HAWAII HEALTH SYSTEMS
CORPORATION
"Touching Lives Everyday"

January 30, 2009

B-09-002

The Honorable Colleen Hanabusa
Senate President
The Senate
Hawaii State Capitol, Room 003
Honolulu, Hawaii 96813

Dear Madame President:

In accordance to Act 178, SLH 2005, Section 160, the Hawaii Health Systems Corporation submits a revised report on the certification of losses under the state plan amendment for the fiscal year ending June 30, 2008.

Should you have any questions, please call Kelley C. Roberson, Chief Operating Officer and Chief Financial Officer, at 733-4171.

Sincerely,

Tom Driskill

THOMAS M. DRISKILL, Jr.
President and Chief Executive Officer

Attachment

3675 KILAUEA AVENUE • HONOLULU, HAWAII 96816 • PHONE: (808) 733-4020 • FAX: (808) 733-4028

HILO • HONOKAA • KAU • KONA • KOHALA • WAIMEA • KAPAA • WAILUKU • KULA • LANAI • HONOLULU

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
"Touching Lives Everyday"

January 30, 2009

B-09-002

The Honorable Calvin Say
Speaker
House of Representatives
Hawaii State Capitol, Room 431
Honolulu, Hawaii 96813

Dear Mr. Speaker:

In accordance to Act 178, SLH 2005, Section 160, the Hawaii Health Systems Corporation submits a revised report on the certification of losses under the state plan amendment for the fiscal year ending June 30, 2008.

Should you have any questions, please call Kelley C. Roberson, Chief Operating Officer and Chief Financial Officer, at 733-4171.

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HAWAII HEALTH SYSTEMS
CORPORATION

"Touching Lives Every Day"

January 23, 2009

COO/CFO-09-03

Ms. Ann H. Kinningham
State of Hawaii, Dept. of Health
Med-Quest Division
601 Kamokila Blvd, Room 518
Kapolei, HI 96707

SUBJECT: Adjustment to the Certification of HHSC Medicaid Losses for FYE 6/30/08 Medicaid Cost Report as Filed

Dear Ann:

Enclosed is the revised HHSC Medicaid certified losses of $25,841,391 for fiscal year ended June 30, 2008 based on the Medicaid cost report as filed. These numbers represents an increase in Medicaid Losses of $4,964,785 from the previous FY 2008 reported losses of $20,876,606 on July 22, 2008.

Please note that the enclosed Medicaid SPA attachment includes Critical Access Hospital losses related to Long Term Care services due to costs exceeding FY 2007 Peer Group Averages. The funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51. These claimed expenditures have not previously been nor shall subsequently be used for federal match in this or any other program. I am aware that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claims Act.

Sincerely,

Kelley C. Roberson
Chief Operating Officer & Chief Financial Officer

Attachments

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HAWAII HEALTH SYSTEMS CORPORATION
LOSSES FROM MEDICAID FEE FOR SERVICE PROGRAM
FYE 6/30/08 BASED ON COST REPORT AS FILED

	ACUTE SERVICES: 7/1/07-6/30/08 SVC DATES						WAITLISTED SERVICES: 7/1/07-6/30/08 SVC DATES						
FACILITY	CHARGES	COST	REIMB	TTL LOSS	PRIOR REPORTED LOSS	DIFF	CHARGES	COST	REIMB	REIMB/CHG %	TTL LOSS	PRIOR REPORTED LOSS	DIFF
HAMAKUA							-	-	-		-	-	-
HILO	10,863,012	5,719,224	2,828,749	(2,890,475)	(3,586,113)	695,638	2,354,378	1,821,563	515,925	21.91%	(1,305,638)	-	(1,305,638)
KAU (CAH)							-	-	-		-	-	-
KVMH (CAH)							-	-	-		-	-	-
KOHALA (CAH)													
KONA	4,326,446	2,459,000	1,348,805	(1,110,195)	(1,773,356)	663,161	78,800	63,620	17,829	22.63%	(45,791)	-	(45,791)
KULA											0	0	
LANAI (CAH)													
LEAHI													
MALUHIA													
MAUI	13,892,244	7,549,211	3,308,438	(4,240,773)	(5,913,631)	1,672,858	3,149,532	2,933,057	641,097	20.36%	(2,291,960)	-	(2,291,960)
SMMH	-	-	-	-	-	-					-	-	-
TOTAL HHSC	29,081,702	15,727,435	7,485,992	(8,241,443)	(11,273,099)	3,031,656	5,582,710	4,818,239	1,174,851	21.04%	(3,643,388)	-	(3,643,388)

