

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: 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: 10/01/2008	To: 09/30/2009

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 10/01/2008 and ending 09/30/2009 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/2008 To: 09/30/2009

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	379	138,335		107,637	77.81%		26,265	4.65
2.	Rehab	26	9,490		8,829	93.03%		575	15.35
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	45	16,425		14,464	88.06%			
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.	Total	450	164,250		130,930	79.71%		26,840	4.88
23.	Observation Bed Days				4,600				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Rehab			195	1,251			68	18.40
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.	Total			195	1,251	0.96%		68	18.40

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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/2008 To: 09/30/2009

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	86,998,133	279,966,815	0.310744	77,267		24,010	
2.	Recovery Room	3,713,987	27,009,502	0.137507	6,416		882	
3.	Delivery and Labor Room	8,620,694	10,695,480	0.806013				
4.	Anesthesiology	3,999,019	85,515,493	0.046764	10,011		468	
5.	Radiology - Diagnostic	76,589,111	467,663,968	0.163770	98,230		16,087	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	38,078,887	437,316,206	0.087074	144,118		12,549	
9.	Blood							
10.	Blood - Administration	7,074,139	13,429,301	0.526769	1,254		661	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,799,266	102,440,551	0.105420	109,701		11,565	
13.	Physical Therapy	14,870,447	36,900,291	0.402990	1,309,971		527,905	
14.	Occupational Therapy							
15.	Speech Pathology	1,418,433	3,605,714	0.393385	194,236		76,410	
16.	EKG	5,321,370	54,630,012	0.097407	1,510		147	
17.	EEG	1,194,247	4,978,644	0.239874	2,818		676	
18.	Med. / Surg. Supplies	6,802,164	63,505,385	0.107112	122,118		13,080	
19.	Drugs Charged to Patients	35,967,053	169,127,250	0.212663	253,470		53,904	
20.	Renal Dialysis	2,102,275	4,711,863	0.446166				
21.	Ambulance	10,686,846	22,665,817	0.471496	1,273		600	
22.	Digestive Diseases	6,136,677	47,516,845	0.129147	5,078		656	
23.	Cardiac Cath Lab	22,255,100	121,558,099	0.183082	8,811		1,613	
24.	Special Clinics	545,243	975,534	0.558917	4,394		2,456	
25.	Sisters Clinic	4,586,662	3,595,218	1.275767	4,848		6,185	
26.	Wound Care	1,151,975	3,509,811	0.328216				
27.	Psychology	346,321	546,188	0.634069				
28.	Neuro Diagnostic	1,145,944	1,996,480	0.573982	42,449		24,365	
29.	Urological	152,292	624,806	0.243743	5,262		1,283	
30.	Lithotripsy	234,976	1,136,037	0.206838				
31.	Sleep Disorders	4,008,622	14,357,415	0.279202	1,068		298	
32.	Pain Program	2,262,731	3,686,330	0.613817	1,126		691	
33.	Comp Epilepsy	813,148	4,374,663	0.185877	62,100		11,543	
34.	Kidney Acquisition	3,744,047	3,744,047	1.000000				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	25,392,466	90,917,505	0.279291	8,110		2,265	
45.	Observation	2,094,939	1,168,482	1.792872				
46.	Total				2,413,539		778,756	

* 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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/2008 To: 09/30/2009

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)	105,812,436	5,877,637		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	112,237	8,829		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	942.76	665.72		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		1,251		
3.	Program general inpatient routine cost (Line 1c X Line 2)		832,816		
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)		195		
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)		832,816		

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	24,828,483	14,464	1,716.57		
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)					778,756
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,611,572

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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/2008 To: 09/30/2009

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)
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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/2008 To: 09/30/2009

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	483,068	85,515,493	0.005649	10,011		57	
5.	Radiology - Diagnostic	1,876,992	467,663,968	0.004014	98,230		394	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	35,304	102,440,551	0.000345	109,701		38	
13.	Physical Therapy	515,969	36,900,291	0.013983	1,309,971		18,317	
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.	Digestive Diseases							
23.	Cardiac Cath Lab							
24.	Special Clinics	188,901	975,534	0.193639	4,394		851	
25.	Sisters Clinic	5,683	3,595,218	0.001581	4,848		8	
26.	Wound Care							
27.	Psychology							
28.	Neuro Diagnostic	333,110	1,996,480	0.166849	42,449		7,083	
29.	Urological							
30.	Lithotripsy							
31.	Sleep Disorders	1,193,467	14,357,415	0.083125	1,068		89	
32.	Pain Program	191,897	3,686,330	0.052056	1,126		59	
33.	Comp Epilepsy	491,289	4,374,663	0.112303	62,100		6,974	
34.	Kidney Acquisition							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	4,459,975	90,917,505	0.049055	8,110		398	
45.	Observation							
46.	Ancillary Total						34,268	

* 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/2008 To: 09/30/2009

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	587,321	112,237	5.23				
48.	Rehab							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	103,672	14,464	7.17				
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)						34,268	
69.	Total (Lines 67-68)						34,268	

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

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/2008 To: 09/30/2009

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)	1,611,572	
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)	34,268	
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)	154,210	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,800,050	
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)	2,475,639	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Rehab	993,506	
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	3,469,145	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,669,095
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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/2008 To: 09/30/2009

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)	1,800,050	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,800,050	
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)	1,800,050	

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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/2008 To: 09/30/2009

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)	1,669,095
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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehab	Period Covered by Statement: From: 10/01/2008 To: 09/30/2009

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)

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/2008 To: 09/30/2009

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	6,475,394	279,966,815	0.023129	77,267		1,787	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	590,952	85,515,493	0.006910	10,011		69	
5.	Radiology - Diagnostic	5,622,856	467,663,968	0.012023	98,230		1,181	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	22,985	437,316,206	0.000053	144,118		8	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	159,198	4,978,644	0.031976	2,818		90	
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	1,992,389	3,595,218	0.554178	4,848		2,687	
26.	Wound Care							
27.	Psychology							
28.	Neuro Diagnostic							
29.	Urological							
30.	Lithotripsy							
31.	Sleep Disorders							
32.	Pain Program							
33.	Comp Epilepsy							
34.	Kidney Acquisition							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Centers								
43.	Clinic							
44.	Emergency	5,828,807	90,917,505	0.064111	8,110		520	
45.	Observation							
46.	Ancillary Total						6,342	

* 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 10/01/2008 To: 09/30/2009

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	12,714,041	112,237	113.28				
48.	Rehab	1,043,601	8,829	118.20	1,251		147,868	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	2,606,983	14,464	180.24				
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)						147,868	
68.	Ancillary Total (from line 46)						6,342	
69.	Total (Lines 67-68)						154,210	

