

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: 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: 10/01/2017	To: 09/30/2018	

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) _____

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)) Saint Francis Medical Center 16007 for the cost report beginning 10/01/2017 and ending 09/30/2018 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:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2017 To: 09/30/2018

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	466	170,090		127,400	74.90%		28,203	4.97
2.	Psych								
3.	Rehab	26	9,490		8,197	86.38%		508	16.14
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,615		12,896	69.28%			
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	9,855		4,900	49.72%			
22.	Total	570	208,050		153,393	73.73%		28,711	5.17
23.	Observation Bed Days				9,831				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				8,508			1,785	5.55
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,395				
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				1,197				
22.	Total				11,100	7.24%		1,785	5.55

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:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2017 To: 09/30/2018

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	47,109,032	377,591,507	0.124762	11,449,798		1,428,500	
2.	Recovery Room	6,172,977	62,228,536	0.099198	1,703,460		168,980	
3.	Delivery and Labor Room	7,000,055	26,451,842	0.264634	3,335,835		882,775	
4.	Anesthesiology	6,605,495	220,383,293	0.029973	5,767,130		172,858	
5.	Radiology - Diagnostic	52,397,513	429,430,626	0.122016	4,525,443		552,176	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	41,494,009	519,749,579	0.079835	15,324,795		1,223,455	
9.	Blood							
10.	Blood - Administration	7,542,533	17,867,300	0.422142	899,505		379,719	
11.	Intravenous Therapy	2,589,410	3,991,571	0.648720	241,074		156,390	
12.	Respiratory Therapy	13,217,374	190,574,920	0.069355	7,867,299		545,637	
13.	Physical Therapy	17,205,906	36,936,085	0.465829	596,741		277,979	
14.	Occupational Therapy	3,850,636	15,724,591	0.244880				
15.	Speech Pathology	2,129,022	8,618,157	0.247039	239,303		59,117	
16.	EKG	10,587,675	180,425,226	0.058682	3,030,043		177,809	
17.	EEG	1,379,279	23,236,728	0.059358	1,678,791		99,650	
18.	Med. / Surg. Supplies	45,167,343	297,264,345	0.151943	13,967,259		2,122,227	
19.	Drugs Charged to Patients	83,581,435	642,553,552	0.130077	20,828,800		2,709,348	
20.	Renal Dialysis	3,947,475	17,084,158	0.231061	380,386		87,892	
21.	Ambulance	95,436						
22.	CT Scan	7,523,203	157,563,757	0.047747	3,907,041		186,549	
23.	MRI	9,815,235	84,525,939	0.116121	1,787,421		207,557	
24.	Cardiac Catheterization	4,411,772	111,889,233	0.039430	1,282,386		50,564	
25.								
26.	Implantable Devices	56,798,188	268,026,230	0.211913				
27.	Digestive Diseases	6,494,407	69,982,798	0.092800				
28.	Enterostomal	629,701	2,880,402	0.218616				
29.	Diabetic Service	2,738,004	2,768,392	0.989023				
30.	Wound Care	2,010,266	7,967,362	0.252313				
31.	Psychology	3,795,436	8,935,951	0.424738				
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders	2,811,703	18,385,481	0.152931				
36.	Pain Program	2,123,994	17,942,733	0.118376				
37.	Cardiac Rehab	3,404,458	2,118,422	1.607073				
38.	Lithotripsy							
39.	Kidney Acquisition	3,786,014	4,693,845	0.806591				
40.	Pancreas Acquisition	238,738	261,390	0.913340				
41.								
42.								
Outpatient Service Cost Centers								
43.	Clinic	4,149,417	6,057,109	0.685049				
44.	Emergency	30,994,145	141,071,262	0.219706	461,800		101,460	
45.	Observation	17,416,291	30,990,992	0.561979	269,918		151,688	
46.	Total				99,544,228		11,742,330	

* 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: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	144,338,337		5,899,382	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	137,231		8,197	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,051.79		719.70	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	8,508			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,948,629			
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)	8,948,629			

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	28,232,590	12,896	2,189.25	1,395	3,054,004
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	6,854,081	4,900	1,398.79	1,197	1,674,352
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					11,742,330
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					25,419,315