	LTC ROUTINE SERVICES (7/1/07-6/30/08 SVC DATES)						TOTAL MEDICAID LOSS FYE 6/30/08		
FACILITY	CHARGES	COST	REIMB	TTL LOSS	PRIOR REPORTED LOSS	DIFF	CURRENT RPT	PRIOR RPTED	DIFF
HAMAKUA (CAH)	5,823,031	6,305,948	6,048,682	(257,266)	-	(257,266)	(257,266)	-	(257,266)
HILO	9,698,193	9,665,615	6,944,104	(2,721,511)	(2,072,114)	(649,397)	(6,917,624)	(5,658,227)	(1,259,397)
KAU (CAH)	2,148,867	2,714,421	2,112,608	(601,813)		(601,813)	(601,813)	-	(601,813)
KVMH (CAH)				-			-	-	-
KOHALA (CAH)				-				-	
KONA	3,232,920	3,418,122	1,595,677	(1,822,445)	(1,698,232)	(124,213)	(2,978,431)	(3,471,588)	493,157
KULA ICF MR	1,457,778	1,494,876	941,919	(552,957)	-	(552,957)	(552,957)	-	(552,957)
LANAI (CAH)	1,539,950	1,780,279	1,258,933	(521,346)		(521,346)	(521,346)	-	(521,346)
LEAHI	15,412,584	16,874,526	12,068,827	(4,805,699)	(3,751,590)	(1,054,109)	(4,805,699)	(3,751,590)	(1,054,109)
MALUHIA	11,678,338	13,038,469	10,431,788	(2,606,681)	(2,081,571)	(525,110)	(2,606,681)	(2,081,571)	(525,110)
MAUI	-	-	-	-	-	-	(6,532,733)	(5,913,631)	(619,102)
SMMH (CAH)	6,259,683	7,900,265	7,833,423	(66,842)	-	(66,842)	(66,842)	-	(66,842)
TOTAL HHSC	57,251,344	63,192,521	49,235,961	(13,956,560)	(9,603,507)	(4,353,053)	(25,841,391)	(20,876,606)	(4,964,785)

Incorporates CAH losses due to costs exceeding FY 2007 Peer Group Average, latest available
All information per FY 2008 Medicaid Cost Report As Filed

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES

TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07-06/30/08)

Provider Name: Hale Ho'ola Hamakua

Level of Care:

Provider No: 578263

SNF x
ICF x

Period: From _07/01/07_ To _06/30/08_

1. **Prospective Payment Amounts (For Information Only)**

		Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
SNF	a.	338.36	7/1/2007	6/30/2008	15,036	5,087,581	
ICF	b.						
	c.						
	d.						
	e.						
	f.	Total Prospective Payment Amounts (For Information Only)					5,087,581

Comparison of Payments and Costs

2.	Medicaid Cost Based Limited to Peer Group Average Cost	6,048,682
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	6,048,682
5.	Routine Service Costs	6,305,948
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	257,266

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE FOR SERVICE COST
ACUTE CARE (Public Providers)
SPA - ATTACHMENT 4.19-A Section III.F TN No. 03-002 Effective Date: 07/01/03

Provider Name: Hilo Medical Center
Medicaid Provider Number: 0025174501
Cost Reporting Period: 07/01/07 to 06/30/08

SUMMARY OF MEDICAID ACUTE PAYMENT

(1)	Acute PPS Claims Payments	$	2,556,026
(2)	Payments from Other Payors/Patient Share		
(3)	Reimbursable Medicaid Acute Capital Related Pass Through Cost (From line 4, Medicaid cost report capital addendum)		272,723
(4)	Total Medicaid Fee for Service Payments Received (Lines 1 to 3)	$	2,828,749

