

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: Memorial Medical Center		Medicare Provider Number: 14-0148	
Street: 701 North First Street		Medicaid Provider Number: 19006	
City: Springfield	State: Illinois	Zip: 62781-0001	
Period Covered by Statement:	From: 10/01/2010	To: 09/30/2011	

Type of Control

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

Type of Hospital

☐ XXXX XXXX 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)

☐ XXXX XXXX Medicaid Hospital	☐ Medicaid Sub II Rehab	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ 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)) Memorial Medical Center 19006 for the cost report beginning 10/01/2010 and ending 09/30/2011 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

Email Address

Name (Typewritten)

Title

Date

Telephone Number

Email Address

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). 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:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

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	353	128,712		91,059	70.75%		23,083	4.53
2.	Psych	36	13,078		10,497	80.26%		1,177	8.92
3.	Rehab	30	10,950		5,087	46.46%		451	11.28
4.	Other (Sub)								
5.	Intensive Care Unit	37	13,505		10,996	81.42%			
6.	Coronary Care Unit								
7.	Burn Unit	9	3,285		2,442	74.34%			
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	16	6,007		2,055	34.21%			
22.	Total	481	175,537		122,136	69.58%		24,711	4.86
23.	Observation Bed Days				1,959				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				9,693			2,548	4.13
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				341				
6.	Coronary Care Unit								
7.	Burn Unit				491				
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				761				
22.	Total				11,286	9.24%		2,548	4.13

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:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, 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	30,905,754	141,657,931	0.218172	7,677,289		1,674,969	
2.	Recovery Room							
3.	Delivery and Labor Room	3,784,553	8,883,811	0.426006	3,498,785		1,490,503	
4.	Anesthesiology	5,111,908	65,357,870	0.078214	3,356,027		262,488	
5.	Radiology - Diagnostic	34,304,481	245,989,277	0.139455	7,374,285		1,028,381	
6.	Radiology - Therapeutic	5,584,206	33,993,170	0.164274	185,337		30,446	
7.	Nuclear Medicine							
8.	Laboratory	35,234,659	163,536,797	0.215454	6,986,977		1,505,372	
9.	Blood							
10.	Blood - Administration	6,417,406	20,566,574	0.312031	1,345,401		419,807	
11.	Intravenous Therapy							
12.	Respiratory Therapy	8,431,779	44,207,055	0.190734	3,115,041		594,144	
13.	Physical Therapy	11,925,614	27,511,948	0.433470	362,583		157,169	
14.	Occupational Therapy	2,497,931	8,563,073	0.291710	268,744		78,395	
15.	Speech Pathology	907,852	2,784,774	0.326006	119,973		39,112	
16.	EKG	33,526,762	190,114,436	0.176350	5,287,100		932,380	
17.	EEG	710,995	4,737,214	0.150087	660,446		99,124	
18.	Med. / Surg. Supplies	49,220,287	147,570,326	0.333538	9,883,847		3,296,639	
19.	Drugs Charged to Patients	30,516,082	103,343,490	0.295288	8,964,652		2,647,154	
20.	Renal Dialysis	2,091,814	8,184,930	0.255569	352,479		90,083	
21.	Ambulance							
22.	GI Diagnostics Unit	5,027,973	19,696,424	0.255273	525,204		134,070	
23.	Vascular Lab	880,294	6,457,112	0.136329	268,713		36,633	
24.	Ambulatory Surgery(ASC)	7,028,724	32,330,462	0.217403	222,824		48,443	
25.	Renal Transplant Lab	780,145	650,693	1.198945	996		1,194	
26.	Kidney Acquisition	1,511,982	1,511,982	1.000000				
27.	Pancreas Acquisition	269,871	269,871	1.000000				
28.	Other							
29.	Other							
30.	Other							
31.	Other							
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	17,103,736	59,355,344	0.288158	1,587,747		457,522	
45.	Observation	1,531,879	1,785,626	0.857895				
46.	Total				62,044,450		15,024,028	

* 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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 10/01/2010 To: 09/30/2011

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	72,670,333	9,289,131	3,395,627	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	93,018	10,497	5,087	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	781.25	884.93	667.51	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	9,693			
3.	Program general inpatient routine cost (Line 1c X Line 2)	7,572,656			
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)	7,572,656			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	15,981,331	10,996	1,453.38	341	495,603
9.	Coronary Care Unit					
10.	Burn Unit	3,154,058	2,442	1,291.59	491	634,171
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	1,177,604	2,055	573.04	761	436,083
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					15,024,028
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					24,162,541

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

PRELIMINARY

Medicare Provider Number:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	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.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn Unit						
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 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	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)	
		(1)	(2)	(3)	(4)	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

