

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: Blessing Hospital		Medicare Provider Number: 14-0015	
Street: 1005 Broadway		Medicaid Provider Number: 17001	
City: Quincy	State: Illinois	Zip: 62301	
Period Covered by Statement:	From: 10/01/2018	To: 09/30/2019	

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)) Blessing Hospital 17001 for the cost report beginning 10/01/2018 and ending 09/30/2019 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:	14-0015	Medicaid Provider Number:	17001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2018 To: 09/30/2019

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	223	81,395		39,656	48.72%		11,606	3.82
2.	Psych	41	14,965		11,621	77.65%		2,007	5.79
3.	Rehab	18	6,570		4,307	65.56%		291	14.80
4.	Other (Sub)								
5.	Intensive Care Unit	25	9,125		4,634	50.78%			
6.	Coronary Care Unit								
7.	Other								
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	25	9,125		2,293	25.13%			
22.	Total	332	121,180		62,511	51.59%		13,904	4.33
23.	Observation Bed Days				6,256				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,003			296	3.68
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				85				
6.	Coronary Care Unit								
7.	Other								
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				529				
22.	Total				1,617	2.59%		296	3.68

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:		Medicaid Provider Number:	
14-0015		17001	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 10/01/2018	To: 09/30/2019

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	29,864,793	145,843,326	0.204773	974,666		199,585	
2.	Recovery Room							
3.	Delivery and Labor Room	2,124,287	9,588,529	0.221545	155,570		34,466	
4.	Anesthesiology	1,108,865	37,668,252	0.029438	252,110		7,422	
5.	Radiology - Diagnostic	9,776,125	62,510,274	0.156392	463,914		72,552	
6.	Radiology - Therapeutic	3,649,619	18,880,318	0.193303	52,751		10,197	
7.	Nuclear Medicine							
8.	Laboratory	11,608,892	140,334,106	0.082723	1,786,180		147,758	
9.	Blood							
10.	Blood - Administration	1,957,071	8,341,776	0.234611	48,041		11,271	
11.	Intravenous Therapy							
12.	Respiratory Therapy	4,053,495	25,916,626	0.156405	381,647		59,691	
13.	Physical Therapy	2,476,525	5,330,106	0.464630	22,859		10,621	
14.	Occupational Therapy	1,446,150	3,961,286	0.365071	15,685		5,726	
15.	Speech Pathology	443,532	1,587,002	0.279478	2,484		694	
16.	EKG	5,930,393	103,048,292	0.057550	629,664		36,237	
17.	EEG	995,909	3,483,977	0.285854	18,309		5,234	
18.	Med. / Surg. Supplies	16,239,560	105,478,949	0.153960	623,304		95,964	
19.	Drugs Charged to Patients	28,675,983	188,033,508	0.152505	2,560,556		390,498	
20.	Renal Dialysis	1,101,382	2,866,889	0.384173	65,069		24,998	
21.	Ambulance							
22.	Implantable Devices	19,260,287	72,983,586	0.263899	375,610		99,123	
23.	Outpatient Infusion	1,140,648	3,122,859	0.365258				
24.	CT Scan	1,693,676	91,292,347	0.018552	788,394		14,626	
25.	MRI	1,192,542	24,401,568	0.048872	132,964		6,498	
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	817,948	831,248	0.984000				
44.	Emergency	12,231,720	52,592,037	0.232577	407,644		94,809	
45.	Observation	7,899,201	27,717,996	0.284985	62,995		17,953	
46.	Total				9,820,416		1,345,923	

* 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: 14-0015	Medicaid Provider Number: 17001
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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)	57,957,071	12,811,508	4,673,819	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	45,912	11,621	4,307	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,262.35	1,102.44	1,085.17	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,003			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,266,137			
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)	1,266,137			

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	9,786,584	4,634	2,111.91	85	179,512
9.	Coronary Care Unit					
10.	Other					
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	914,393	2,293	398.78	529	210,955
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,345,923
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,002,527

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

Preliminary

Medicare Provider Number:	14-0015	Medicaid Provider Number:	17001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2018 To: 09/30/2019

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.	Other						
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:		Medicaid Provider Number:	
14-0015		17001	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 10/01/2018	To: 09/30/2019

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	1,402,761	145,843,326	0.009618	974,666		9,374	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,262,604	62,510,274	0.020198	463,914		9,370	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implantable Devices							
23.	Outpatient Infusion							
24.	CT Scan							
25.	MRI							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	7,054,620	52,592,037	0.134139	407,644		54,681	
45.	Observation							
46.	Ancillary Total						73,425	

* 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:	14-0015	Medicaid Provider Number:	17001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2018 To: 09/30/2019

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	3,372,162	45,912	73.45	1,003		73,670	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,276,642	4,634	275.49	85		23,417	
52.	Coronary Care Unit							
53.	Other							
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)						97,087	
68.	Ancillary Total (from line 46)						73,425	
69.	Total (Lines 67-68)						170,512	

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0015		Medicaid Provider Number: 17001	
Program: Medicaid Hospital		Period Covered by Statement: From: 10/01/2018 To: 09/30/2019	
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)	3,002,527	
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)	170,512	
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)	105,017	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	3,278,056	
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)	9,820,416	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,490,570	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	674,064	
	F. Coronary Care Unit		
	G. Other		
	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	659,257	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	13,644,307	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		10,366,251
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: 14-0015	Medicaid Provider Number: 17001
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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)	3,278,056	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,278,056	
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)	3,278,056	

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:	14-0015	Medicaid Provider Number:	17001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2018 To: 09/30/2019

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)	10,366,251
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

Preliminary

Medicare Provider Number: 14-0015	Medicaid Provider Number: 17001
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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:	14-0015	Medicaid Provider Number:	17001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2018 To: 09/30/2019

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	170,393	145,843,326	0.001168	974,666		1,138	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	34,674	37,668,252	0.000921	252,110		232	
5.	Radiology - Diagnostic	10,424	62,510,274	0.000167	463,914		77	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	13,827	140,334,106	0.000099	1,786,180		177	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	159,970	103,048,292	0.001552	629,664		977	
17.	EEG	135,506	3,483,977	0.038894	18,309		712	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implantable Devices							
23.	Outpatient Infusion							
24.	CT Scan							
25.	MRI							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	396,308	52,592,037	0.007536	407,644		3,072	
45.	Observation							
46.	Ancillary Total						6,385	

* 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:	14-0015	Medicaid Provider Number:	17001
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2018 To: 09/30/2019

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	3,097,495	45,912	67.47	1,003		67,672	
48.	Psych	135,506	11,621	11.66				
49.	Rehab	93,812	4,307	21.78				
50.	Other (Sub)							
51.	Intensive Care Unit	114,660	4,634	24.74	85		2,103	
52.	Coronary Care Unit							
53.	Other							
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	125,083	2,293	54.55	529		28,857	
67.	Routine Total (lines 47-66)						98,632	
68.	Ancillary Total (from line 46)						6,385	
69.	Total (Lines 67-68)						105,017	

Preliminary

Medicare Provider Number: 14-0015	Medicaid Provider Number: 17001
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,088		1,088
Newborn Days	529		529
Total Inpatient Revenue	13,644,307		13,644,307
Ancillary Revenue	9,820,416		9,820,416
Routine Revenue	3,823,891		3,823,891
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]