

Hospital Statement of Cost

BHF Page 1

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: 10/01/2009	To: 09/30/2010

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☐ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ Other (Specify)	☐ Corporation	☐ County

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify)

Health Care Program

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

☐ Medicaid Hospital	☐ Medicaid Sub II	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Rehabilitation Unit	☐ Medicaid Sub III	☐ 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 10/01/2009 and ending 09/30/2010 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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

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	378	137,970		107,209	77.70%		26,484	4.59
2.	Rehab Unit	26	9,490		8,291	87.37%		578	14.34
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	44	16,060		14,242	88.68%			
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	448	163,520		129,742	79.34%		27,062	4.79
23.	Observation Bed Days				3,893				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Rehab Unit			221	1,171			70	16.73
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			221	1,171	0.90%		70	16.73

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0067		16007	
Program:		Period Covered by Statement:	
Medicaid-Rehabilitation		From: 10/01/2009	To: 09/30/2010

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	38,858,511	142,234,870	0.273200	11,000		3,005	
2.	Recovery Room	3,852,144	27,419,541	0.140489	2,784		391	
3.	Delivery and Labor Room	8,684,053	10,655,249	0.815002				
4.	Anesthesiology	3,576,254	93,019,681	0.038446	3,593		138	
5.	Radiology - Diagnostic	64,509,645	465,139,383	0.138689	158,196		21,940	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	36,141,381	310,304,967	0.116471	209,166		24,362	
9.	Blood							
10.	Blood - Administration	8,113,247	14,339,278	0.565806	5,291		2,994	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,072,625	72,652,018	0.138642	106,052		14,703	
13.	Physical Therapy	14,380,203	39,967,332	0.359799	1,369,122		492,609	
14.	Occupational Therapy							
15.	Speech Pathology	1,297,379	3,505,553	0.370093	215,060		79,592	
16.	EKG	5,173,876	48,129,540	0.107499	3,512		378	
17.	EEG	1,106,840	6,555,924	0.168831	5,260		888	
18.	Med. / Surg. Supplies	34,566,763	231,636,474	0.149228	271,081		40,453	
19.	Drugs Charged to Patients	36,274,958	209,938,493	0.172789	385,619		66,631	
20.	Renal Dialysis	2,032,135	5,724,251	0.355005	23,725		8,422	
21.	Ambulance	9,900,983	23,360,965	0.423826				
22.	Implants Device	43,592,957	137,740,878	0.316485	1,741		551	
23.	Digestive Diseases	4,694,980	39,048,770	0.120234	18,594		2,236	
24.	Cardiac Cath Lab	6,303,313	68,024,197	0.092663	1,205		112	
25.	Special Clinics	621,239	1,750,059	0.354982	30,152		10,703	
26.	Sisters Clinic	4,693,549	3,782,919	1.240722	4,907		6,088	
27.	Diabetes Clinic	843,815	141,268	5.973150	174		1,039	
28.	Wound Care	1,412,332	4,454,471	0.317059				
29.	Psychology	468,339	612,661	0.764434				
30.	Neuro Diagnostic	1,145,810	2,112,359	0.542431	57,522		31,202	
31.	Urological	133,347	641,102	0.207997	3,956		823	
32.	Lithotripsy	209,850	1,199,698	0.174919				
33.	Sleep Disorders	3,754,864	15,310,635	0.245245	2,264		555	
34.	Pain Program	1,901,513	3,961,784	0.479964				
35.	Comp Epilepsy	890,018	5,519,832	0.161240	68,914		11,112	
36.	Kidney Acquisition	3,912,520	4,023,807	0.972343				
37.	Pancreas Acquisition	317,576	317,576	1.000000				
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	25,668,296	97,617,202	0.262948	1,582		416	
45.	Observation-Distinct Part	1,914,493	2,336,561	0.819364				
46.	Total				2,960,472		821,343	

* 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

BHF Page 4

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Rehab 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)	101,690,095	5,907,632		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	111,102	8,291		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	915.29	712.54		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		1,171		
3.	Program general inpatient routine cost (Line 1c X Line 2)		834,384		
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)		221		
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)		834,384		

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	24,430,729	14,242	1,715.40		
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)					821,343
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,655,727

