

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. Luke's Hospital		Medicare Provider Number: 26-0179	
Street: 232 S. Woods Mill Road		Medicaid Provider Number: 19036	
City: Chesterfield	State: MO	Zip: 63017	
Period Covered by Statement:	From: 07/01/2019	To: 06/30/2020	

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)) St. Luke's Hospital 19036 for the cost report beginning 07/01/2019 and ending 06/30/2020 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:	26-0179	Medicaid Provider Number:	19036
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	356	126,969	84,979	52,305	41.20%		13,159	4.51
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	18	6,588		3,524	53.49%			
6.	Coronary Care Unit	16	5,856		3,515	60.02%			
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	37	13,542		4,059	29.97%			
22.	Total	427	152,955	84,979	63,403	41.45%		13,159	4.51
23.	Observation Bed Days				5,256				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				13			8	4.13
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				20				
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				4				
22.	Total				37	0.06%		8	4.13

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:	26-0179	Medicaid Provider Number:	19036
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	44,631,113	121,475,719	0.367408	99,378		36,512	
2.	Recovery Room	2,708,825	8,567,457	0.316176	425		134	
3.	Delivery and Labor Room	3,064,999	5,980,496	0.512499				
4.	Anesthesiology	856,401	18,093,031	0.047333	11,205		530	
5.	Radiology - Diagnostic	27,767,845	150,011,525	0.185105	7,878		1,458	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	18,671,234	157,785,355	0.118333	98,016		11,599	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	41,488,330	178,494,204	0.232435				
12.	Respiratory Therapy	3,539,854	15,276,379	0.231721	37,708		8,738	
13.	Physical Therapy	12,476,312	27,648,577	0.451246	2,110		952	
14.	Occupational Therapy	1,415,562	4,331,146	0.326833	1,473		481	
15.	Speech Pathology	328,652	998,891	0.329017	823		271	
16.	EKG	5,038,362	59,106,666	0.085242	10,023		854	
17.	EEG	4,130,773	8,190,693	0.504325				
18.	Med. / Surg. Supplies	15,862,169	45,022,974	0.352313	137,061		48,288	
19.	Drugs Charged to Patients	20,574,111	123,463,225	0.166642	175,579		29,259	
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	3,604,409	82,776,139	0.043544	1,523		66	
23.	MRI	1,701,387	23,490,299	0.072429	2,600		188	
24.	Cardiac Catheterization	4,734,696	54,695,227	0.086565	9,500		822	
25.	Nutrition/Diabetes Educ.	1,245,475	2,884,946	0.431715				
26.	Cardiac Rehab	4,366,457	7,260,311	0.601415				
27.	Hyperbaric Oxygen Ther.	1,592,384	2,950,697	0.539664				
28.	Adult Down Syndrome	206,566	3,961	52.149962				
29.	Implant Devices Charged	43,493,153	85,898,360	0.506333				
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	58,817	108,255	0.543319	400		217	
44.	Emergency	24,950,425	90,769,996	0.274875	2,000		550	
45.	Observation	5,749,381	19,106,902	0.300906	1,599		481	
46.	Total				599,301		141,400	

* 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: 26-0179	Medicaid Provider Number: 19036
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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)	62,265,358			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	57,561			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,081.73			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	13			
3.	Program general inpatient routine cost (Line 1c X Line 2)	14,062			
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)	14,062			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	6,865,277	3,524	1,948.15	20	38,963
9.	Coronary Care Unit	7,977,330	3,515	2,269.51		
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	9,034,731	4,059	2,225.85	4	8,903
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					141,400
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					203,328

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

Preliminary

Medicare Provider Number:	26-0179	Medicaid Provider Number:	19036
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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:	26-0179	Medicaid Provider Number:	19036
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	1,341,287	121,475,719	0.011042	99,378		1,097	
2.	Recovery Room							
3.	Delivery and Labor Room	26,000	5,980,496	0.004347				
4.	Anesthesiology	560,000	18,093,031	0.030951	11,205		347	
5.	Radiology - Diagnostic	118,719	150,011,525	0.000791	7,878		6	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	91,997	178,494,204	0.000515				
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	1,145,075	8,190,693	0.139802				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	49,010	82,776,139	0.000592	1,523		1	
23.	MRI							
24.	Cardiac Catheterization							
25.	Nutrition/Diabetes Educ.							
26.	Cardiac Rehab	147,227	7,260,311	0.020278				
27.	Hyperbaric Oxygen Ther.	226,912	2,950,697	0.076901				
28.	Adult Down Syndrome							
29.	Implant Devices Charged							
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	8,881,168	90,769,996	0.097843	2,000		196	
45.	Observation							
46.	Ancillary Total						1,647	

