

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: Rockford Memorial Hospital		Medicare Provider Number: 14-0239	
Street: 2400 N. Rockton Avenue		Medicaid Provider Number: 18005	
City: Rockford	State: Illinois	Zip: 61103	
Period Covered by Statement:	From: 01/01/2010	To: 12/31/2010	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation XXXX XXXX	<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 XXXX XXXX	<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 XXXX XXXX	<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)) Rockford Memorial Hospital 18005 for the cost report beginning 01/01/2010 and ending 12/31/2010 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

 Name (Typewritten)
 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:	14-0239	Medicaid Provider Number:	18005
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	221	80,665		49,715	61.63%		14,857	4.72
2.	Psychiatric Unit	12	4,380		2,737	62.49%		663	4.13
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	22	8,030		5,926	73.80%			
6.	Coronary Care Unit								
7.	Neonatal ICU	46	16,790		13,411	79.87%			
8.	Pediatric ICU	7	2,555		1,137	44.50%			
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	21	7,665		3,154	41.15%			
22.	Total	329	120,085		76,080	63.36%		15,520	4.70
23.	Observation Bed Days				3,949				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				12,004			5,646	3.73
2.	Psychiatric Unit								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				1,164				
6.	Coronary Care Unit								
7.	Neonatal ICU				7,203				
8.	Pediatric ICU				678				
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				2,996				
22.	Total				24,045	31.60%		5,646	3.73

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:	14-0239	Medicaid Provider Number:	18005
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	21,273,872	41,537,496	0.512161	4,602,776		2,357,362	
2.	Recovery Room	2,155,393	7,433,945	0.289939	974,045		282,414	
3.	Delivery and Labor Room	5,997,149	10,174,311	0.589440	3,099,457		1,826,944	
4.	Anesthesiology	2,310,632	9,004,119	0.256619	937,865		240,674	
5.	Radiology - Diagnostic	7,491,023	35,459,835	0.211254	3,383,234		714,722	
6.	Radiology - Therapeutic	2,608,524	7,818,464	0.333636	31,016		10,348	
7.	Nuclear Medicine	1,199,306	6,214,316	0.192991	209,684		40,467	
8.	Laboratory	13,335,514	54,483,655	0.244762	11,994,231		2,935,732	
9.	Blood							
10.	Blood - Administration	2,751,370	13,429,542	0.204874	2,001,110		409,975	
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,074,054	34,600,831	0.204448	10,619,476		2,171,131	
13.	Physical Therapy	2,181,457	4,675,235	0.466598	859,680		401,125	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,736,041	22,013,570	0.124289	1,624,464		201,903	
17.	EEG	221,488	1,180,304	0.187653	294,485		55,261	
18.	Med. / Surg. Supplies	40,117,130	191,998,216	0.208945	26,891,920		5,618,932	
19.	Drugs Charged to Patients	21,241,341	80,682,901	0.263269	20,628,573		5,430,864	
20.	Renal Dialysis	919,680	1,501,780	0.612393	182,855		111,979	
21.	Ambulance	3,962,823	4,898,623	0.808967	170,895		138,248	
22.	G.I. Lab	1,913,040	8,199,525	0.233311	327,547		76,420	
23.	MRI	1,491,719	20,620,089	0.072343	901,340		65,206	
24.	CT Scan	2,115,785	40,105,710	0.052755	2,750,814		145,119	
25.	Cardiac Cath	2,903,198	12,699,978	0.228599	417,160		95,362	
26.								
27.	Special Surgical Services	642,607	1,600,122	0.401599				
28.	Genetic Services	1,163,546	605,289	1.922298				
29.	Pain Center	2,054,777	12,022,152	0.170916				
30.	Antenatal Center	1,097,374	3,812,776	0.287815	24,614		7,084	
31.	Child Psychiatric Clinic	810,464	468,744	1.729012				
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	12,942,759	48,721,910	0.265646	150,347		39,939	
45.	Observation	3,743,020	6,347,420	0.589692				
46.	Total				93,077,588		23,377,211	

* 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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	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)	50,863,804	3,258,358		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	53,664	2,737		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	947.82	1,190.49		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	12,004			
3.	Program general inpatient routine cost (Line 1c X Line 2)	11,377,631			
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)	11,377,631			

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	9,983,511	5,926	1,684.70	1,164	1,960,991
9.	Coronary Care Unit					
10.	Neonatal ICU	12,628,463	13,411	941.65	7,203	6,782,705
11.	Pediatric ICU	2,103,259	1,137	1,849.83	678	1,254,185
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,566,238	3,154	1,447.76	2,996	4,337,489
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					23,377,211
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					49,090,212

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

Medicare Provider Number: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

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.	Psychiatric Unit						
4.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Neonatal ICU						
9.	Pediatric ICU						
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:	14-0239	Medicaid Provider Number:	18005
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	51,252	41,537,496	0.001234	4,602,776		5,680	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	388,028	54,483,655	0.007122	11,994,231		85,423	
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.	G.I. Lab							
23.	MRI							
24.	CT Scan							
25.	Cardiac Cath							
26.								
27.	Special Surgical Services							
28.	Genetic Services							
29.	Pain Center							
30.	Antenatal Center							
31.	Child Psychiatric Clinic							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total						91,103	

* 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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psychiatric Unit	124,001	2,737	45.31				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	595,661	5,926	100.52	1,164		117,005	
52.	Coronary Care Unit							
53.	Neonatal ICU							
54.	Pediatric ICU							
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)						117,005	
68.	Ancillary Total (from line 46)						91,103	
69.	Total (Lines 67-68)						208,108	

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

PRELIMINARY

Medicare Provider Number: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

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)	49,090,212	
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)	208,108	
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)	49,298,320	
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)	93,077,588	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	51,837,843	
	B. Psychiatric Unit		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Neonatal ICU		
	H. Pediatric ICU		
	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)	144,915,431	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		95,617,111
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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

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)	49,298,320	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	49,298,320	
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)	49,298,320	

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: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	95,617,111
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)
			(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

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

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0239	Medicaid Provider Number: 18005
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2010 To: 12/31/2010

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psychiatric Unit	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 Psychiatric Unit	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 Psychiatric Unit	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:	14-0239	Medicaid Provider Number:	18005
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	G.I. Lab							
23.	MRI							
24.	CT Scan							
25.	Cardiac Cath							
26.								
27.	Special Surgical Services							
28.	Genetic Services							
29.	Pain Center							
30.	Antenatal Center							
31.	Child Psychiatric Clinic							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

PRELIMINARY

Medicare Provider Number:	14-0239	Medicaid Provider Number:	18005
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2010 To: 12/31/2010

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psychiatric Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal ICU							
54.	Pediatric ICU							
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)							