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-Rehabilitation	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 5) (6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Rehab 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) (1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552, W/S C, Pt.1, Lines 60-63) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45) (5A) (5B)		Program Expenses (Col. 4 X Cols. 5A-B) (6A) (6B)	
23.	Clinic								
24.	Emergency								
25.	Observation-Distinct Part								
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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

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							
2.	Recovery Room							
3.	Delivery and Labor Room	116,541	10,655,249	0.010937				
4.	Anesthesiology	35,751	93,019,681	0.000384	3,593		1	
5.	Radiology - Diagnostic	1,950,959	465,139,383	0.004194	158,196		663	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	5,884	72,652,018	0.000081	106,052		9	
13.	Physical Therapy	560,610	39,967,332	0.014027	1,369,122		19,205	
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.	Implants Device							
23.	Digestive Diseases							
24.	Cardiac Cath Lab							
25.	Special Clinics	238,426	1,750,059	0.136239	30,152		4,108	
26.	Sisters Clinic	5,925	3,782,919	0.001566	4,907		8	
27.	Diabetes Clinic							
28.	Wound Care							
29.	Psychology							
30.	Neuro Diagnostic	340,543	2,112,359	0.161215	57,522		9,273	
31.	Urological							
32.	Lithotripsy							
33.	Sleep Disorders	1,002,210	15,310,635	0.065458	2,264		148	
34.	Pain Program	397,079	3,961,784	0.100227				
35.	Comp Epilepsy	554,160	5,519,832	0.100394	68,914		6,919	
36.	Kidney Acquisition							
37.	Pancreas Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	5,043,677	97,617,202	0.051668	1,582		82	
45.	Observation-Distinct Part							
46.	Ancillary Total						40,416	

* 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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

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	586,261	111,102	5.28				
48.	Rehab Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	16,070	14,242	1.13				
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)						40,416	
69.	Total (Lines 67-68)						40,416	

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

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)		1,655,727	
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)		40,416	
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)		160,224	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		1,856,367	
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)		2,960,472	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics			
B. Rehab Unit		1,096,301	
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)		4,056,773	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			2,200,406
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

BHF Page 8

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

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)	1,856,367	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,856,367	
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)	1,856,367	

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

BHF Page 9

PRELIMINARY

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

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)	2,200,406
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	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
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)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

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 Rehab 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 Rehab 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 Rehab 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

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	6,326,944	142,234,870	0.044482	11,000		489	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	527,072	93,019,681	0.005666	3,593		20	
5.	Radiology - Diagnostic	5,833,810	465,139,383	0.012542	158,196		1,984	
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	145,169	6,555,924	0.022143	5,260		116	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implants Device							
23.	Digestive Diseases							
24.	Cardiac Cath Lab							
25.	Special Clinics							
26.	Sisters Clinic	2,035,565	3,782,919	0.538094	4,907		2,640	
27.	Diabetes Clinic							
28.	Wound Care							
29.	Psychology							
30.	Neuro Diagnostic							
31.	Urological							
32.	Lithotripsy							
33.	Sleep Disorders							
34.	Pain Program							
35.	Comp Epilepsy							
36.	Kidney Acquisition							
37.	Pancreas Acquisition							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	6,123,596	97,617,202	0.062731	1,582		99	
45.	Observation-Distinct Part							
46.	Ancillary Total						5,348	

* 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-Rehabilitation	Period Covered by Statement:	From: 10/01/2009 To: 09/30/2010

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	14,294,538	111,102	128.66				
48.	Rehab Unit	1,096,532	8,291	132.26	1,171		154,876	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	2,766,949	14,242	194.28				
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)						154,876	
68.	Ancillary Total (from line 46)						5,348	
69.	Total (Lines 67-68)						160,224	

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/2009 To: 09/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,171		1,171
Newborn Days			
Total Inpatient Revenue	4,056,773		4,056,773
Ancillary Revenue	2,960,472		2,960,472
Routine Revenue	1,096,301		1,096,301
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Spread between Acute & Children's Hospital.

BHF Pg3 Charges for Radiology-Diagnostic, Physical Therapy, EEG, Special Clinics, Sister's Clinic, Neuro Diagnostic, Sleep Disorders, Pain Program, Comp Epilepsy, Kidney Acquisition, ER, and Observation are greater than filed W/S C, Pt 1, Col 8.

Pancreas Acquisition Charges were adjusted to filed W/S D-6, Pt III & IV, Line 51.