Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

PRELIMINARY

Name of Hospital: Saint Francis Medical Center	**Medicare Provider Number:** 14-0067
Street: 530 NE Glen Oak Ave	**Medicaid Provider Number:** 16007
City: Peoria **State:** Illinois **Zip:** 61637	
Period Covered by Statement: **From:** 10/01/2009 **To:** 09/30/2010	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
XXXX XXXX	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
	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		DHS - Office of Rehabilitation Services
	Medicaid Sub I		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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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			5,730	16,022			4,217	4.26
2.	Rehab Unit								
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit				1,928				
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**			**5,730**	**17,950**	**13.84%**		**4,217**	**4.26**

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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	7,932,946		2,167,281	
2.	Recovery Room	3,852,144	27,419,541	0.140489	1,951,620		274,181	
3.	Delivery and Labor Room	8,684,053	10,655,249	0.815002	3,508,598		2,859,514	
4.	Anesthesiology	3,576,254	93,019,681	0.038446	6,174,411		237,381	
5.	Radiology - Diagnostic	64,509,645	465,139,383	0.138689	15,632,824		2,168,101	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	36,141,381	310,304,967	0.116471	15,283,374		1,780,070	
9.	Blood							
10.	Blood - Administration	8,113,247	14,339,278	0.565806	1,151,523		651,539	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,072,625	72,652,018	0.138642	5,749,674		797,146	
13.	Physical Therapy	14,380,203	39,967,332	0.359799	1,288,505		463,603	
14.	Occupational Therapy							
15.	Speech Pathology	1,297,379	3,505,553	0.370093	158,124		58,521	
16.	EKG	5,173,876	48,129,540	0.107499	811,019		87,184	
17.	EEG	1,106,840	6,555,924	0.168831	1,944,439		328,282	
18.	Med. / Surg. Supplies	34,566,763	231,636,474	0.149228	16,602,165		2,477,508	
19.	Drugs Charged to Patients	36,274,958	209,938,493	0.172789	20,343,334		3,515,104	
20.	Renal Dialysis	2,032,135	5,724,251	0.355005	509,387		180,835	
21.	Ambulance	9,900,983	23,360,965	0.423826	2,665,915		1,129,884	
22.	Implants Device	43,592,957	137,740,878	0.316485	8,373,184		2,649,987	
23.	Digestive Diseases	4,694,980	39,048,770	0.120234	787,532		94,688	
24.	Cardiac Cath Lab	6,303,313	68,024,197	0.092663	1,379,348		127,815	
25.	Special Clinics	621,239	1,750,059	0.354982	44,713		15,872	
26.	Sisters Clinic	4,693,549	3,782,919	1.240722	6,678		8,286	
27.	Diabetes Clinic	843,815	141,268	5.973150	235		1,404	
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	78,679		42,678	
31.	Urological	133,347	641,102	0.207997	5,323		1,107	
32.	Lithotripsy	209,850	1,199,698	0.174919				
33.	Sleep Disorders	3,754,864	15,310,635	0.245245	3,098		760	
34.	Pain Program	1,901,513	3,961,784	0.479964	47		23	
35.	Comp Epilepsy	890,018	5,519,832	0.161240	94,257		15,198	
36.	Kidney Acquisition	3,912,520	4,023,807	0.972343	175,340		170,491	
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	3,138,638		825,299	
45.	Observation-Distinct Part	1,914,493	2,336,561	0.819364	104,513		85,634	
46.	**Total**				**115,899,443**		**23,215,376**	

* 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:	Medicaid Provider Number:		
14-0067	16007		
Program:	**Period Covered by Statement:**		
Medicaid-Hospital	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)	16,022			
3.	Program general inpatient routine cost (Line 1c X Line 2)	14,664,776			
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)	5,730			
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)	14,664,776			

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	1,928	3,307,291
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)					23,215,376
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**41,187,443**

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

PRELIMINARY

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

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Rehab 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 Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	3,508,598		38,374	
4.	Anesthesiology	35,751	93,019,681	0.000384	6,174,411		2,371	
5.	Radiology - Diagnostic	1,950,959	465,139,383	0.004194	15,632,824		65,564	
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	5,749,674		466	
13.	Physical Therapy	560,610	39,967,332	0.014027	1,288,505		18,074	
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	44,713		6,092	
26.	Sisters Clinic	5,925	3,782,919	0.001566	6,678		10	
27.	Diabetes Clinic							
28.	Wound Care							
29.	Psychology							
30.	Neuro Diagnostic	340,543	2,112,359	0.161215	78,679		12,684	
31.	Urological							
32.	Lithotripsy							
33.	Sleep Disorders	1,002,210	15,310,635	0.065458	3,098		203	
34.	Pain Program	397,079	3,961,784	0.100227	47		5	
35.	Comp Epilepsy	554,160	5,519,832	0.100394	94,257		9,463	
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	3,138,638		162,167	
45.	Observation-Distinct Part							
46.	**Ancillary Total**						**315,473**	

* 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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	16,022		84,596	
48.	Rehab Unit							
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	16,070	14,242	1.13	1,928		2,179	
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)**						**86,775**	
68.	**Ancillary Total (from line 46)**						**315,473**	
69.	**Total (Lines 67-68)**						**402,248**	

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

PRELIMINARY

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

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	41,187,443	
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)	402,248	
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)	3,263,426	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**44,853,117**	
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 (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	115,899,443	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	16,171,086	
	B. Rehab Unit		
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit	6,725,390	
	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)**	138,795,919	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		93,942,802
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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 10/01/2009 To: 09/30/2010

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	44,853,117	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	44,853,117	
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)**	**44,853,117**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	93,942,802
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 **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
14-0067	**16007**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	7,932,946		352,873	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	527,072	93,019,681	0.005666	6,174,411		34,984	
5.	Radiology - Diagnostic	5,833,810	465,139,383	0.012542	15,632,824		196,067	
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	1,944,439		43,056	
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	6,678		3,593	
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	3,138,638		196,890	
45.	Observation-Distinct Part							
46.	**Ancillary Total**						**827,463**	

* 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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	16,022		2,061,391	
48.	Rehab Unit	1,096,532	8,291	132.26				
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	2,766,949	14,242	194.28	1,928		374,572	
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)**						**2,435,963**	
68.	**Ancillary Total (from line 46)**						**827,463**	
69.	**Total (Lines 67-68)**						**3,263,426**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

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

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	17,950		17,950
Newborn Days			
Total Inpatient Revenue	138,795,919		138,795,919
Ancillary Revenue	115,899,443		115,899,443
Routine Revenue	22,896,476		22,896,476
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.