Hospital

[XXXX]	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)

[XXXX]	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)) St. Mary's Medical Center 5038 for the cost report beginning 07/01/2009 and ending 06/30/2010 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

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	284	103,660		52,500	50.65%		15,709	4.81
2.	Psych	14	5,110		2,393	46.83%		414	5.78
3.	Rehab	24	11,433		6,675	58.38%		501	13.32
4.	Sub III								
5.	Intensive Care Unit	62	22,630		12,660	55.94%			
6.	Coronary Care Unit	9	3,285		1,710	52.05%			
7.	NICU	40	14,600		8,694	59.55%			
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				3,232				
22.	**Total**	**433**	**160,718**		**87,864**	**54.67%**		**16,624**	**5.09**
23.	Observation Bed Days				5,136				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				424				
2.	Psych								
3.	Rehab								
4.	Sub III								
5.	Intensive Care Unit				60				
6.	Coronary Care Unit				4				
7.	NICU				223				
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				491				
22.	**Total**				**1,202**	**1.37%**			

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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

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	49,105,186	140,498,099	0.349508	287,453		100,467	
2.	Recovery Room	2,821,641	12,082,769	0.233526	24,757		5,781	
3.	Delivery and Labor Room	4,258,540	9,768,010	0.435968	245,205		106,902	
4.	Anesthesiology	279,580	10,974,160	0.025476	16,141		411	
5.	Radiology - Diagnostic	10,046,911	50,682,389	0.198233	142,872		28,322	
6.	Radiology - Therapeutic	236,281	13,572	17.409446				
7.	Nuclear Medicine	2,677,519	17,122,809	0.156371	19,830		3,101	
8.	Laboratory	14,005,488	60,787,392	0.230401	263,600		60,734	
9.	Blood							
10.	Blood - Administration	3,558,355	6,945,600	0.512318	16,792		8,603	
11.	Intravenous Therapy	1,830,191	6,584,957	0.277935	11,825		3,287	
12.	Respiratory Therapy	5,019,219	26,476,346	0.189574	460,525		87,304	
13.	Physical Therapy	4,623,198	17,262,763	0.267813	8,485		2,272	
14.	Occupational Therapy	1,681,072	6,937,046	0.242333	8,295		2,010	
15.	Speech Pathology	451,320	3,260,480	0.138421	31,665		4,383	
16.	EKG	5,862,995	33,159,937	0.176810	133,794		23,656	
17.	EEG	1,515,612	5,131,988	0.295326	1,300		384	
18.	Med. / Surg. Supplies	41,549,453	147,895,218	0.280938	370,591		104,113	
19.	Drugs Charged to Patients	22,543,835	92,598,761	0.243457	561,286		136,649	
20.	Renal Dialysis	1,103,722	2,330,300	0.473639				
21.	Ambulance	3,456,451	6,616,950	0.522363				
22.	CT Scan	4,915,147	61,082,968	0.080467	73,805		5,939	
23.	Ultrasound	1,311,077	12,819,287	0.102274				
24.	Cardiac Cath Lab	7,394,192	43,546,749	0.169799	54,100		9,186	
25.	Cardiopulmonary	818,755	785,449	1.042404				
26.	Diabetes Center	814,487	318,613	2.556352				
27.	Ancillary Psych	133,285	953,791	0.139742	250		35	
28.	Outreach Clinic	816,399	560,552	1.456420				
29.	Senior Health	404,426	29,088	13.903534				
30.	OB / Peds Clinic	166,811						
31.	Bariatrics	469,858	290,702	1.616287				
32.								
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	590,551	810,167	0.728925	1,207		880	
44.	Emergency	18,738,856	80,371,348	0.233153	16,065		3,746	
45.	Observation	2,881,656	6,202,798	0.464574	2,591		1,204	
46.	**Total**				**2,752,434**		**699,369**	

* 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:	Medicaid Provider Number:			
15-0100	5038			
Program:	**Period Covered by Statement:**			
Medicaid-Hospital	From:	07/01/2009	To:	06/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	32,337,636	2,050,053	4,549,480	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	57,636	2,393	6,675	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	561.07	856.69	681.57	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	424			
3.	Program general inpatient routine cost (Line 1c X Line 2)	237,894			
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)	237,894			