SUMMARY OF COSTS INCURRED:

(5)	Medicaid Inpatient Costs (W/S D-1, Part II, Ln 49) (10% capital cost reduction is not applied)	$	5,719,224
(6)	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Ln 5 minus Ln 4)	$	2,890,475

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07 - 6/30/08)

Provider Name: Hilo Medical Center Level of Care: LT

Provider No: 0025174501

Period: From _07/01/07_ To _06/30/08

1. **Prospective Payment Amounts (For Information Only)**

	Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
a.	222.19	7/1/2006	6/30/2007	31,253	6,944,104	
b.						
c.						
d.						
e.						
f.	Total Prospective Payment Amounts (For Information Only)					6,944,104

Comparison of Payments and Costs

2.	Medicaid PPS Payment	6,944,104
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	6,944,104
5	Routine Service Costs	9,665,615
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	2,721,511

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE-FOR-SERVICE COST	WAITLISTED CARE (Public Providers)
SPA - ATTACHMENT 4.19-A Section III.F TN No. 03-002 Effective Date: 07/01/03	

Provider Name: Hilo Medical Center Level of Care: LT

Provider No: 0025174501

Period: From 07/01/07 To 06/30/08

1. **Prospective Payment Amounts - Waitlisted Payments (For Information Only)**

	Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
a.	222.19	7/1/2007	6/30/2008	2,322	515,925	
b.					0	
c.					-	
d.					-	
e.						
f.	Total Prospective Payment Amounts (For Information Only)					515,925

Comparison of Payments and Costs

2.	Medicaid PPS Payment	515,925
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service Waitlisted Payments (Lines 2 to 3)	515,925
5.	Routine Service Costs*	1,821,563
6	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	1,305,638

* W/S D-1, Part II, Ln 38 multiplied by Medicaid waitlisted days.

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

SPA - ATTACHMENT 4.19-D Section XI.D. TN No. 03-002 Effective Date: 09/01/03

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07-06/30/08)

Provider Name: Kau Hospital

Level of Care:

Provider No: 567501

SNF x
ICF x

Period From _07/01/07_ To _06/30/08_

1 Prospective Payment Amounts (For Information Only)

		Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
SNF	a.	285.28	7/1/2007	6/30/2008	5,493	1,567,064	
ICF	b.						
	c.						
	d.						
	e.						
	f.	Total Prospective Payment Amounts (For Information Only)					1,567,064

Comparison of Payments and Costs

2.	Medicaid Cost Based Limited to Peer Group Average Cost	2,112,608
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	2,112,608
5.	Routine Service Costs	2,714,421
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	601,813

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE FOR SERVICE COST
ACUTE CARE (Public Providers)
SPA - ATTACHMENT 4.19-A Section III.F TN No. 03-002 Effective Date: 07/01/03

Provider Name: Kona Community Hospital
Medicaid Provider Number: 005774
Cost Reporting Period: 07/01/07 to 06/30/08

SUMMARY OF MEDICAID ACUTE PAYMENT

(1)	Acute PPS Claims Payments	$ 1,205,490
(2)	Payments from Other Payors/Patient Share	0
(3)	Reimbursable Medicaid Acute Capital Related Pass Through Cost (From line 4. Medicaid cost report capital addendum)	143,315
(4)	Total Medicaid Fee for Service Payments Received (Lines 1 to 3)	$ 1,348,805

SUMMARY OF COSTS INCURRED:

(5)	Medicaid Inpatient Costs (W/S D-1, Part II, Ln 49) (10% capital cost reduction is not applied)	$ 2,459,000
(6)	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Ln 5 minus Ln 4)	$ 1,110,195

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE-FOR-SERVICE COST	WAITLISTED CARE (Public Providers)
SPA - ATTACHMENT 4.19-A Section III.F TN No. 03-002 Effective Date: 07/01/03	

Provider Name: Kona Community Hospital Level of Care: LT

Provider No: 5774

Period: From 07/01/07 To 06/30/08

1. **Prospective Payment Amounts - Waitlisted Payments (For Information Only)**

	Per Diem Rate (1)	Effective Dates From (2)	To (3)	Patient Days (4)	Payment Amount (5)	(6)
a.	222.86	7/1/2007	6/30/2008	80	17,829	
b.					0	
c.					-	
d.					-	
e.						
f.	Total Prospective Payment Amounts (For Information Only)					17,829

Comparison of Payments and Costs

2.	Medicaid PPS Payment	17,829
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service Waitlisted Payments (Lines 2 to 3)	17,829
5.	Routine Service Costs*	63,620
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	45,791

* W/S D-1, Part II, Ln 38 multiplied by Medicaid waitlisted days.

