

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: 07/01/2020	To: 06/30/2021	

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)) St. John's Hospital 19007 for the cost report beginning 07/01/2020 and ending 06/30/2021 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:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	273	99,615		76,095	76.39%		17,562	5.24
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	64	22,910		15,941	69.58%			
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				1,557				
22.	Total	337	122,525		93,593	76.39%		17,562	5.24
23.	Observation Bed Days				2,613				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,139			706	3.71
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				483				
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				189				
22.	Total				2,811	3.00%		706	3.71

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: 07/01/2020 To: 06/30/2021

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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	35,223,091	236,390,778	0.149004	3,661,276		545,545	
2.	Recovery Room	5,069,261	24,093,476	0.210400	186,694		39,280	
3.	Delivery and Labor Room	9,109,155	29,112,809	0.312892	981,913		307,233	
4.	Anesthesiology	3,844,419	61,617,868	0.062391	756,924		47,225	
5.	Radiology - Diagnostic	8,887,993	87,981,394	0.101021	1,094,133		110,530	
6.	Radiology - Therapeutic	1,796,359	16,034,606	0.112030				
7.	Nuclear Medicine	2,308,888	19,947,471	0.115748	91,392		10,578	
8.	Laboratory	23,580,069	168,349,626	0.140066	2,708,096		379,312	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,279,154	66,155,084	0.110032	1,358,720		149,503	
13.	Physical Therapy	9,004,732	33,917,677	0.265488	280,873		74,568	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,688,559	101,813,486	0.065694	1,346,673		88,468	
17.	EEG	1,260,397	10,025,052	0.125725	77,453		9,738	
18.	Med. / Surg. Supplies	34,466,283	109,966,773	0.313425				
19.	Drugs Charged to Patients	35,328,619	203,850,022	0.173307	3,361,678		582,602	
20.	Renal Dialysis	2,364,707	7,249,700	0.326180	105,557		34,431	
21.	Ambulance							
22.	Gastrodiagnostic Unit	4,133,325	21,783,304	0.189747	119,897		22,750	
23.	Pain Management Center							
24.	CT Scan	2,736,789	146,807,802	0.018642	2,323,494		43,315	
25.	MRI	1,504,267	28,856,127	0.052130	626,028		32,635	
26.	Cardiac Cath Lab	16,204,181	264,658,461	0.061227	3,474,036		212,705	
27.	Implants	40,037,752	117,521,460	0.340685				
28.	Other Ancillary Services	4,045,762	12,879,699	0.314119	27,894		8,762	
29.	Cardiac Rehab	1,503,155	2,937,428	0.511725				
30.	Hyperbarid Oxygen	1,428,337	4,656,590	0.306735	31		10	
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	20,631,076	104,803,107	0.196856	1,161,333		228,615	
45.	Observation	2,316,204	7,156,110	0.323668				
46.	Total				23,744,095		2,927,805	

* 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: 07/01/2020 To: 06/30/2021

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)	65,783,769			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	78,708			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	835.80			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,139			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,787,776			
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)	1,787,776			

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	27,562,230	15,941	1,729.02	483	835,117
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	964,462	1,557	619.44	189	117,074
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,927,805
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					5,667,772

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: 07/01/2020 To: 06/30/2021

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.	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: 07/01/2020 To: 06/30/2021

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	1,314,630	29,112,809	0.045156	981,913		44,339	
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,621	66,155,084	0.000145	1,358,720		197	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,778,267	101,813,486	0.027288	1,346,673		36,748	
17.	EEG	6,172	10,025,052	0.000616	77,453		48	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Gastrodiagnostic Unit	314,860	21,783,304	0.014454	119,897		1,733	
23.	Pain Management Center							
24.	CT Scan	7,227	146,807,802	0.000049	2,323,494		114	
25.	MRI							
26.	Cardiac Cath Lab							
27.	Implants							
28.	Other Ancillary Services							
29.	Cardiac Rehab							
30.	Hyperbarid 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	10,396,812	104,803,107	0.099203	1,161,333		115,208	
45.	Observation							
46.	Ancillary Total						198,387	