**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:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2017 To: 09/30/2018

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)

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2017 To: 09/30/2018

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	81,114	26,451,842	0.003066	3,335,835		10,228	
4.	Anesthesiology							
5.	Radiology - Diagnostic	2,755,471	429,430,626	0.006417	4,525,443		29,040	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,128,595	519,749,579	0.002171	15,324,795		33,270	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	62,889	3,991,571	0.015755	241,074		3,798	
12.	Respiratory Therapy	45,522	190,574,920	0.000239	7,867,299		1,880	
13.	Physical Therapy	170,528	36,936,085	0.004617	596,741		2,755	
14.	Occupational Therapy							
15.	Speech Pathology	40	8,618,157	0.000005	239,303		1	
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI	5,259	84,525,939	0.000062	1,787,421		111	
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases	98,583	69,982,798	0.001409				
28.	Enterostomal							
29.	Diabetic Service	89,538	2,768,392	0.032343				
30.	Wound Care	90,518	7,967,362	0.011361				
31.	Psychology	61,756	8,935,951	0.006911				
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders							
36.	Pain Program	523,464	17,942,733	0.029174				
37.	Cardiac Rehab	169,827	2,118,422	0.080167				
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition							
41.								
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	62,328	6,057,109	0.010290				
44.	Emergency	14,518,421	141,071,262	0.102916	461,800		47,527	
45.	Observation							
46.	Ancillary Total						128,610	

* 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:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2017 To: 09/30/2018

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	13,765,756	137,231	100.31	8,508		853,437	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	41,680	12,896	3.23	1,395		4,506	
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)						857,943	
68.	Ancillary Total (from line 46)						128,610	
69.	Total (Lines 67-68)						986,553	

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

BHF Page 7

Medicare Provider Number: 14-0067		Medicaid Provider Number: 16007	
Program: Medicaid Hospital		Period Covered by Statement: From: 10/01/2017 To: 09/30/2018	
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)	25,419,315	
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)	986,553	
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)	2,517,951	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	28,923,819	
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)	99,544,228	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	18,265,791	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,194,581	
	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	2,370,173	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	123,374,773	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		94,450,954
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: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	28,923,819	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	28,923,819	
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)	28,923,819	

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: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	94,450,954
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: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2017 To: 09/30/2018

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	8,297,922	377,591,507	0.021976	11,449,798		251,621	
2.	Recovery Room							
3.	Delivery and Labor Room	1,582,478	26,451,842	0.059825	3,335,835		199,566	
4.	Anesthesiology	350,566	220,383,293	0.001591	5,767,130		9,176	
5.	Radiology - Diagnostic	5,584,847	429,430,626	0.013005	4,525,443		58,853	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	246,562	519,749,579	0.000474	15,324,795		7,264	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	216,974	180,425,226	0.001203	3,030,043		3,645	
17.	EEG	462,640	23,236,728	0.019910	1,678,791		33,425	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	491,330	157,563,757	0.003118	3,907,041		12,182	
23.	MRI	627,612	84,525,939	0.007425	1,787,421		13,272	
24.	Cardiac Catheterization	2,999,087	111,889,233	0.026804	1,282,386		34,373	
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	41,243	18,385,481	0.002243				
36.	Pain Program							
37.	Cardiac Rehab							
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition							
41.								
42.								
	Outpatient Ancillary Centers							
43.	Clinic	1,782,417	6,057,109	0.294269				
44.	Emergency	10,234,551	141,071,262	0.072549	461,800		33,503	
45.	Observation							
46.	Ancillary Total						656,880	

* 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:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2017 To: 09/30/2018

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	23,597,814	137,231	171.96	8,508		1,463,036	
48.	Psych							
49.	Rehab	31,268	8,197	3.81				
50.	Other (Sub)							
51.	Intensive Care Unit	3,679,664	12,896	285.33	1,395		398,035	
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)						1,861,071	
68.	Ancillary Total (from line 46)						656,880	
69.	Total (Lines 67-68)						2,517,951	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	9,903		9,903
Newborn Days	1,197		1,197
Total Inpatient Revenue	123,374,773		123,374,773
Ancillary Revenue	99,544,228		99,544,228
Routine Revenue	23,830,545		23,830,545
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]