* 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:	26-0179	Medicaid Provider Number:	19036
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	9,358,805	57,561	162.59	13		2,114	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,881,056	3,524	533.78	20		10,676	
52.	Coronary Care Unit	1,587,339	3,515	451.59				
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	50,000	4,059	12.32	4		49	
67.	Routine Total (lines 47-66)						12,839	
68.	Ancillary Total (from line 46)						1,647	
69.	Total (Lines 67-68)						14,486	

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

BHF Page 7

Preliminary

Medicare Provider Number: 26-0179		Medicaid Provider Number: 19036	
Program: Medicaid Hospital		Period Covered by Statement: From: 07/01/2019 To: 06/30/2020	
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)	203,328	
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)	14,486	
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)	5,505	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	223,319	
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)	599,301	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	132,300	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	731,601	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		508,282
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: 26-0179	Medicaid Provider Number: 19036
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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)	223,319	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	223,319	
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)	223,319	

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:	Medicaid Provider Number:
26-0179	19036
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2019 To: 06/30/2020

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)	508,282
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	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 26-0179	Medicaid Provider Number: 19036
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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:	26-0179	Medicaid Provider Number:	19036
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	40,783	121,475,719	0.000336	99,378		33	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	109,800	18,093,031	0.006069	11,205		68	
5.	Radiology - Diagnostic	109,800	150,011,525	0.000732	7,878		6	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	232,149	15,276,379	0.015197	37,708		573	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	222,738	59,106,666	0.003768	10,023		38	
17.	EEG	138,035	8,190,693	0.016853				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Catheterization	310,578	54,695,227	0.005678	9,500		54	
25.	Nutrition/Diabetes Educ.							
26.	Cardiac Rehab							
27.	Hyperbaric Oxygen Ther.	138,035	2,950,697	0.046780				
28.	Adult Down Syndrome							
29.	Implant Devices Charged							
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	247,835	108,255	2.289363	400		916	
44.	Emergency	203,914	90,769,996	0.002246	2,000		4	
45.	Observation							
46.	Ancillary Total						1,692	

* 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:	Medicaid Provider Number:
26-0179	19036
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2019 To: 06/30/2020

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	3,400,674	57,561	59.08	13		768	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	536,453	3,524	152.23	20		3,045	
52.	Coronary Care Unit	34,509	3,515	9.82				
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)						3,813	
68.	Ancillary Total (from line 46)						1,692	
69.	Total (Lines 67-68)						5,505	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 26-0179	Medicaid Provider Number: 19036
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4	29	33
Newborn Days		4	4
Total Inpatient Revenue	501,121	230,480	731,601
Ancillary Revenue	386,487	212,814	599,301
Routine Revenue	114,634	17,666	132,300
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF page 3 - Operating costs/charges include all data from lines 50-50.04.
BHF page 3 - Radiology Diagnostic costs/charges include all data from lines 54-54.02.
BHF page 3 - CT Scan costs/charges include all data from lines 57-57.01
BHF page 3 - MRI costs/charges include all data from lines 58-58.01
BHF-page 3 - IV Therapy costs/charges include all data from lines 64-64.01
BHF page 3 - Respiratory Therapy costs/charges include all data from lines 65-65.01
BHF page 3 - Physical Therapy costs/charges include all data from lines 66-66.02
BHF page 3 - EKG costs/charges include all data from lines 69-69.01
BHF page 3 - EEG costs/charges include all data from lines 70-70.01
BHF page 3 - Medicaid Cardiac Rehab charges of \$274 were excluded as non-covered by IL Medicaid
BHF Page 2 - changed the Medicaid days to agree with the IPCR. The hospital never responded to the email asking about the discrepancy between the IPCR and the cost report regarding their program days.
BHF Page 2 - changed the discharge days to agree with the hospital discharge days calculated as follows: 37 I/P Program days / 4.51 length of stay per Hospital = 8 program discharge days
BHF Page 3 - Emailed the hospital to explain the discrepancy between their cost report and the IPCR; no response received by the hospital. So, adjusted the Program charges to agree with the IPCR.
BHF Page 3 - Combined the blood admin costs on IPCR with lab as no offsetting costs on the cost report.
BHF Page 3 - Combined the renal dialysis charges on IPCR with the drugs as no offsetting costs on cost report
BHF Page 3 - Combined the covered days on the IPCR with the RT.
BHF Page 7 - Routine costs were changed to agree with the IPCR; lumped all under A&P since database lumps as one sum also.