

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

Name of Hospital: Children's Hospital of Illinois		Medicare Provider Number: 14-0067	
Street: 530 NE Glen Oak Avenue		Medicaid Provider Number: 16008	
City: Peoria	State: Illinois	Zip: 61637-0001	
Period Covered by Statement:	From: 10/01/2016	To: 09/30/2017	

Type of Control

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

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☒ Other (Specify) Children's Hospital

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

☒ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐

**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)) Children's Hospital of Illinois 16008 for the cost report beginning 10/01/2016 and ending 09/30/2017 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.

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2016 To: 09/30/2017

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	68	24,820		20,107	81.01%		4,890	6.62
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	16	5,840		3,947	67.59%			
6.	Coronary Care Unit								
7.	Premature ICU	28	10,220		8,314	81.35%			
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	112	40,880		32,368	79.18%		4,890	6.62
23.	Observation Bed Days				2,654				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				7,334			1,856	6.85
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,714				
6.	Coronary Care Unit								
7.	Premature ICU				3,665				
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				12,713	39.28%		1,856	6.85

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

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2016 To: 09/30/2017

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	49,489,029	353,625,111	0.139948	8,122,966		1,136,793	
2.	Recovery Room	6,133,092	59,032,560	0.103893	930,560		96,679	
3.	Delivery and Labor Room	6,765,174	23,203,904	0.291553	115,244		33,600	
4.	Anesthesiology	4,103,350	210,972,590	0.019450	4,726,915		91,938	
5.	Radiology - Diagnostic	44,276,207	429,275,003	0.103142	4,560,001		470,328	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	40,153,645	489,736,973	0.081990	12,053,952		988,304	
9.	Blood							
10.	Blood - Administration	7,767,375	17,119,072	0.453726	748,094		339,430	
11.	Intravenous Therapy	2,435,534	3,964,569	0.614325	226,070		138,880	
12.	Respiratory Therapy	12,040,655	167,503,583	0.071883	18,557,370		1,333,959	
13.	Physical Therapy	21,485,390	50,677,907	0.423960	581,503		246,534	
14.	Occupational Therapy							
15.	Speech Pathology	1,428,772	5,770,955	0.247580	454,816		112,603	
16.	EKG	10,860,336	167,358,570	0.064893	1,732,742		112,443	
17.	EEG	1,051,767	19,219,728	0.054723	1,259,628		68,931	
18.	Med. / Surg. Supplies	46,878,825	299,166,090	0.156698	6,690,358		1,048,366	
19.	Drugs Charged to Patients	71,134,828	565,885,460	0.125705	20,227,860		2,542,743	
20.	Renal Dialysis	3,250,011	12,231,411	0.265710	87,004		23,118	
21.	Ambulance	93,956						
22.	CT Scan	6,868,040	138,887,882	0.049450	948,928		46,924	
23.	MRI	9,207,309	79,363,178	0.116015	900,041		104,418	
24.	Cardiac Catheterization	4,629,367	108,175,613	0.042795	220,193		9,423	
25.								
26.	Implantable Devices	52,578,949	240,730,831	0.218414	3,649,426		797,086	
27.	Digestive Diseases	6,650,123	61,165,727	0.108723	46,115		5,014	
28.	Enterostomal	619,460	2,215,153	0.279647	34,164		9,554	
29.	Diabetic Service	2,640,284	2,098,609	1.258111				
30.	Wound Care	2,032,732	8,009,468	0.253791	13,696		3,476	
31.	Psychology	3,863,313	8,082,631	0.477977	37,892		18,112	
32.	Neuro Diagnostic Ctr.	251,306						
33.								
34.	Comp Epilepsy	449,037						
35.	Sleep Disorders	2,350,160	17,250,575	0.136237				
36.	Pain Program	2,035,724	14,442,003	0.140959				
37.	Cardiac Rehab	3,055,654	1,985,399	1.539063				
38.	Lithotripsy	19,711	2,060,344	0.009567				
39.	Kidney Acquisition	3,427,758	3,939,334	0.870136				
40.	Pancreas Acquisition	103,899	261,390	0.397487				
41.								
42.								
Outpatient Service Cost Centers								
43.	Clinic	3,427,405	4,746,576	0.722079	1,597		1,153	
44.	Emergency	27,651,980	130,354,103	0.212130	3,245,222		688,409	
45.	Observation	18,095,398	29,289,081	0.617821	234,413		144,825	
46.	Total				90,406,770		10,613,043	

* 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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)	23,302,394			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	22,761			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,023.79			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	7,334			
3.	Program general inpatient routine cost (Line 1c X Line 2)	7,508,476			
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)	7,508,476			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	8,613,884	3,947	2,182.39	1,714	3,740,616
9.	Coronary Care Unit					
10.	Premature ICU	17,660,690	8,314	2,124.21	3,665	7,785,230
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)					10,613,043
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					29,647,365