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	12,258,571	12,660	968.29	60	58,097
9.	Coronary Care Unit	2,111,116	1,710	1,234.57	4	4,938
10.	NICU	6,309,347	8,694	725.71	223	161,833
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	951,252	3,232	294.32	491	144,511
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					699,369
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,306,642**

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Psych						
4.	Rehab						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NICU						
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 Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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	Outpatient	Inpatient	Outpatient
		(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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

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	1,046,621	140,498,099	0.007449	287,453		2,141	
2.	Recovery Room							
3.	Delivery and Labor Room	400,695	9,768,010	0.041021	245,205		10,059	
4.	Anesthesiology	2,239,088	10,974,160	0.204033	16,141		3,293	
5.	Radiology - Diagnostic	14,158	50,682,389	0.000279	142,872		40	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	392,062	60,787,392	0.006450	263,600		1,700	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	105,469	17,262,763	0.006110	8,485		52	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	137,080	33,159,937	0.004134	133,794		553	
17.	EEG	1,000	5,131,988	0.000195	1,300			
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	2,100	61,082,968	0.000034	73,805		3	
23.	Ultrasound							
24.	Cardiac Cath Lab							
25.	Cardiopulmonary							
26.	Diabetes Center							
27.	Ancillary Psych							
28.	Outreach Clinic	535	560,552	0.000954				
29.	Senior Health	2,700	29,088	0.092822				
30.	OB / Peds Clinic							
31.	Bariatrics	107,817	290,702	0.370885				
32.								
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	1,175,625	80,371,348	0.014627	16,065		235	
45.	Observation							
46.	**Ancillary Total**						**18,076**	

* 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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

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							
48.	Psych	325,276	2,393	135.93				
49.	Rehab							
50.	Sub III							
51.	Intensive Care Unit	832,664	12,660	65.77	60		3,946	
52.	Coronary Care Unit							
53.	NICU							
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)**						**3,946**	
68.	**Ancillary Total (from line 46)**						**18,076**	
69.	**Total (Lines 67-68)**						**22,022**	

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	1,306,642	
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)	22,022	
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)	1,967	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,330,631**	
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 (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	2,752,434	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,265,049	
	B. Psych		
	C. Rehab		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. NICU		
	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)**	4,017,483	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,686,852
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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	1,330,631	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,330,631	
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)**	**1,330,631**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

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)	2,686,852
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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)					
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)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(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 **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
15-0100	**5038**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 07/01/2009 To: 06/30/2010**

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 Psych**	**Sub II Rehab**	**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 Psych**	**Sub II Rehab**	**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 Psych**	**Sub II Rehab**	**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: 15-0100	**Medicaid Provider Number:** 5038
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 07/01/2009 To: 06/30/2010

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							
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.	Cardiac Cath Lab							
25.	Cardiopulmonary							
26.	Diabetes Center							
27.	Ancillary Psych							
28.	Outreach Clinic							
29.	Senior Health							
30.	OB / Peds Clinic							
31.	Bariatrics							
32.								
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							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**							

* 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: 15-0100	**Medicaid Provider Number:** 5038
Program: Medicaid-Hospital	**Period Covered by Statement:** From: 07/01/2009 To: 06/30/2010

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	267,398	57,636	4.64	424		1,967	
48.	Psych							
49.	Rehab							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU							
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)**						**1,967**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**1,967**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2009 To: 06/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	711		711
Newborn Days	491		491
Total Inpatient Revenue	2,752,434	1,265,049	4,017,483
Ancillary Revenue	2,752,434		2,752,434
Routine Revenue		1,265,049	1,265,049
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Adjusted Total Psych days to W/S S-3.
Reclassified Blood as Blood-Admin.
BHF Page 3 Costs/Charges match filed W/S C.
Medical Supplies data includes Implant Devices charged to Patients.
Filed Cost Report is based upon Paid Claims Summary of 11/3/2009.
Routine Charges for A&P were taken from that IPCR per instruction of BKD. -- DW (12/08/2010)