

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: St. John's Hospital		Medicare Provider Number: 14-0053	
Street: 800 East Carpenter		Medicaid Provider Number: 19007	
City: Springfield	State: Illinois	Zip: 62769	
Period Covered by Statement:	From: 07/01/2018	To: 06/30/2019	

Type of Control

Voluntary Nonprofit

☐ XXXX
XXXX

Church

☐

Corporation

☐

Other (Specify)

Proprietary

☐

Individual

☐

Partnership

☐

Corporation

Government (Non-Federal)

☐

State

☐

City

☐

County

☐

Township

☐

Hospital District

☐

Other (Specify)

Type of Hospital

☐ XXXX
XXXX

General Short-Term

☐

Psychiatric

☐

Cancer

☐

General Long-Term

☐

Rehabilitation

☐

Other (Specify)

Health Care Program

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

☐ XXXX
XXXX

Medicaid Hospital

☐

Medicaid Sub II

Rehab

☐
☐

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)) St. John's Hospital 19007 for the cost report beginning 07/01/2018 and ending 06/30/2019 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:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

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	252	89,248		64,011	71.72%		16,748	4.54
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	45	18,475		12,067	65.32%			
6.	Coronary Care Unit								
7.	Other								
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.	Newborn Nursery				2,923				
22.	Total	297	107,723		79,001	73.34%		16,748	4.54
23.	Observation Bed Days				2,630				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,393			1,285	3.19
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				710				
6.	Coronary Care Unit								
7.	Other								
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.	Newborn Nursery				839				
22.	Total				4,942	6.26%		1,285	3.19

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:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients (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	31,102,054	200,417,077	0.155187	3,792,287		588,514	
2.	Recovery Room	5,094,206	18,381,891	0.277132	183,309		50,801	
3.	Delivery and Labor Room	9,155,712	21,167,160	0.432543	1,621,747		701,475	
4.	Anesthesiology	4,848,195	50,007,407	0.096950	840,749		81,511	
5.	Radiology - Diagnostic	9,579,289	79,800,920	0.120040	1,296,086		155,582	
6.	Radiology - Therapeutic	1,325,452	8,379,891	0.158171	204,468		32,341	
7.	Nuclear Medicine	2,361,090	20,605,431	0.114586	194,073		22,238	
8.	Laboratory	19,938,635	131,087,786	0.152101	3,571,887		543,288	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,199,355	49,089,141	0.146659	1,689,498		247,780	
13.	Physical Therapy	9,792,366	32,680,086	0.299643	444,344		133,145	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,513,356	88,052,819	0.073971	1,532,265		113,343	
17.	EEG	1,780,969	15,728,794	0.113230	495,134		56,064	
18.	Med. / Surg. Supplies	31,506,539	94,010,473	0.335139				
19.	Drugs Charged to Patients	30,762,007	174,975,940	0.175807	4,458,354		783,810	
20.	Renal Dialysis	1,758,553	3,888,265	0.452272	212,956		96,314	
21.	Ambulance							
22.	Gastrodiagnostic Unit	2,622,524	19,856,741	0.132072	345,366		45,613	
23.	Pain Management Center							
24.	CT Scan	2,805,147	117,678,258	0.023837	2,402,076		57,258	
25.	MRI	1,693,157	19,894,202	0.085108	488,885		41,608	
26.	Cardiac Cath Lab	15,419,958	267,064,883	0.057739	3,428,319		197,948	
27.	Implants	39,708,318	114,753,533	0.346031				
28.	Other Ancillary Services	4,516,643	11,901,118	0.379514	43,056		16,340	
29.	Cardiac Rehab	1,276,979	2,813,841	0.453821	21,898		9,938	
30.	Hyperbaric Oxygen	1,550,204	4,372,657	0.354522				
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							
44.	Emergency	17,519,931	93,774,303	0.186831	1,391,046		259,891	
45.	Observation	2,857,717	6,703,726	0.426288				
46.	Total				28,657,803		4,234,802	

