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

Type of Control

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

Type of Hospital

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	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)) Memorial Medical Center 19006 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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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	346	126,513		93,771	74.12%		23,063	4.65
2.	Psychiatric Unit	35	12,775		10,532	82.44%		1,218	8.65
3.	Rehabilitation Unit	30	10,950		4,932	45.04%		424	11.63
4.	Sub III								
5.	Intensive Care Unit	37	13,412		11,042	82.33%			
6.	Coronary Care Unit								
7.	Burn ICU	9	3,285		2,321	70.65%			
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	17	6,301		2,190	34.76%			
22.	**Total**	**474**	**173,236**		**124,788**	**72.03%**		**24,705**	**4.96**
23.	Observation Bed Days				2,629				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				9,617			2,395	4.31
2.	Psychiatric Unit								
3.	Rehabilitation Unit								
4.	Sub III								
5.	Intensive Care Unit				330				
6.	Coronary Care Unit								
7.	Burn ICU				377				
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				774				
22.	**Total**				**11,098**	**8.89%**		**2,395**	**4.31**

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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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	30,408,125	124,985,064	0.243294	6,686,351		1,626,749	
2.	Recovery Room							
3.	Delivery and Labor Room	3,740,462	8,199,889	0.456160	3,196,072		1,457,920	
4.	Anesthesiology	4,298,719	61,046,639	0.070417	3,116,412		219,448	
5.	Radiology - Diagnostic	33,054,448	231,298,924	0.142908	6,793,975		970,913	
6.	Radiology - Therapeutic	6,694,045	30,708,408	0.217987	173,255		37,767	
7.	Nuclear Medicine							
8.	Laboratory	33,203,777	156,410,689	0.212286	6,369,408		1,352,136	
9.	Blood							
10.	Blood - Administration	6,483,976	20,456,118	0.316970	1,563,504		495,584	
11.	Intravenous Therapy							
12.	Respiratory Therapy	8,381,441	42,747,602	0.196068	3,034,773		595,022	
13.	Physical Therapy	11,934,557	25,840,757	0.461850	325,633		150,394	
14.	Occupational Therapy	2,556,774	7,887,656	0.324149	226,650		73,468	
15.	Speech Pathology	829,839	2,430,526	0.341424	92,975		31,744	
16.	EKG	26,179,378	196,534,468	0.133205	5,515,754		734,726	
17.	EEG	664,181	3,514,223	0.188998	399,694		75,541	
18.	Med. / Surg. Supplies	53,042,826	126,893,861	0.418009	8,195,094		3,425,623	
19.	Drugs Charged to Patients	31,103,424	99,856,500	0.311481	8,579,582		2,672,377	
20.	Renal Dialysis	2,142,904	7,869,290	0.272312	397,545		108,256	
21.	Ambulance							
22.	GI Diagnostics Unit	4,531,956	16,646,639	0.272245	407,861		111,038	
23.	Vascular Lab	910,162	6,410,985	0.141969	259,898		36,897	
24.	Ambulatory Surgery(ASC)	8,588,252	37,594,844	0.228442	198,448		45,334	
25.	Renal Transplant Lab	668,365	381,770	1.750701	282		494	
26.	Kidney Acquisition	1,379,663	1,379,663	1.000000				
27.	Pancreas Acquisition	160,430	160,430	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	16,072,145	59,813,567	0.268704	1,724,995		463,513	
45.	Observation	1,970,856	2,201,669	0.895165				
46.	**Total**				**57,258,161**		**14,684,944**	

* 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:		
14-0148	19006		
Program:	**Period Covered by Statement:**		
Medicaid-Hospital [Acute]	From: 10/01/2009	To:	09/30/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psychiatric Unit	Sub II Rehabilitation Un	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	72,215,998	9,166,524	3,395,282	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	96,400	10,532	4,932	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	749.13	870.35	688.42	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	9,617			
3.	Program general inpatient routine cost (Line 1c X Line 2)	7,204,383			
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)	7,204,383			

