

# Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

**General Information** **Revised PRELIMINARY**

Name of Hospital: Saint Francis Medical Center		Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Ave		Medicaid Provider Number: 16007
City: Peoria	State: Illinois	Zip: 61637
Period Covered by Statement:	From: 10/01/07	To: 09/30/08

**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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Rehab	<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)) Saint Francis Medical Center 16007 for the cost report beginning 10/01/07 and ending 09/30/08 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

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	377	137,982		106,738	77.36%		24,475	4.97
2.	Rehab	25	9,150		8,863	96.86%		572	15.49
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	45	16,470		14,834	90.07%			
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								
22.	<b>Total</b>	<b>447</b>	<b>163,602</b>		<b>130,435</b>	<b>79.73%</b>		<b>25,047</b>	<b>5.21</b>
23.	Observation Bed Days				3,253				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Rehab			133	961			50	19.22
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit								
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								
22.	<b>Total</b>			<b>133</b>	<b>961</b>	<b>0.74%</b>		<b>50</b>	<b>19.22</b>

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

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	75,169,030	223,805,681	0.335867	18,376		6,172	
2.	Recovery Room	3,627,929	25,046,578	0.144847				
3.	Delivery and Labor Room	7,553,787	10,096,656	0.748147				
4.	Anesthesiology	3,373,711	77,602,460	0.043474				
5.	Radiology - Diagnostic	71,492,529	420,909,661	0.169852	68,143		11,574	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	34,536,030	414,791,352	0.083261	141,873		11,812	
9.	Blood							
10.	Blood - Administration	5,616,601	12,031,594	0.466821	15,237		7,113	
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,896,180	90,515,846	0.109331	91,293		9,981	
13.	Physical Therapy	13,508,585	32,177,368	0.419816	933,151		391,752	
14.	Occupational Therapy							
15.	Speech Pathology	1,263,955	3,400,685	0.371677	136,408		50,700	
16.	EKG	3,322,826	27,499,707	0.120831	2,358		285	
17.	EEG	1,148,533	4,198,799	0.273538	2,205		603	
18.	Med. / Surg. Supplies	6,758,909	54,377,692	0.124296	71,519		8,890	
19.	Drugs Charged to Patients	33,411,639	149,912,350	0.222874	205,599		45,823	
20.	Renal Dialysis	1,609,822	5,158,523	0.312070	11,803		3,683	
21.	Ambulance	9,210,763	21,373,686	0.430939				
22.	Digestive Diseases	5,927,428	49,548,070	0.119630				
23.	Cardiac Cath Lab	23,342,265	117,127,948	0.199289	1,713		341	
24.	Special Clinics	499,737	825,762	0.605183	3,775		2,285	
25.	Sisters Clinic	3,047,949	3,085,021	0.987983	3,596		3,553	
26.	Neuro Diagnostic	1,127,135	1,840,817	0.612301	39,401		24,125	
27.	Lithotripsy	193,532	957,606	0.202100				
28.								
29.	Sleep Disorders	3,355,310	13,461,679	0.249249	2,407		600	
30.	Pain Program	2,203,387	3,544,383	0.621656	1,200		746	
31.	Comp Epilepsy	698,449	4,127,408	0.169222	37,871		6,409	
32.	Urological	137,420	550,581	0.249591	2,273		567	
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic							
44.	Emergency	24,038,305	82,470,080	0.291479	13,510		3,938	
45.	Observation	3,268,027	1,060,234	3.082364				
46.	<b>Total</b>				<b>1,803,711</b>		<b>590,952</b>	

\* 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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/07 To: 09/30/08

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Rehab	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)	94,554,628	5,541,605		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	109,991	8,863		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	859.66	625.25		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		961		
3.	Program general inpatient routine cost (Line 1c X Line 2)		600,865		
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)		133		
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)		600,865		

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	23,659,268	14,834	1,594.94		
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					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					590,952
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>1,191,817</b>

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

Medicare Provider Number: <b>14-0067</b>	Medicaid Provider Number: <b>16007</b>
Program: <b>Medicaid-Rehab</b>	Period Covered by Statement: From: <b>10/01/07</b> To: <b>09/30/08</b>

