

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: 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: 10/01/2020	To: 09/30/2021	

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 10/01/2020 and ending 09/30/2021 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2020 To: 09/30/2021

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	486	177,390		122,324	68.96%		26,430	5.21
2.	Psych								
3.	Rehab	26	9,490		8,407	88.59%		424	19.83
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,615		15,313	82.26%			
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		3,643	36.97%			
22.	Total	590	215,350		149,687	69.51%		26,854	5.44
23.	Observation Bed Days				14,800				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,431			729	5.94
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				896				
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				848				
22.	Total				5,175	3.46%		729	5.94

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:	
14-0067		16007	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 10/01/2020	To: 09/30/2021

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	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)		(4)	(5)	(6)	(7)
1.	Operating Room	57,608,326	432,874,260	0.133083	5,842,826		777,581	
2.	Recovery Room	6,701,488	70,236,995	0.095413	728,092		69,469	
3.	Delivery and Labor Room	9,186,545	26,337,482	0.348801	1,139,771		397,553	
4.	Anesthesiology	6,995,561	248,534,194	0.028147	2,942,819		82,832	
5.	Radiology - Diagnostic	60,577,916	465,870,931	0.130032	2,720,171		353,709	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	40,078,228	550,195,618	0.072844	8,158,756		594,316	
9.	Blood							
10.	Blood - Administration	6,994,279	16,393,211	0.426657	782,990		334,068	
11.	Intravenous Therapy	3,168,787	10,665,369	0.297110	324,110		96,296	
12.	Respiratory Therapy	15,104,191	194,690,517	0.077581	5,456,143		423,293	
13.	Physical Therapy	15,159,610	42,979,296	0.352719	544,254		191,969	
14.	Occupational Therapy	4,601,241	18,473,678	0.249070	388,032		96,647	
15.	Speech Pathology	2,489,322	8,927,318	0.278843	212,181		59,165	
16.	EKG	8,727,089	182,923,639	0.047709	1,135,550		54,176	
17.	EEG	2,536,895	24,686,270	0.102765	517,763		53,208	
18.	Med. / Surg. Supplies	48,265,300	134,131,717	0.359835	3,746,136		1,347,991	
19.	Drugs Charged to Patients	90,378,234	692,196,688	0.130567	11,780,049		1,538,086	
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	7,779,547	201,248,494	0.038656	2,315,895		89,523	
23.	MRI	8,221,174	86,594,213	0.094939	798,966		75,853	
24.	Cardiac Catheterization	4,164,838	113,135,762	0.036813	715,250		26,330	
25.	Digestive Diseases	6,631,469	101,306,331	0.065460	843,793		55,235	
26.	Enterostomal	1,540,972	3,572,864	0.431299				
27.	Diabetic Service	2,813,474	3,522,823	0.798642				
28.	Wound Care	1,796,835	7,327,960	0.245203				
29.	Psychology	4,369,642	10,179,470	0.429260	27,496		11,803	
30.	Sleep Disorders	3,305,369	21,773,803	0.151805				
31.	Pain Program	2,221,761	23,104,862	0.096160				
32.	Cardiac Rehab	2,325,782	3,684,674	0.631204				
33.	Implant Devices	65,439,336	287,511,730	0.227606				
34.	Kidney Acquisition	4,020,411	6,340,060	0.634128				
35.	Pancreas Acquisition	189,565	112,907	1.678948				
36.								
37.								
38.								
39.								
40.								
41.								
42.								
Outpatient Service Cost Centers								
43.	Clinic	8,186,086	8,651,758	0.946176	1,092		1,033	
44.	Emergency	32,317,605	194,180,876	0.166430	391,335		65,130	
45.	Observation	28,009,986	46,314,450	0.604779	100,258		60,634	
46.	Total				51,613,728		6,855,900	

* 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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2020 To: 09/30/2021

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)	188,678,510		9,050,831	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	137,124		8,407	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,375.97		1,076.58	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,431			
3.	Program general inpatient routine cost (Line 1c X Line 2)	4,720,953			
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)	4,720,953			

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	40,607,784	15,313	2,651.85	896	2,376,058
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	4,053,026	3,643	1,112.55	848	943,442
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					6,855,900
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					14,896,353

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

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2020 To: 09/30/2021

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Premature ICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2020 To: 09/30/2021

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							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
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.	CT Scan							
23.	MRI							
24.	Cardiac Catheterization							
25.	Digestive Diseases							
26.	Enterostomal							
27.	Diabetic Service							
28.	Wound Care							
29.	Psychology							
30.	Sleep Disorders							
31.	Pain Program							
32.	Cardiac Rehab							
33.	Implant Devices							
34.	Kidney Acquisition							
35.	Pancreas Acquisition							
36.								
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2020 To: 09/30/2021

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
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)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2020 To: 09/30/2021

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)		14,896,353	
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)			
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)		1,613,022	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		16,509,375	
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)		51,613,728	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		10,428,059	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		3,403,405	
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		1,835,375	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		67,280,567	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			50,771,192
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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2020 To: 09/30/2021

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)	16,509,375	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	16,509,375	
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)	16,509,375	

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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2020 To: 09/30/2021

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)	50,771,192
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)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2020 To: 09/30/2021

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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2020 To: 09/30/2021

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	7,351,372	432,874,260	0.016983	5,842,826		99,229	
2.	Recovery Room							
3.	Delivery and Labor Room	1,044,729	26,337,482	0.039667	1,139,771		45,211	
4.	Anesthesiology	487,923	248,534,194	0.001963	2,942,819		5,777	
5.	Radiology - Diagnostic	5,590,066	465,870,931	0.011999	2,720,171		32,639	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	264,052	550,195,618	0.000480	8,158,756		3,916	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,256,163	194,690,517	0.006452	5,456,143		35,203	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	4,217,185	182,923,639	0.023054	1,135,550		26,179	
17.	EEG	263,096	24,686,270	0.010658	517,763		5,518	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	658,218	201,248,494	0.003271	2,315,895		7,575	
23.	MRI	375,031	86,594,213	0.004331	798,966		3,460	
24.	Cardiac Catheterization							
25.	Digestive Diseases							
26.	Enterostomal							
27.	Diabetic Service	103,325	3,522,823	0.029330				
28.	Wound Care							
29.	Psychology							
30.	Sleep Disorders	913,659	21,773,803	0.041961				
31.	Pain Program							
32.	Cardiac Rehab							
33.	Implant Devices							
34.	Kidney Acquisition							
35.	Pancreas Acquisition							
36.								
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	12,314,792	194,180,876	0.063419	391,335		24,818	
45.	Observation							
46.	Ancillary Total						289,525	

* 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:
14-0067	16007
Program:	Period Covered by Statement:
Medicaid Hospital	From: 10/01/2020 To: 09/30/2021

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	30,342,350	137,124	221.28	3,431		759,212	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,893,844	15,313	319.59	896		286,353	
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	1,193,976	3,643	327.75	848		277,932	
67.	Routine Total (lines 47-66)						1,323,497	
68.	Ancillary Total (from line 46)						289,525	
69.	Total (Lines 67-68)						1,613,022	

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2020 To: 09/30/2021

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	4,564	(237)	4,327
Newborn Days	611	237	848
Total Inpatient Revenue	67,145,475	135,092	67,280,567
Ancillary Revenue	51,478,636	135,092	51,613,728
Routine Revenue	15,666,839		15,666,839
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]