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

SPA - ATTACHMENT 4.19-D Section XI.D. TN No. 03-002 Effective Date: 09/01/03

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07 - 6/30/08)

Provider Name: Kona Community Hospital Level of Care: LT

Provider No: 005774

Period: From _07/01/07_ To _06/30/08_

1. **Prospective Payment Amounts (For Information Only)**

	Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
a.	222.86	7/1/2007	6/30/2008	7,160	1,595,677	
b.						
c.						
d.						
e.						
f.	Total Prospective Payment Amounts (For Information Only)					1,595,677

Comparison of Payments and Costs

2.	Medicaid PPS Payment	1,595,677
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	1,595,677
5.	Routine Service Costs	3,418,122
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	1,822,445

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07-06/30/08)

Provider Name: Kula Hospital

Provider No: 578271

Period: From _07/01/07_ To _06/30/08_

Level of Care:

SNF ______

ICF ______

ICF MR x

1. **Prospective Payment Amounts (For Information Only)**

		Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
	a.	367.65	7/1/2007	6/30/2008	2,562	941,919	
ICF	b.						
	c.						
	d.						
	e.						
	f.	Total Prospective Payment Amounts (For Information Only)					941,919

Comparison of Payments and Costs

2.	Medicaid PPS Payment	941,919
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	941,919
5.	Routine Service Costs	1,494,876
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	552,957

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

SPA - ATTACHMENT 4.19-D Section XI.D. TN No. 03-002 Effective Date: 09/01/03

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07-06/30/08)

Provider Name: Lanai Community Hospital

Level of Care:

Provider No: 251877

SNF x
ICF x

Period: From _07/01/07_ To _06/30/08_

1. **Prospective Payment Amounts (For Information Only)**

		Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
SNF	a.	273.36	7/1/2007	6/30/2008	3,242	886,233	
ICF	b.						
	c.						
	d.						
	e.						
	f.	Total Prospective Payment Amounts (For Information Only)					886,233

Comparison of Payments and Costs

2.	Medicaid Cost Based Limited to Peer Group Average Cost	1,258,933
3.	Patient's Share/Co-insurance	0
4	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	1,258,933
5.	Routine Service Costs	1,780,279
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	521,346

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

SPA - ATTACHMENT 4:19-D Section XI.D. TN No. 03-002 Effective Date: 09/01/03

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07 - 6/30/08)

Provider Name: Leahi Hospital

Level of Care:

Provider No: 3145

SNF x

ICF x

Period: From _07/01/07_ To _06/30/08

1 **Prospective Payment Amounts (For Information Only)**

	Per Diem Rate (1)	Effective Dates From (2)	To (3)	Patient Days (4)	Payment Amount (5)	(6)
a.	216.73	7/1/2007	6/30/2008	55,686	12,068,827	
b.						
c.						
d.						
e.						
f.	Total Prospective Payment Amounts (For Information Only)					12,068,827

Comparison of Payments and Costs

2.	Medicaid PPS Payment	12,068,827
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	12,068,827
5.	Routine Service Costs	16,874,526
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	4,805,699

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07 - 6/30/08)

Provider Name: Maluhia — Level of Care:

Provider No: 67594 — SNF x — ICF x

Period: From _07/01/07_ To _06/30/08

1. **Prospective Payment Amounts (For Information Only)**

		Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
SNF/ICF	a.	217.22	7/1/2007	6/30/2008	48,025	10,431,788	
	b.						
	c.						
	d.						
	e.						
	f.	Total Prospective Payment Amounts (For Information Only)					10,431,788