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, 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	700	141,657,931	0.000005	7,677,289		38	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	11,608,833	65,357,870	0.177620	3,356,027		596,098	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	933,230	163,536,797	0.005707	6,986,977		39,875	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,545	44,207,055	0.000035	3,115,041		109	
13.	Physical Therapy	81,572	27,511,948	0.002965	362,583		1,075	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	361,951	190,114,436	0.001904	5,287,100		10,067	
17.	EEG	6,702	4,737,214	0.001415	660,446		935	
18.	Med. / Surg. Supplies	3,612	147,570,326	0.000024	9,883,847		237	
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	GI Diagnostics Unit							
23.	Vascular Lab	2,299	6,457,112	0.000356	268,713		96	
24.	Ambulatory Surgery(ASC)	167,892	32,330,462	0.005193	222,824		1,157	
25.	Renal Transplant Lab							
26.	Kidney Acquisition	8,447	1,511,982	0.005587				
27.	Pancreas Acquisition							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
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	14,208	59,355,344	0.000239	1,587,747		379	
45.	Observation							
46.	Ancillary Total						650,066	

* 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:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	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	17,650	93,018	0.19	9,693		1,842	
48.	Psych	5,997	10,497	0.57				
49.	Rehab	238	5,087	0.05				
50.	Other (Sub)							
51.	Intensive Care Unit	6,949	10,996	0.63	341		215	
52.	Coronary Care Unit							
53.	Burn Unit	21,316	2,442	8.73	491		4,286	
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	2,230	2,055	1.08	761		822	
67.	Routine Total (lines 47-66)						7,165	
68.	Ancillary Total (from line 46)						650,066	
69.	Total (Lines 67-68)						657,231	

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 10/01/2010 To: 09/30/2011

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)		24,162,541	
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)		657,231	
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)		645,073	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		25,464,845	
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)		62,044,450	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		9,212,364	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		2,881,738	
F. Coronary Care Unit			
G. Burn Unit		908,112	
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		526,800	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		75,573,464	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			50,108,619
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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 10/01/2010 To: 09/30/2011

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)	25,464,845	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	25,464,845	
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, Ch. 1, Sec. 115.2		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	25,464,845	

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:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

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 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	50,108,619
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)
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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 10/01/2010 To: 09/30/2011

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 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
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 Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(A)	General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B)	Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C)	Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
(A)	Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B)	Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, 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 2552-10, 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 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, 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	2,095,825	141,657,931	0.014795	7,677,289		113,585	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	453,273	245,989,277	0.001843	7,374,285		13,591	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	95,366	44,207,055	0.002157	3,115,041		6,719	
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	43,474	8,184,930	0.005311	352,479		1,872	
21.	Ambulance							
22.	GI Diagnostics Unit							
23.	Vascular Lab							
24.	Ambulatory Surgery(ASC)							
25.	Renal Transplant Lab							
26.	Kidney Acquisition							
27.	Pancreas Acquisition							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
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	345,564	59,355,344	0.005822	1,587,747		9,244	
45.	Observation							
46.	Ancillary Total						145,011	

* 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:	14-0148	Medicaid Provider Number:	19006
Program:	Medicaid-Hospital [Acute]	Period Covered by Statement:	From: 10/01/2010 To: 09/30/2011

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	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	4,798,426	93,018	51.59	9,693		500,062	
48.	Psych	1,016,498	10,497	96.84				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn Unit							
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)						500,062	
68.	Ancillary Total (from line 46)						145,011	
69.	Total (Lines 67-68)						645,073	

PRELIMINARY

Medicare Provider Number: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid-Hospital [Acute]	Period Covered by Statement: From: 10/01/2010 To: 09/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	10,525		10,525
Newborn Days	761		761
Total Inpatient Revenue	75,573,464		75,573,464
Ancillary Revenue	62,044,450		62,044,450
Routine Revenue	13,529,014		13,529,014
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Costs for Adults & Peds, ICU, Burn Unit, and Nursery are allocated between Acute Hospital and Children's Hospital for : costs on BHF page 4. HBP costs on BHF Page 6. and for GME costs on BHF Supplement No. 2(b)

Provider has included costs & charges for CT Scan and MRI with Radiology- Diagnostic on BHF Page 3.

OHF Supp. 2 charges for Anesthesiology are greater than the Medicare W/S C charges.

Kidney Acquisition and Pancreas Acquisition charges come from W/S D-4.

Anesthesiology on BHF Page 6, Column 1 includes CRNA Costs from W/S A-8, Lines 38.04,38.05, 38.06 and 38.07, and W/S A-8-2, Line 53.

On BHF Page 7, Psych Routine charges (36,752) have been included with Adults & Peds Room and Board.