

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 Avenue		Medicaid Provider Number: 16007
City: Peoria	State: Illinois	Zip: 61637-0001
Period Covered by Statement:	From: 10/01/2015	To: 09/30/2016

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 10/01/2015 and ending 09/30/2016 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

Name (Typewritten)

Title	Date
Firm	
Telephone Number	
Email Address	

Name (Typewritten)

Title	Date
Telephone Number	
Email Address	

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

BHF Page 2

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2015 To: 09/30/2016

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	455	166,710		113,570	68.12%		28,523	4.46
2.	Psych								
3.	Rehab	26	9,485		8,116	85.57%		540	15.03
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,666		13,574	72.72%			
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	27	9,882		4,730	47.86%			
22.	Total	559	204,743		139,990	68.37%		29,063	4.65
23.	Observation Bed Days				8,793				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,583			1,531	4.93
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				959				
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				597				
22.	Total				8,139	5.81%		1,531	4.93

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

BHF Page 3

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2015 To: 09/30/2016

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	49,409,553	316,000,881	0.156359	13,818,010		2,160,570	
2.	Recovery Room	5,845,716	52,410,429	0.111537	1,710,252		190,756	
3.	Delivery and Labor Room	6,696,045	21,790,062	0.307298	2,407,445		739,803	
4.	Anesthesiology	3,991,573	181,145,061	0.022035	6,091,398		134,224	
5.	Radiology - Diagnostic	44,377,519	399,329,241	0.111130	4,635,030		515,091	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	39,090,779	447,194,017	0.087413	14,899,834		1,302,439	
9.	Blood							
10.	Blood - Administration	7,467,318	17,445,755	0.428031	1,076,108		460,608	
11.	Intravenous Therapy	2,387,128	3,226,367	0.739881	137,675		101,863	
12.	Respiratory Therapy	12,491,556	152,168,581	0.082090	7,870,479		646,088	
13.	Physical Therapy	17,601,448	43,689,393	0.402877	1,051,116		423,470	
14.	Occupational Therapy							
15.	Speech Pathology	1,045,736	4,330,318	0.241492	190,778		46,071	
16.	EKG	5,278,720	88,767,476	0.059467	3,910,902		232,570	
17.	EEG	1,093,612	15,992,175	0.068384	1,788,031		122,273	
18.	Med. / Surg. Supplies	75,085,917	349,491,819	0.214843	23,502,687		5,049,388	
19.	Drugs Charged to Patients	44,415,835	527,093,146	0.084266	24,118,729		2,032,389	
20.	Renal Dialysis	3,364,598	13,087,265	0.257089	484,410		124,536	
21.	Ambulance	73,229						
22.	CT Scan	6,593,050	111,993,644	0.058870	3,393,774		199,791	
23.	MRI	9,064,455	66,353,736	0.136608	1,416,513		193,507	
24.	Cardiac Catheterization	5,665,395	218,258,318	0.025957	2,485,930		64,527	
25.								
26.	Implantable Devices	49,310,853	234,806,339	0.210006				
27.	Digestive Diseases	6,096,314	56,562,481	0.107780				
28.	Enterostomal	609,320	1,768,469	0.344547	1,158,362		399,110	
29.	Diabetic Service	2,464,831	2,468,940	0.998336				
30.	Wound Care	1,754,595	7,953,254	0.220613				
31.	Psychology	3,823,390	7,428,660	0.514681	144,529		74,386	
32.	Neuro Diagnostic Ctr.							
33.	Sleep Disorders	2,259,706	14,767,486	0.153019				
34.	Pain Program	1,828,986	8,826,515	0.207215				
35.	Cardiac Rehab	875,444	1,846,487	0.474113				
36.	Lithotripsy	136,522	1,909,928	0.071480				
37.	Kidney Acquisition	3,218,135	4,135,642	0.778146				
38.	Pancreas Acquisition	68,473	155,588	0.440092				
39.	Other							
40.	Other							
41.	Other							
42.								
Outpatient Service Cost Centers								
43.	Clinic	3,002,620	4,512,191	0.665446	3,099		2,062	
44.	Emergency	23,628,806	118,679,185	0.199098	205,938		41,002	
45.	Observation	13,282,303	25,545,036	0.519956	136,940		71,203	
46.	Total				116,637,969		15,327,727	

* 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 Hospital	Period Covered by Statement: From: 10/01/2015 To: 09/30/2016

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)	128,698,672		7,162,619	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	122,363		8,116	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,051.78		882.53	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,583			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,923,868			
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)	6,923,868			

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	29,577,231	13,574	2,178.96	959	2,089,623
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	5,705,910	4,730	1,206.32	597	720,173
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					15,327,727
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					25,061,391

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 Hospital	Period Covered by Statement:	From: 10/01/2015 To: 09/30/2016

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						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 Hospital	Period Covered by Statement:	From: 10/01/2015 To: 09/30/2016

