

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: 10/01/2010	To: 09/30/2011

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 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)) Saint Francis Medical Center 16007 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
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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehabilitation	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	400	146,000		112,383	76.97%		29,859	4.32
2.	Psych								
3.	Rehab	26	9,490		8,691	91.58%		574	15.14
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,615		16,685	89.63%			
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	477	174,105		137,759	79.12%		30,433	4.53
23.	Observation Bed Days				3,551				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				1,025			68	15.07
4.	Other (Sub)								
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				1,025	0.74%		68	15.07

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: 10/01/2010	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	45,487,085	188,171,224	0.241732	4,987		1,206	
2.	Recovery Room	4,058,515	28,764,424	0.141095	1,742		246	
3.	Delivery and Labor Room	8,727,990	12,189,668	0.716015				
4.	Anesthesiology	3,619,732	100,152,682	0.036142	6,430		232	
5.	Radiology - Diagnostic	45,630,355	275,725,620	0.165492	86,023		14,236	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	36,863,905	345,640,058	0.106654	162,481		17,329	
9.	Blood							
10.	Blood - Administration	8,732,695	15,340,293	0.569265	4,736		2,696	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,225,531	90,031,219	0.113578	208,918		23,728	
13.	Physical Therapy	14,077,199	45,288,978	0.310831	1,126,496		350,150	
14.	Occupational Therapy							
15.	Speech Pathology	1,372,540	3,701,563	0.370800	148,022		54,887	
16.	EKG	5,011,579	52,122,150	0.096151	7,245		697	
17.	EEG	1,441,981	7,874,300	0.183125	1,570		288	
18.	Med. / Surg. Supplies	29,551,497	261,622,021	0.112955	384,830		43,468	
19.	Drugs Charged to Patients	37,994,799	278,845,057	0.136258	417,352		56,868	
20.	Renal Dialysis	2,498,434	6,888,813	0.362680	227		82	
21.	Ambulance	10,956,918	26,587,076	0.412114				
22.	CT Scan	8,275,572	149,756,516	0.055260	43,313		2,393	
23.	MRI	8,330,937	104,281,083	0.079889	9,104		727	
24.	Enterostomal	330,403	812,228	0.406786				
25.	Eating Disorders	845,947	262,733	3.219797				
26.	St. Jude Clinic	1,968	230,750	0.008529	158		1	
27.	Implant Devices	36,265,099	128,696,095	0.281789				
28.	Digestive Diseases	5,185,755	52,475,108	0.098823				
29.	Cardiac Cath Lab	8,462,174	110,605,340	0.076508	956		73	
30.	Special Clinics	548,253	2,101,979	0.260827	1,117		291	
31.	Sisters Clinic	4,609,884	3,791,400	1.215879	832		1,012	
32.	Diabetic Service	1,244,111	190,820	6.519814				
33.	Wound Care	1,434,976	4,892,826	0.293282	362		106	
34.	Psychology	1,435,167	3,643,370	0.393912				
35.	Neuro Diagnostic	996,329	2,663,829	0.374021				
36.	Urological	101,599	822,595	0.123510	5,932		733	
37.	Lithotripsy	251,595	1,736,061	0.144923				
38.	Sleep Disorders	3,761,839	16,454,100	0.228626				
39.	Pain Program	1,748,211	4,438,752	0.393852				
40.	Comp Epilepsy	1,169,228	6,650,607	0.175808				
41.	Kidney Acquisition	3,437,408	3,515,686	0.977735	254,362		248,699	
42.	Pancreas Acquisition	330,017	289,275	1.140842				
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	26,715,310	108,419,642	0.246407	11,078		2,730	
45.	Observation	2,176,159	2,962,540	0.734559				
46.	Total				2,888,273		822,878	

* 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: 10/01/2010 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)	98,820,290		5,796,331	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	115,934		8,691	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	852.38		666.93	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,025	
3.	Program general inpatient routine cost (Line 1c X Line 2)			683,603	
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)			683,603	

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	30,591,999	16,685	1,833.50		
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)					822,878
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,506,481