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.	Rehab						
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)
		(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

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	150,000	77,602,460	0.001933				
5.	Radiology - Diagnostic	2,056,946	420,909,661	0.004887	68,143		333	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	20,703	90,515,846	0.000229	91,293		21	
13.	Physical Therapy	492,768	32,177,368	0.015314	933,151		14,290	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	520,245	27,499,707	0.018918	2,358		45	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	70	21,373,686	0.000003				
22.	Digestive Diseases							
23.	Cardiac Cath Lab							
24.	Special Clinics	177,365	825,762	0.214789	3,775		811	
25.	Sisters Clinic	741	3,085,021	0.000240	3,596		1	
26.	Neuro Diagnostic	301,243	1,840,817	0.163646	39,401		6,448	
27.	Lithotripsy							
28.								
29.	Sleep Disorders	759,621	13,461,679	0.056428	2,407		136	
30.	Pain Program	195,066	3,544,383	0.055035	1,200		66	
31.	Comp Epilepsy	436,057	4,127,408	0.105649	37,871		4,001	
32.	Urological							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency	3,243,794	82,470,080	0.039333	13,510		531	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>26,683</b>	

\* 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

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	580,828	109,991	5.28				
48.	Rehab							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	127,473	14,834	8.59				
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>						26,683	
69.	<b>Total (Lines 67-68)</b>						26,683	

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

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/07 To: 09/30/08

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)	1,191,817	
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)	26,683	
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)	106,022	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>1,324,522</b>	
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)	1,803,711	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Rehab	735,210	
	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.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>2,538,921</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,214,399
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**

Revised PRELIMINARY

<b>Medicare Provider Number:</b> 14-0067	<b>Medicaid Provider Number:</b> 16007
<b>Program:</b> Medicaid-Rehab	<b>Period Covered by Statement:</b> From: 10/01/07 To: 09/30/08

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)	1,324,522	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,324,522	
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	<b>1,324,522</b>	

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>		

\* Line 9 DOES NOT APPLY to the Medicaid program.

**Hospital Statement of Cost / Recovery of Excess Reasonable Cost**

Revised PRELIMINARY

Medicare Provider Number: <b>14-0067</b>	Medicaid Provider Number: <b>16007</b>
Program: <b>Medicaid-Rehab</b>	Period Covered by Statement: From: <b>10/01/07</b> To: <b>09/30/08</b>

**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)	1,214,399
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.	<b>Total (Sum of Lines 1 - 3)</b>					

**Hospital Statement of Cost  
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/07 To: 09/30/08

**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 Rehab	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 Rehab	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 Rehab	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)

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	5,823,278	223,805,681	0.026019	18,376		478	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	326,629	77,602,460	0.004209				
5.	Radiology - Diagnostic	5,628,140	420,909,661	0.013371	68,143		911	
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	132,427	4,198,799	0.031539	2,205		70	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Digestive Diseases							
23.	Cardiac Cath Lab							
24.	Special Clinics							
25.	Sisters Clinic	1,844,283	3,085,021	0.597819	3,596		2,150	
26.	Neuro Diagnostic							
27.	Lithotripsy							
28.								
29.	Sleep Disorders							
30.	Pain Program							
31.	Comp Epilepsy							
32.	Urological							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic							
44.	Emergency	5,274,185	82,470,080	0.063953	13,510		864	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>4,473</b>	

\* 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)

Revised PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/07 To: 09/30/08

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	11,269,437	109,991	102.46				
48.	Rehab	936,563	8,863	105.67	961		101,549	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	2,528,825	14,834	170.47				
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.	<b>Routine Total (lines 47-66)</b>						<b>101,549</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>4,473</b>	
69.	<b>Total (Lines 67-68)</b>						<b>106,022</b>	

**Hospital Statement of Cost  
Reconciliation of Patient Days and Revenue**

Revised PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/07 To: 09/30/08

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	961		961
Newborn Days			
Total Inpatient Revenue	2,538,921		2,538,921
Ancillary Revenue	1,803,711		1,803,711
Routine Revenue	735,210		735,210
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

Reclassified blood as Blood-Admin