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	22,531	316,000,881	0.000071	13,818,010		981	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	2,692,079	399,329,241	0.006742	4,635,030		31,249	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,092,691	447,194,017	0.002443	14,899,834		36,400	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	3,185	3,226,367	0.000987	137,675		136	
12.	Respiratory Therapy	20,462	152,168,581	0.000134	7,870,479		1,055	
13.	Physical Therapy	720,812	43,689,393	0.016499	1,051,116		17,342	
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.	CT Scan							
23.	MRI	5,030	66,353,736	0.000076	1,416,513		108	
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service	41,536	2,468,940	0.016823				
30.	Wound Care							
31.	Psychology	99,561	7,428,660	0.013402	144,529		1,937	
32.	Neuro Diagnostic Ctr.							
33.	Sleep Disorders	211,340	14,767,486	0.014311				
34.	Pain Program	515,401	8,826,515	0.058392				
35.	Cardiac Rehab	96,038	1,846,487	0.052011				
36.	Lithotripsy							
37.	Kidney Acquisition							
38.	Pancreas Acquisition							
39.	Other							
40.	Other							
41.	Other							
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	196,768	4,512,191	0.043608	3,099		135	
44.	Emergency	15,920,491	118,679,185	0.134147	205,938		27,626	
45.	Observation	1,179	25,545,036	0.000046	136,940		6	
46.	Ancillary Total						116,975	

* 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 Hospital	Period Covered by Statement:	From: 10/01/2015 To: 09/30/2016

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	876,234	122,363	7.16	6,583		47,134	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,887,185	13,574	139.03	959		133,330	
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)						180,464	
68.	Ancillary Total (from line 46)						116,975	
69.	Total (Lines 67-68)						297,439	

**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 Hospital	Period Covered by Statement: From: 10/01/2015 To: 09/30/2016

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)		25,061,391	
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)		297,439	
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)		2,134,456	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		27,493,286	
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)		116,637,969	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		16,220,989	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		8,092,986	
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		927,869	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		141,879,813	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			114,386,527
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 Hospital	Period Covered by Statement: From: 10/01/2015 To: 09/30/2016

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)	27,493,286	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	27,493,286	
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)	27,493,286	

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 Hospital	Period Covered by Statement: From: 10/01/2015 To: 09/30/2016

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)	114,386,527
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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 Hospital	Period Covered by Statement: From: 10/01/2015 To: 09/30/2016

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 Hospital	Period Covered by Statement:	From: 10/01/2015 To: 09/30/2016

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	5,896,524	316,000,881	0.018660	13,818,010		257,844	
2.	Recovery Room							
3.	Delivery and Labor Room	2,976,383	21,790,062	0.136594	2,407,445		328,843	
4.	Anesthesiology	500,238	181,145,061	0.002762	6,091,398		16,824	
5.	Radiology - Diagnostic	4,902,638	399,329,241	0.012277	4,635,030		56,904	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	215,298	447,194,017	0.000481	14,899,834		7,167	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	346,234	88,767,476	0.003900	3,910,902		15,253	
17.	EEG	322,507	15,992,175	0.020167	1,788,031		36,059	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	433,231	111,993,644	0.003868	3,393,774		13,127	
23.	MRI	345,356	66,353,736	0.005205	1,416,513		7,373	
24.	Cardiac Catherization	2,413,971	218,258,318	0.011060	2,485,930		27,494	
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.							
33.	Sleep Disorders	188,935	14,767,486	0.012794				
34.	Pain Program							
35.	Cardiac Rehab							
36.	Lithotripsy							
37.	Kidney Acquisition							
38.	Pancreas Acquisition							
39.	Other							
40.	Other							
41.	Other							
42.								
	Outpatient Ancillary Centers							
43.	Clinic	672,257	4,512,191	0.148987	3,099		462	
44.	Emergency	9,774,520	118,679,185	0.082361	205,938		16,961	
45.	Observation							
46.	Ancillary Total						784,311	

* 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: 10/01/2015 To: 09/30/2016

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	21,883,027	122,363	178.84	6,583		1,177,304	
48.	Psych							
49.	Rehab	32,515	8,116	4.01				
50.	Other (Sub)							
51.	Intensive Care Unit	2,446,469	13,574	180.23	959		172,841	
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)						1,350,145	
68.	Ancillary Total (from line 46)						784,311	
69.	Total (Lines 67-68)						2,134,456	

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2015 To: 09/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,542		7,542
Newborn Days	597		597
Total Inpatient Revenue	141,879,813		141,879,813
Ancillary Revenue	116,637,969		116,637,969
Routine Revenue	25,241,844		25,241,844
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Adjusted Adults & Peds Beds and Bed Days Available to agree with as filed W/S S-3, Cols. 2 and 3.
BHF Page 3 - Total costs & Charges agree with as filed W/S C Part 1, cols. 1 and 8.
BHF Page 3 - Clinic costs & charges include all Clinic data, W/S C lines 90.01-90.07.
BHF Page 6 - In Column 1 made adjustments to properly include figures from W/S A-8-2, Column 4.
Spread Adults & Peds and ICU costs between Acute and Children's Hospitals.