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: 10/01/2010 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.	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 2552-10, 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid-Rehabilitation	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	719,243	188,171,224	0.003822	4,987		19	
2.	Recovery Room							
3.	Delivery and Labor Room	9,951	12,189,668	0.000816				
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,942,452	275,725,620	0.007045	86,023		606	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	717,525	45,288,978	0.015843	1,126,496		17,847	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	50,000	52,122,150	0.000959	7,245		7	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI	6,786	104,281,083	0.000065	9,104		1	
24.	Enterostomal							
25.	Eating Disorders							
26.	St. Jude Clinic							
27.	Implant Devices							
28.	Digestive Diseases	54,000	52,475,108	0.001029				
29.	Cardiac Cath Lab							
30.	Special Clinics	287,798	2,101,979	0.136918	1,117		153	
31.	Sisters Clinic	11,884	3,791,400	0.003134	832		3	
32.	Diabetic Service							
33.	Wound Care							
34.	Psychology							
35.	Neuro Diagnostic	523,752	2,663,829	0.196616				
36.	Urological							
37.	Lithotripsy							
38.	Sleep Disorders	789,506	16,454,100	0.047982				
39.	Pain Program	446,680	4,438,752	0.100632				
40.	Comp Epilepsy	773,321	6,650,607	0.116278				
41.	Kidney Acquisition							
42.	Pancreas Acquisition							
Outpatient Ancillary Cost Centers								
43.	Clinic							
44.	Emergency	6,392,954	108,419,642	0.058965	11,078		653	
45.	Observation							
46.	Ancillary Total						19,289	

* 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: 10/01/2010 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	768,973	115,934	6.63				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,983	16,685	0.12				
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)						19,289	
69.	Total (Lines 67-68)						19,289	

**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: 10/01/2010 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)		1,506,481	
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)		19,289	
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)		131,607	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		1,657,377	
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)		2,888,273	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics			
B. Psych			
C. Rehab		1,011,454	
D. Other (Sub)			
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)		3,899,727	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			2,242,350
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: 10/01/2010 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)	1,657,377	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,657,377	
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)	1,657,377	

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: 10/01/2010 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)	2,242,350
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: 10/01/2010 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

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(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: 14-0067		Medicaid Provider Number: 16007	
Program: Medicaid-Rehabilitation		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	5,415,831	188,171,224	0.028781	4,987		144	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	471,360	100,152,682	0.004706	6,430		30	
5.	Radiology - Diagnostic	6,475,519	275,725,620	0.023485	86,023		2,020	
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	12,144	52,122,150	0.000233	7,245		2	
17.	EEG	121,295	7,874,300	0.015404	1,570		24	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Enterostomal							
25.	Eating Disorders							
26.	St. Jude Clinic							
27.	Implant Devices							
28.	Digestive Diseases							
29.	Cardiac Cath Lab							
30.	Special Clinics							
31.	Sisters Clinic	1,972,819	3,791,400	0.520341	832		433	
32.	Diabetic Service							
33.	Wound Care							
34.	Psychology							
35.	Neuro Diagnostic							
36.	Urological							
37.	Lithotripsy							
38.	Sleep Disorders							
39.	Pain Program							
40.	Comp Epilepsy							
41.	Kidney Acquisition							
42.	Pancreas Acquisition							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	6,414,523	108,419,642	0.059164	11,078		655	
45.	Observation							
46.	Ancillary Total						3,308	

* 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: 10/01/2010 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	14,946,641	115,934	128.92				
48.	Psych							
49.	Rehab	1,087,884	8,691	125.17	1,025		128,299	
50.	Other (Sub)							
51.	Intensive Care Unit	2,733,622	16,685	163.84				
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)						128,299	
68.	Ancillary Total (from line 46)						3,308	
69.	Total (Lines 67-68)						131,607	

PRELIMINARY

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 10/01/2010 To: 09/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,025		1,025
Newborn Days			
Total Inpatient Revenue	3,899,727		3,899,727
Ancillary Revenue	2,888,273		2,888,273
Routine Revenue	1,011,454		1,011,454
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Spread between Acute & Children's Hospital.

Adults & Peds days adjusted to remove the Labor Room days which were claimed on the "as-filed" report.

Included the 5 Rehab-Observation Room days on BHF Page 2, Column 4, Line 3.

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