Comparison of Payments and Costs

2.	Medicaid PPS Payment	10,431,788
3.	Patient's Share/Co-insurance	0
4	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	10,431,788
5.	Routine Service Costs Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	13,038,469
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	2,606,681

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE FOR SERVICE COST
ACUTE CARE (Public Providers)
SPA - ATTACHMENT 4.19-A Section III.F TN No. 03-002 Effective Date: 07/01/03

Provider Name: Maui Memorial Medical Center
Medicaid Provider Number: 005796
Cost Reporting Period: July 1, 2007 - June 30, 2008

SUMMARY OF MEDICAID ACUTE PAYMENT

(1)	Acute PPS Claims Payments	$ 2,827,735
(2)	Payments from Other Payors/Patient Share	0
(3)	Reimbursable Medicaid Acute Capital Related Pass Through Cost (From line 4. Medicaid cost report capital addendum)	480,703
(4)	Total Medicaid Fee for Service Payments Received (Lines 1 to 3)	$ 3,308,438

SUMMARY OF COSTS INCURRED:

(5)	Medicaid Inpatient Costs (W/S D-1, Part II, Ln 49) (10% capital cost reduction is not applied)	7,549,211
(6)	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Ln 5 minus Ln 4)	4,240,773

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

MEDICAID FEE-FOR-SERVICE COST **WAITLISTED CARE** (Public Providers)

SPA - ATTACHMENT 4.19-A Section III.F TN No. 03-002 Effective Date: 07/01/03

Provider Name: Maui Memorial Medical Center Level of Care:

Provider No: 005796 SNF W/L X

ICF W/L X

Period: From 07/01/07 To 6/30/08

1. **Prospective Payment Amounts - Waitlisted Payments (For Information Only)**

		Per Diem Rate (1)	Effective Dates From (2)	To (3)	Patient Days (4)	Payment Amount (5)	(6)
SNF & ICF WL	a.	227.42	7/1/2007	6/30/2008	2,819	641,097	
	b.						
	d.						
	e.						
	f.	Total Prospective Payment Amounts (For Information Only)					641,097

Comparison of Payments and Costs

2.	Medicaid PPS Payment	641,097
3	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service Waitlisted Payments (Lines 2 to 3)	641,097
5.	Routine Service Costs*	2,933,057
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	2,291,960

* W/S D-1, Part II, Ln 38 multiplied by Medicaid waitlisted days.

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.

SPA - ATTACHMENT 4.19-D Section XI.D. TN No. 03-002 Effective Date: 09/01/03

MEDICAID FEE-FOR-SERVICE COST LONG TERM CARE SERVICES	TRANSITION PAYMENT ADDENDUM (For LTC services rendered 07/01/07-06/30/08)

Provider Name: Samuel Mahelona Memorial Hospital

Level of Care:

Provider No: 578601

SNF x

ICF x

Period: From _07/01/07_ To _06/30/08_

1. **Prospective Payment Amounts (For Information Only)**

		Per Diem Rate (1)	Effective Dates From (2)	Effective Dates To (3)	Patient Days (4)	Payment Amount (5)	(6)
SNF	a.	285.33	7/1/2007	6/30/2008	20,317	5,796,973	
ICF	b.						
	c.						
	d.						
	e.						
	f.	Total Prospective Payment Amounts (For Information Only)					5,796,973

Comparison of Payments and Costs

2.	Medicaid Cost Based Limited to Peer Group Average Cost	7,833,423
3.	Patient's Share/Co-insurance	0
4.	Total Medicaid Fee-for-service LTC PPS Payments (Lines 2 to 3)	7,833,423
5.	Routine Service Costs	7,900,265
	Freestanding, Form 2540-96, W/S D-1, Part I, Ln 16, multiplied by patient days on Ln 1 Hospital-based, Form 2552-96, W/S D-1, Part III, Ln 67, multiplied by patient days on Ln 1	
6.	**Uncompensated Costs for Serving Medicaid-eligible Patients** (Line 5 minus Line 4)	66,842

Publicly owned and operated facilities must certify that the uncompensated costs are accurate and are based on actual expenditures incurred for the period.