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 Avenue		**Medicaid Provider Number:** 16007
City: Peoria	**State:** Illinois	**Zip:** 61637-0001
Period Covered by Statement:	**From:** 10/01/2011	**To:** 09/30/2012

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 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 10/01/2011 and ending 09/30/2012 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

Signed (Officer or Administrator of Provider(s)):

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2011 To: 09/30/2012

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	403	147,498		119,606	81.09%		30,805	4.41
2.	Psych								
3.	Rehab	26	9,516		9,039	94.99%		592	15.27
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,666		16,097	86.24%			
6.	Coronary Care Unit								
7.	Premature ICU								
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**	**480**	**175,680**		**144,742**	**82.39%**		**31,397**	**4.61**
23.	Observation Bed Days				3,811				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				17,877			5,620	3.67
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,753				
6.	Coronary Care Unit								
7.	Premature ICU								
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**				**20,630**	**14.25%**		**5,620**	**3.67**

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: 10/01/2011 To: 09/30/2012

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	47,622,283	209,142,395	0.227703	12,661,309		2,883,018	
2.	Recovery Room	4,298,012	32,266,274	0.133204	2,469,114		328,896	
3.	Delivery and Labor Room	9,124,406	13,594,697	0.671174	4,153,535		2,787,745	
4.	Anesthesiology	3,476,011	112,977,934	0.030767	7,892,859		242,840	
5.	Radiology - Diagnostic	43,328,274	292,490,716	0.148136	10,805,085		1,600,622	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	37,869,928	393,998,408	0.096117	21,932,254		2,108,062	
9.	Blood							
10.	Blood - Administration	8,535,397	16,621,295	0.513522	1,424,888		731,711	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,419,626	99,911,430	0.104289	10,904,699		1,137,240	
13.	Physical Therapy	15,031,345	51,794,768	0.290210	2,038,050		591,462	
14.	Occupational Therapy							
15.	Speech Pathology	1,457,330	4,507,255	0.323330	267,806		86,590	
16.	EKG	4,901,665	55,612,956	0.088139	1,563,841		137,835	
17.	EEG	1,439,695	9,666,027	0.148944	1,560,427		232,416	
18.	Med. / Surg. Supplies	30,694,417	292,337,367	0.104997	23,895,785		2,508,986	
19.	Drugs Charged to Patients	39,047,072	306,761,744	0.127288	32,384,118		4,122,110	
20.	Renal Dialysis	2,541,448	7,328,904	0.346771	542,802		188,228	
21.	Ambulance	10,475,717	28,566,017	0.366720	3,518,592		1,290,338	
22.	CT Scan	7,172,722	155,512,917	0.046123	6,275,621		289,450	
23.	MRI	7,845,275	109,359,649	0.071738	2,716,410		194,870	
24.	Cardiac Catherization	7,500,318	126,038,805	0.059508	2,981,463		177,421	
25.	Sisters Clinic	4,527,976	4,618,576	0.980384	8,205		8,044	
26.	Implantable Devices	43,375,474	157,129,303	0.276050	9,241,206		2,551,035	
27.	Digestive Diseases	5,895,289	62,190,263	0.094794	1,536,374		145,639	
28.	Enterostomal	394,152	872,838	0.451575				
29.	Diabetic Service	1,027,697	174,145	5.901387				
30.	Wound Care	1,648,944	5,620,012	0.293406				
31.	Psychology	1,696,362	3,643,970	0.465526				
32.	Neuro Diagnostic Ctr.	1,186,432	3,729,994	0.318079	184,501		58,686	
33.	Eating Disorder	801,803	294,510	2.722498				
34.	Urological	130,663	743,561	0.175726	6,798		1,195	
35.	Sleep Disorders	3,684,720	18,854,038	0.195434	7,226		1,412	
36.	Pain Program	1,716,514	5,861,192	0.292861	539		158	
37.	Comp Epilepsy	1,315,041	7,722,048	0.170297	106,571		18,149	
38.	Cardiac Rehab	753,947	1,327,332	0.568017				
39.	Lithotripsy	279,799	2,471,192	0.113224	12,916		1,462	
40.	Kidney Acquisition	3,545,887	3,259,098	1.087996				
41.	St. Judes Clinic	1,073,430	1,214,887	0.883564	6,041		5,338	
42.	Special Clinics	522,852	2,295,521	0.227771	76,532		17,432	
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	26,560,323	123,256,546	0.215488	4,661,238		1,004,441	
45.	Observation	3,333,106	4,066,759	0.819598	125,173		102,592	
46.	**Total**				**165,961,978**		**25,555,423**	

* 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: 10/01/2011 To: 09/30/2012

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)	109,273,605		6,223,479	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	123,417		9,039	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	885.40		688.51	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	17,877			
3.	Program general inpatient routine cost (Line 1c X Line 2)	15,828,296			
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)	15,828,296			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	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	30,148,348	16,097	1,872.92	2,753	5,156,149
9.	Coronary Care Unit					
10.	Premature ICU					
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)					25,555,423
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**46,539,868**