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

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2016 To: 09/30/2017

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	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)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2016 To: 09/30/2017

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	33,588	353,625,111	0.000095	8,122,966		772	
2.	Recovery Room							
3.	Delivery and Labor Room	36,000	23,203,904	0.001551	115,244		179	
4.	Anesthesiology							
5.	Radiology - Diagnostic	3,440,955	429,275,003	0.008016	4,560,001		36,553	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,134,520	489,736,973	0.002317	12,053,952		27,929	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	39,384	3,964,569	0.009934	226,070		2,246	
12.	Respiratory Therapy	25,116	167,503,583	0.000150	18,557,370		2,784	
13.	Physical Therapy	859,875	50,677,907	0.016967	581,503		9,866	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	417		#DIV/0!				
22.	CT Scan							
23.	MRI	5,024	79,363,178	0.000063	900,041		57	
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service	69,270	2,098,609	0.033008				
30.	Wound Care							
31.	Psychology	87,696	8,082,631	0.010850	37,892		411	
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders							
36.	Pain Program	515,885	14,442,003	0.035721				
37.	Cardiac Rehab	138,163	1,985,399	0.069590				
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition	4,025	261,390	0.015398				
41.								
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	92,526	4,746,576	0.019493	1,597		31	
44.	Emergency	13,551,962	130,354,103	0.103963	3,245,222		337,383	
45.	Observation	247,944	29,289,081	0.008465	234,413		1,984	
46.	Ancillary Total						420,195	

* 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)

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2016 To: 09/30/2017

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	137,051	22,761	6.02	7,334		44,151	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	278,833	3,947	70.64	1,714		121,077	
52.	Coronary Care Unit							
53.	Premature ICU	196,250	8,314	23.60	3,665		86,494	
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)						251,722	
68.	Ancillary Total (from line 46)						420,195	
69.	Total (Lines 67-68)						671,917	

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

BHF Page 7

Medicare Provider Number: 14-0067		Medicaid Provider Number: 16008	
Program: Medicaid Hospital		Period Covered by Statement: From: 10/01/2016 To: 09/30/2017	
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)	29,647,365	
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)	671,917	
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)	3,189,598	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	33,508,880	
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)	90,406,770	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	8,876,165	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	6,194,058	
	F. Coronary Care Unit		
	G. Premature ICU	12,617,936	
	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)	118,094,929	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		84,586,049
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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)	33,508,880	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	33,508,880	
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)	33,508,880	

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.

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)	84,586,049
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)	(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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2016 To: 09/30/2017

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	7,762,034	353,625,111	0.021950	8,122,966		178,299	
2.	Recovery Room							
3.	Delivery and Labor Room	1,949,392	23,203,904	0.084011	115,244		9,682	
4.	Anesthesiology	646,751	210,972,590	0.003066	4,726,915		14,493	
5.	Radiology - Diagnostic	5,806,549	429,275,003	0.013526	4,560,001		61,679	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	185,801	489,736,973	0.000379	12,053,952		4,568	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	678,226	167,358,570	0.004053	1,732,742		7,023	
17.	EEG	404,093	19,219,728	0.021025	1,259,628		26,484	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	682,287	138,887,882	0.004913	948,928		4,662	
23.	MRI	558,420	79,363,178	0.007036	900,041		6,333	
24.	Cardiac Catheterization	3,315,998	108,175,613	0.030654	220,193		6,750	
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders	309,669	17,250,575	0.017951				
36.	Pain Program							
37.	Cardiac Rehab							
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition							
41.								
42.								
	Outpatient Ancillary Centers							
43.	Clinic	2,208,295	4,746,576	0.465240	1,597		743	
44.	Emergency	11,056,709	130,354,103	0.084821	3,245,222		275,263	
45.	Observation							
46.	Ancillary Total						595,979	

* 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)

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2016 To: 09/30/2017

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	4,529,997	22,761	199.02	7,334		1,459,613	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,232,315	3,947	312.22	1,714		535,145	
52.	Coronary Care Unit							
53.	Premature ICU	1,358,482	8,314	163.40	3,665		598,861	
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)						2,593,619	
68.	Ancillary Total (from line 46)						595,979	
69.	Total (Lines 67-68)						3,189,598	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	12,713		12,713
Newborn Days			
Total Inpatient Revenue	118,094,929		118,094,929
Ancillary Revenue	90,406,770		90,406,770
Routine Revenue	27,688,159		27,688,159
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, Col. 8 (col. 3 was wrong since used 366 day year)

BHF Page 3 - Total costs & Charges agree with as filed W/S C Part 1, col. 8 (col 1 adjusted to tie).

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.