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	16,020,225	11,042	1,450.84	330	478,777
9.	Coronary Care Unit					
10.	Burn ICU	2,933,931	2,321	1,264.08	377	476,558
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	1,270,546	2,190	580.16	774	449,044
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					14,684,944
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**23,293,706**

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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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.	Psychiatric Unit						
4.	Rehabilitation Unit						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
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								
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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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	51,680	124,985,064	0.000413	6,686,351		2,761	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	11,037,519	61,046,639	0.180805	3,116,412		563,463	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	781,810	156,410,689	0.004998	6,369,408		31,834	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	22,500	25,840,757	0.000871	325,633		284	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	392,431	196,534,468	0.001997	5,515,754		11,015	
17.	EEG	1,002	3,514,223	0.000285	399,694		114	
18.	Med. / Surg. Supplies	66,825	126,893,861	0.000527	8,195,094		4,319	
19.	Drugs Charged to Patients							
20.	Renal Dialysis	2,000	7,869,290	0.000254	397,545		101	
21.	Ambulance							
22.	GI Diagnostics Unit	32,500	16,646,639	0.001952	407,861		796	
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 Cost Centers							
43.	Clinic							
44.	Emergency	4,735	59,813,567	0.000079	1,724,995		136	
45.	Observation							
46.	**Ancillary Total**						**614,823**	

* 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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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	1,835	96,400	0.02	9,617		192	
48.	Psychiatric Unit	159	10,532	0.02				
49.	Rehabilitation Unit							
50.	Sub III							
51.	Intensive Care Unit	100	11,042	0.01	330		3	
52.	Coronary Care Unit							
53.	Burn ICU							
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	2,555	2,190	1.17	774		906	
67.	**Routine Total (lines 47-66)**						**1,101**	
68.	**Ancillary Total (from line 46)**						**614,823**	
69.	**Total (Lines 67-68)**						**615,924**	

Rev. 10 / 08

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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)	23,293,706	
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)	615,924	
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)	629,095	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**24,538,725**	
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)	57,258,161	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	8,571,636	
	B. Psychiatric Unit		
	C. Rehabilitation Unit		
	D. Sub III		
	E. Intensive Care Unit	2,511,537	
	F. Coronary Care Unit		
	G. Burn ICU	1,413,574	
	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	504,240	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	70,259,148	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		45,720,423
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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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)	24,538,725	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	24,538,725	
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)**	**24,538,725**	

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.

Rev. 10 / 08

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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)	45,720,423
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:**
14-0148	**19006**
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	**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 Psychiatric Unit**	**Sub II Rehabilitation Ur**	**Sub III Sub III**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	**General Service**	**Sub I Psychiatric Unit**	**Sub II Rehabilitation Ur**	**Sub III Sub III**
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 Psychiatric Unit**	**Sub II Rehabilitation Ur**	**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 1c)**				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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	2,014,150	124,985,064	0.016115	6,686,351		107,751	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	546,874	231,298,924	0.002364	6,793,975		16,061	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	247,156	42,747,602	0.005782	3,034,773		17,547	
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	54,852	7,869,290	0.006970	397,545		2,771	
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	76,048	59,813,567	0.001271	1,724,995		2,192	
45.	Observation							
46.	**Ancillary Total**						**146,322**	

* 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:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	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	4,839,145	96,400	50.20	9,617		482,773	
48.	Psychiatric Unit	1,072,498	10,532	101.83				
49.	Rehabilitation Unit							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
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)**						**482,773**	
68.	**Ancillary Total (from line 46)**						**146,322**	
69.	**Total (Lines 67-68)**						**629,095**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0148	19006
Program:	**Period Covered by Statement:**
Medicaid-Hospital [Acute]	From: 10/01/2009 To: 09/30/2010

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	10,324		10,324
Newborn Days	774		774
Total Inpatient Revenue	70,259,148		70,259,148
Ancillary Revenue	57,258,161		57,258,161
Routine Revenue	13,000,987		13,000,987
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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

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 40.

Kidney Acquisition and Pancreas Acquisition costs from W/S B Part 1 and charges come from W/S D-6.