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: 10/01/2011 To: 09/30/2012

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Premature 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 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						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:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2011 To: 09/30/2012

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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	185,252	112,977,934	0.001640	7,892,859		12,944	
5.	Radiology - Diagnostic	1,608,104	292,490,716	0.005498	10,805,085		59,406	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	810,216	51,794,768	0.015643	2,038,050		31,881	
14.	Occupational Therapy							
15.	Speech Pathology	5,200	4,507,255	0.001154	267,806		309	
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI	213	109,359,649	0.000002	2,716,410		5	
24.	Cardiac Catherization							
25.	Sisters Clinic							
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.	710,255	3,729,994	0.190417	184,501		35,132	
33.	Eating Disorder							
34.	Urological							
35.	Sleep Disorders	788,657	18,854,038	0.041830	7,226		302	
36.	Pain Program	556,269	5,861,192	0.094907	539		51	
37.	Comp Epilepsy	1,154,639	7,722,048	0.149525	106,571		15,935	
38.	Cardiac Rehab	115,300	1,327,332	0.086866				
39.	Lithotripsy							
40.	Kidney Acquisition							
41.	St. Judes Clinic							
42.	Special Clinics	360,948	2,295,521	0.157240	76,532		12,034	
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	12,778,187	123,256,546	0.103671	4,661,238		483,235	
45.	Observation	5,699	4,066,759	0.001401	125,173		175	
46.	**Ancillary Total**						**651,409**	

* 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: 10/01/2011 To: 09/30/2012

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	987,630	123,417	8.00	17,877		143,016	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	127,720	16,097	7.93	2,753		21,831	
52.	Coronary Care Unit							
53.	Premature 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)**						**164,847**	
68.	**Ancillary Total (from line 46)**						**651,409**	
69.	**Total (Lines 67-68)**						**816,256**	

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: 10/01/2011 To: 09/30/2012

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)	46,539,868	
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)	816,256	
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)	3,717,380	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**51,073,504**	
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)	165,961,978	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	22,893,939	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	10,705,721	
	F. Coronary Care Unit		
	G. Premature ICU		
	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)**	199,561,638	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		148,488,134
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: 10/01/2011 To: 09/30/2012

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)	51,073,504	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	51,073,504	
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)**	**51,073,504**	

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 / 11

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: 10/01/2011 To: 09/30/2012

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)	148,488,134
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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: 10/01/2011 To: 09/30/2012**

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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2011 To: 09/30/2012

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	6,716,010	209,142,395	0.032112	12,661,309		406,580	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	401,080	112,977,934	0.003550	7,892,859		28,020	
5.	Radiology - Diagnostic	6,005,360	292,490,716	0.020532	10,805,085		221,850	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	22,877	393,998,408	0.000058	21,932,254		1,272	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	11,505	55,612,956	0.000207	1,563,841		324	
17.	EEG	137,528	9,666,027	0.014228	1,560,427		22,202	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Catherization							
25.	Sisters Clinic	1,663,431	4,618,576	0.360161	8,205		2,955	
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.							
33.	Eating Disorder							
34.	Urological							
35.	Sleep Disorders							
36.	Pain Program							
37.	Comp Epilepsy							
38.	Cardiac Rehab							
39.	Lithotripsy							
40.	Kidney Acquisition							
41.	St. Judes Clinic							
42.	Special Clinics							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	7,094,214	123,256,546	0.057556	4,661,238		268,282	
45.	Observation							
46.	**Ancillary Total**						**951,485**	

* 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 Hospital	**Period Covered by Statement:** From: 10/01/2011 To: 09/30/2012

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	16,031,336	123,417	129.90	17,877		2,322,222	
48.	Psych							
49.	Rehab	1,231,936	9,039	136.29				
50.	Other (Sub)							
51.	Intensive Care Unit	2,594,200	16,097	161.16	2,753		443,673	
52.	Coronary Care Unit							
53.	Premature 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)**						**2,765,895**	
68.	**Ancillary Total (from line 46)**						**951,485**	
69.	**Total (Lines 67-68)**						**3,717,380**	

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: 10/01/2011 To: 09/30/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	20,630		20,630
Newborn Days			
Total Inpatient Revenue	199,564,638	(3,000)	199,561,638
Ancillary Revenue	165,964,978	(3,000)	165,961,978
Routine Revenue	33,599,660		33,599,660
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Adults & Peds days were adjusted to remove the Labor Room days which were included on the "as filed" report.
BHF Page 3 - Total costs agree with as filed W/S C Part 1, column 1 with the exception of PBP Clinical Lab, Voice Clinic, Lung Clinic and Palliative Care Clinic, Observation Rm and Pancreas Acquisition.
BHF Page 3 - Total charges agree with as filed W/S C Part 1, column 8 with the following exceptions:
Radiology=Diag., Physical Therapy, Special Clinics, Sister's Clinic, Neuro Diagnostic, Sleep Disorders, Pain Program, Comp Epilepsy, EEG Respiratory Therapy, Psychology, and Emergency Rm
Spread costs between Acute and Children's Hospitals.