* 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: 07/01/2020 To: 06/30/2021

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	2,174,768	78,708	27.63	2,139		59,101	
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)						59,101	
68.	Ancillary Total (from line 46)						198,387	
69.	Total (Lines 67-68)						257,488	

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			
2. Inpatient Operating Services (BHF Page 4, Line 25)		5,667,772	
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)		257,488	
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)		544,488	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		6,469,748	
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	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		23,744,095	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		3,740,971	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		1,790,062	
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		345,135	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		29,620,263	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			23,150,515
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: 07/01/2020 To: 06/30/2021

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)	6,469,748	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,469,748	
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)	6,469,748	

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:
14-0053	19007
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2020 To: 06/30/2021

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)	23,150,515
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: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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:	14-0053	Medicaid Provider Number:	19007
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	6,794,701	236,390,778	0.028744	3,661,276		105,240	
2.	Recovery Room							
3.	Delivery and Labor Room	3,314,154	29,112,809	0.113838	981,913		111,779	
4.	Anesthesiology	119,767	61,617,868	0.001944	756,924		1,471	
5.	Radiology - Diagnostic	884,251	87,981,394	0.010050	1,094,133		10,996	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	199,463	19,947,471	0.009999	91,392		914	
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,873	101,813,486	0.000038	1,346,673		51	
17.	EEG	894	10,025,052	0.000089	77,453		7	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Gastrodiagnostic Unit	7,597	21,783,304	0.000349	119,897		42	
23.	Pain Management Center							
24.	CT Scan	49,903	146,807,802	0.000340	2,323,494		790	
25.	MRI	56,160	28,856,127	0.001946	626,028		1,218	
26.	Cardiac Cath Lab	39,774	264,658,461	0.000150	3,474,036		521	
27.	Implants							
28.	Other Ancillary Services	14,747	12,879,699	0.001145	27,894		32	
29.	Cardiac Rehab							
30.	Hyperbarid 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	2,715,318	104,803,107	0.025909	1,161,333		30,089	
45.	Observation							
46.	Ancillary Total						263,150	

* 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: 07/01/2020 To: 06/30/2021

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	8,806,102	78,708	111.88	2,139		239,311	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	227,468	15,941	14.27	483		6,892	
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	289,442	1,557	185.90	189		35,135	
67.	Routine Total (lines 47-66)						281,338	
68.	Ancillary Total (from line 46)						263,150	
69.	Total (Lines 67-68)						544,488	

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	2,622		2,622
Newborn Days	189		189
Total Inpatient Revenue	29,654,892	(34,629)	29,620,263
Ancillary Revenue	23,778,724	(34,629)	23,744,095
Routine Revenue	5,876,168		5,876,168
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Provider reported more Nursery program days than days available on Children's cost report. Emailed the hospital and they revised the children's and hospital's total nursery days reported in Part I-Hospital

BHF Page 2 - Part I-Hospital A&P beds and bed days are split between the Acute and Children's reports - see attached spreadsheet for the allocation

BHF Page 2 - Part I-Hospital Observation Days are split between the Acute and Children's reports - see attached spreadsheet for the allocation

BHF Page 3 Removed Cardiac Rehab charges of \$34,629 since they are not covered by IL Medicaid

BHF Page 4 - Allocated the A&P costs on W/S C-1, line 30, col 1 between the Acute and Children's report - see spreadsheet attached for the allocation

BHF Page 4 - Allocated the Nursery costs on W/S C-1, line 43, col 1 between the Acute and Children's report - see spreadsheet attached for the allocation

BHF Page 6(b) - Adults & Peds Pro Fee costs spilt between Acute Hospital and Children's Hospital

BHF Supplemental 2b - Allocated the A&P costs on W/S C-1, line 30, col 1 between the Acute and Children's report - see spreadsheet attached for the allocation

BHF Supplemental 2b - Allocated the Nursery costs on W/S C-1, line 43, col 1 between the Acute and Children's report - see spreadsheet attached for the allocation