

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: Alexian Brothers Medical Center		Medicare Provider Number: 14-0258	
Street: 800 Biesterfield Road		Medicaid Provider Number: 5014	
City: Elk Grove Village	State: Illinois	Zip: 60007	
Period Covered by Statement:	From: 01/01/08	To: 12/31/08	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input checked="" type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<input type="checkbox"/> U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Alexian Brothers Medical Cen 5014 for the cost report beginning 01/01/08 and ending 12/31/08 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:	14-0258	Medicaid Provider Number:	5014
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/08 To: 12/31/08

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	276	101,016		74,062	73.32%		18,744	4.42
2.	Rehabilitation Unit	66	24,156		19,062	78.91%		1,372	13.89
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	30	10,980		8,868	80.77%			
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	36	13,140		7,426	56.51%			
22.	Total	408	149,292		109,418	73.29%		20,116	5.07
23.	Observation Bed Days				3,925				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,921			2,355	3.11
2.	Rehabilitation Unit								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				403				
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				3,263				
22.	Total				10,587	9.68%		2,355	3.11

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:	14-0258	Medicaid Provider Number:	5014
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/08 To: 12/31/08

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	33,543,122	148,944,528	0.225205	3,071,966		691,822	
2.	Recovery Room	2,993,510	17,737,651	0.168766	303,080		51,150	
3.	Delivery and Labor Room	8,272,022	12,947,860	0.638872	5,714,542		3,650,861	
4.	Anesthesiology	1,857,194	26,808,859	0.069275	529,967		36,713	
5.	Radiology - Diagnostic	6,624,884	28,908,342	0.229169	642,166		147,165	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	2,651,105	17,745,743	0.149394	340,542		50,875	
8.	Laboratory	19,585,966	189,590,716	0.103307	6,649,984		686,990	
9.	Blood							
10.	Blood - Administration	3,711,058	9,228,499	0.402130	855,624		344,072	
11.	Intravenous Therapy	3,187,297	3,151,776	1.011270	150,392		152,087	
12.	Respiratory Therapy	5,325,704	45,351,600	0.117431	2,685,444		315,354	
13.	Physical Therapy	4,393,836	17,843,658	0.246241				
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,031,593	34,375,759	0.059100	923,122		54,557	
17.	EEG	396,833	1,961,143	0.202348	40,154		8,125	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	26,776,084	136,882,081	0.195614	6,815,732		1,333,253	
20.	Renal Dialysis	1,301,561	4,883,329	0.266531	133,196		35,501	
21.	Ambulance							
22.	Gamma Knife	2,928,347	11,000,741	0.266195				
23.	Endoscopy	5,532,315	38,447,031	0.143894	398,622		57,359	
24.	Implants	18,911,202	26,659,958	0.709349	174,988		124,128	
25.	Ultrasound	2,726,069	19,033,781	0.143223	542,341		77,676	
26.	CT Scan	4,782,738	101,354,500	0.047188	1,910,267		90,142	
27.	MRI	2,895,625	36,222,458	0.079940	812,255		64,932	
28.	PET Scan	1,326,585	4,957,864	0.267572				
29.	Radiation Oncology	3,950,959	16,791,159	0.235300	69,749		16,412	
30.	Mammography	2,478,292	7,031,333	0.352464	3,029		1,068	
31.	OP Physical therapy	2,889,909	9,674,631	0.298710				
32.	IP Physical therapy	2,215,714	8,248,001	0.268636	231,956		62,312	
33.	Cath Lab	29,655,291	98,716,110	0.300410	2,470,932		742,293	
34.	Cardiac Rehab							
35.	Neuro Meg	290,915	645,174	0.450909				
36.	Sleep Lab	1,816,384	6,590,707	0.275598				
37.	Psychology	127,944	84,107	1.521205				
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	2,285,153	6,093,326	0.375026	9,398		3,524	
44.	Emergency	11,413,585	45,991,222	0.248169	577,622		143,348	
45.	Other Clinics	11,475,067	47,208,577	0.243072	16,752		4,072	
46.	Total				36,073,822		8,945,791	

* 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: 14-0258	Medicaid Provider Number: 5014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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)	70,433,124	22,577,536		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	77,987	19,062		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	903.14	1,184.43		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,921			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,250,632			
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)	6,250,632			

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	15,585,677	8,868	1,757.52	403	708,281
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	2,781,027	7,426	374.50	3,263	1,221,994
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					8,945,791
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					17,126,698

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

Medicare Provider Number: 14-0258	Medicaid Provider Number: 5014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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.	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)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Other Clinics								
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:	14-0258	Medicaid Provider Number:	5014
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/08 To: 12/31/08

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	956,824	148,944,528	0.006424	3,071,966		19,734	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	63,945	28,908,342	0.002212	642,166		1,420	
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.	Gamma Knife							
23.	Endoscopy							
24.	Implants							
25.	Ultrasound							
26.	CT Scan							
27.	MRI							
28.	PET Scan							
29.	Radiation Oncology							
30.	Mammography							
31.	OP Physical therapy							
32.	IP Physical therapy							
33.	Cath Lab	1,411,848	98,716,110	0.014302	2,470,932		35,339	
34.	Cardiac Rehab							
35.	Neuro Meg							
36.	Sleep Lab							
37.	Psychology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic							
44.	Emergency	366,000	45,991,222	0.007958	577,622		4,597	
45.	Other Clinics	13,011	47,208,577	0.000276	16,752		5	
46.	Ancillary Total						61,095	

* 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:	14-0258	Medicaid Provider Number:	5014
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/08 To: 12/31/08

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	254,841	77,987	3.27	6,921		22,632	
48.	Rehabilitation Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
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	153,699	7,426	20.70	3,263		67,544	
67.	Routine Total (lines 47-66)						90,176	
68.	Ancillary Total (from line 46)						61,095	
69.	Total (Lines 67-68)						151,271	

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

PRELIMINARY

Medicare Provider Number: 14-0258	Medicaid Provider Number: 5014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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)	17,126,698	
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)	151,271	
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)		
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	17,277,969	
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)	36,073,822	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	7,669,196	
	B. Rehabilitation Unit		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	1,067,896	
	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	3,912,370	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	48,723,284	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		31,445,315
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: 14-0258	Medicaid Provider Number: 5014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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)	17,277,969	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	17,277,969	
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)	17,277,969	

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: 14-0258	Medicaid Provider Number: 5014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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)	31,445,315
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: 14-0258	Medicaid Provider Number: 5014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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:	14-0258	Medicaid Provider Number:	5014
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/08 To: 12/31/08

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.	Gamma Knife							
23.	Endoscopy							
24.	Implants							
25.	Ultrasound							
26.	CT Scan							
27.	MRI							
28.	PET Scan							
29.	Radiation Oncology							
30.	Mammography							
31.	OP Physical therapy							
32.	IP Physical therapy							
33.	Cath Lab							
34.	Cardiac Rehab							
35.	Neuro Meg							
36.	Sleep Lab							
37.	Psychology							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency							
45.	Other Clinics							
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: 14-0258	Medicaid Provider Number: 5014
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/08 To: 12/31/08

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							
48.	Rehabilitation Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
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)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