* 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: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	65,862,993			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	66,641			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	988.33			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,393			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,353,404			
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)	3,353,404			

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	23,001,685	12,067	1,906.16	710	1,353,374
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	1,997,926	2,923	683.52	839	573,473
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					4,234,802
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					9,515,053

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

PRELIMINARY

Medicare Provider Number:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

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.	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)	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)

PRELIMINARY

Medicare Provider Number:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

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	7,549	200,417,077	0.000038	3,792,287		144	
2.	Recovery Room							
3.	Delivery and Labor Room	1,314,000	21,167,160	0.062077	1,621,747		100,673	
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	23,624	49,089,141	0.000481	1,689,498		813	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,630,277	88,052,819	0.029872	1,532,265		45,772	
17.	EEG	7,150	15,728,794	0.000455	495,134		225	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	37,000	3,888,265	0.009516	212,956		2,026	
21.	Ambulance							
22.	Gastrodiagnostic Unit							
23.	Pain Management Center							
24.	CT Scan	17,262	117,678,258	0.000147	2,402,076		353	
25.	MRI							
26.	Cardiac Cath Lab							
27.	Implants							
28.	Other Ancillary Services							
29.	Cardiac Rehab							
30.	Hyperbaric Oxygen							
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	4,468,827	93,774,303	0.047655	1,391,046		66,290	
45.	Observation							
46.	Ancillary Total						216,296	

* 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:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

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	4,381,216	66,641	65.74	3,393		223,056	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
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)						223,056	
68.	Ancillary Total (from line 46)						216,296	
69.	Total (Lines 67-68)						439,352	

Hospital Statement of Cost

BHF Page 7

Computation of Lesser of Reasonable Cost or Customary Charges

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0053		19007	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 07/01/2018	To: 06/30/2019
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)	9,515,053	
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)	439,352	
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)	980,816	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	10,935,221	
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)	28,657,803	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,498,613	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	2,129,328	
	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	1,281,392	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	36,567,136	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		25,631,915
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: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	10,935,221	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	10,935,221	
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)	10,935,221	

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.

PRELIMINARY

Medicare Provider Number:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

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)	25,631,915
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
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 (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			(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

BHF Supplement No. 1

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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

1. Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

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	7,286,731	200,417,077	0.036358	3,792,287		137,880	
2.	Recovery Room							
3.	Delivery and Labor Room	3,175,044	21,167,160	0.149999	1,621,747		243,260	
4.	Anesthesiology	92,884	50,007,407	0.001857	840,749		1,561	
5.	Radiology - Diagnostic	199,234	79,800,920	0.002497	1,296,086		3,236	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	32,746	20,605,431	0.001589	194,073		308	
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.	Gastrodiagnostic Unit							
23.	Pain Management Center							
24.	CT Scan	20,352	117,678,258	0.000173	2,402,076		416	
25.	MRI	25,554	19,894,202	0.001284	488,885		628	
26.	Cardiac Cath Lab	18,822	267,064,883	0.000070	3,428,319		240	
27.	Implants							
28.	Other Ancillary Services	37,338	11,901,118	0.003137	43,056		135	
29.	Cardiac Rehab							
30.	Hyperbaric Oxygen							
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	2,682,926	93,774,303	0.028610	1,391,046		39,798	
45.	Observation							
46.	Ancillary Total						427,462	

* 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:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2018 To: 06/30/2019

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	7,723,702	66,641	115.90	3,393		393,249	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	153	12,067	0.01	710		7	
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	557,766	2,923	190.82	839		160,098	
67.	Routine Total (lines 47-66)						553,354	
68.	Ancillary Total (from line 46)						427,462	
69.	Total (Lines 67-68)						980,816	

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	4,103		4,103
Newborn Days	408	431	839
Total Inpatient Revenue	35,907,483	659,653	36,567,136
Ancillary Revenue	28,657,803		28,657,803
Routine Revenue	7,249,680	659,653	7,909,333
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]