

**Hospital Statement of Cost**

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: 07/01/2015	To: 06/30/2016	

**Type of Contrc**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

**Type of Hospita**

<input type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

**Health Care Program**

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

<input type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> U of I - Division of Specialized Care for Children

**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 07/01/2015 and ending 06/30/2016 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

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	232	84,912		54,054	63.66%		15,203	4.43
2.	Psych	15	5,490		4,524	82.40%		296	15.28
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	54	19,764		13,232	66.95%			
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				2,721				
22.	<b>Total</b>	<b>301</b>	<b>110,166</b>		<b>74,531</b>	<b>67.65%</b>		<b>15,499</b>	<b>4.63</b>
23.	Observation Bed Days				3,326				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,638			2,370	2.92
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,279				
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				194				
22.	<b>Total</b>				<b>7,111</b>	<b>9.54%</b>		<b>2,370</b>	<b>2.92</b>

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

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	36,876,342	187,009,882	0.197189	9,171,407		1,808,501	
2.	Recovery Room	4,772,313	18,463,876	0.258468	537,922		139,036	
3.	Delivery and Labor Room	8,678,906	16,430,323	0.528225	3,088,370		1,631,354	
4.	Anesthesiology	5,295,447	35,827,854	0.147803	1,377,241		203,560	
5.	Radiology - Diagnostic	11,264,325	66,385,155	0.169681	1,830,176		310,546	
6.	Radiology - Therapeutic	1,612,803	4,065,651	0.396690	134,346		53,294	
7.	Nuclear Medicine	2,766,423	23,989,948	0.115316	194,465		22,425	
8.	Laboratory	18,251,653	111,504,670	0.163685	5,870,006		960,832	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	6,351,357	45,882,115	0.138428	2,966,932		410,706	
13.	Physical Therapy	10,632,790	34,936,282	0.304348	674,527		205,291	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,328,090	70,632,146	0.089592	2,087,986		187,067	
17.	EEG	1,977,764	11,968,226	0.165251	281,705		46,552	
18.	Med. / Surg. Supplies	26,091,879	82,459,266	0.316421	585,320		185,208	
19.	Drugs Charged to Patients	24,177,819	143,900,350	0.168018	8,732,131		1,467,155	
20.	Renal Dialysis	1,286,570	3,205,134	0.401409	93,055		37,353	
21.	Ambulance							
22.	Gastrodiagnostic Unit	2,386,027	22,370,151	0.106661	650,430		69,376	
23.	Pain Management Center	225,245	1,758,324	0.128102	20		3	
24.	CT Scan	2,317,019	90,195,944	0.025689	3,322,713		85,357	
25.	MRI	1,689,280	19,181,247	0.088069	1,011,312		89,065	
26.	Cardiac Cath Lab	15,575,087	186,179,458	0.083656	6,503,934		544,093	
27.	Implants	40,207,672	106,520,206	0.377465				
28.	Other Ancillary Services	5,602,711	12,993,600	0.431190	44,198		19,058	
29.	Cardiac Rehab	1,965,015	2,578,720	0.762012				
30.	Hyperbarid Oxygen	1,064,288	5,325,702	0.199840				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic							
44.	Emergency	15,687,242	74,294,165	0.211150	1,563,010		330,030	
45.	Observation	3,119,256	7,348,315	0.424486				
46.	<b>Total</b>				<b>50,721,206</b>		<b>8,805,862</b>	

\* 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

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	47,728,820	3,866,909		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	57,380	4,524		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	831.80	854.75		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	5,638			
3.	Program general inpatient routine cost (Line 1c X Line 2)	4,689,688			
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)	4,689,688			

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	19,048,263	13,232	1,439.56	1,279	1,841,197
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	1,872,379	2,721	688.12	194	133,495
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					8,805,862
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>15,470,242</b>

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

PRELIMINARY

Medicare Provider Number: <b>14-0053</b>	Medicaid Provider Number: <b>19007</b>
Program: <b>Medicaid-Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

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)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	<b>Total (Sum of Lines 22 and 26)</b>								

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

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	165,646	187,009,882	0.000886	9,171,407		8,126	
2.	Recovery Room							
3.	Delivery and Labor Room	1,288,475	16,430,323	0.078421	3,088,370		242,193	
4.	Anesthesiology							
5.	Radiology - Diagnostic	5,130	66,385,155	0.000077	1,830,176		141	
6.	Radiology - Therapeutic	51,768	4,065,651	0.012733	134,346		1,711	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	67,027	45,882,115	0.001461	2,966,932		4,335	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,345,383	70,632,146	0.033206	2,087,986		69,334	
17.	EEG	7,000	11,968,226	0.000585	281,705		165	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	37,000	3,205,134	0.011544	93,055		1,074	
21.	Ambulance							
22.	Gastrodiagnostic Unit							
23.	Pain Management Center	29,760	1,758,324	0.016925	20			
24.	CT Scan	1,700	90,195,944	0.000019	3,322,713		63	
25.	MRI	1,500	19,181,247	0.000078	1,011,312		79	
26.	Cardiac Cath Lab	1,303	186,179,458	0.000007	6,503,934		46	
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							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency	3,822,638	74,294,165	0.051453	1,563,010		80,422	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>407,689</b>	

\* 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: 07/01/2015 To: 06/30/2016

Line No.	Cost Centers	Professional Component	Total Days Including Private	Professional Component Cost Per Diem	Program Days Including Private	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P	Outpatient Program Expenses for H B P
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	(Col. 1 / Col. 2)	(BHF Pg. 2 Pt. II, Col. 4)		(Col. 3 X Col. 4)	(Col. 3 X Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	1,859,699	57,380	32.41	5,638		182,728	
48.	Psych	62,044	4,524	13.71				
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.	<b>Routine Total (lines 47-66)</b>						182,728	
68.	<b>Ancillary Total (from line 46)</b>						407,689	
69.	<b>Total (Lines 67-68)</b>						590,417	

Computation of Lesser of Reasonable Cost or Customary Charge

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	15,470,242	
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)	590,417	
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)	944,486	
7.	<b>Total Reasonable Cost of Covered Services</b> <b>(Sum of Lines 1 through 6)</b>	<b>17,005,145</b>	
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)	50,721,206	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	7,227,299	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,062,166	
	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	175,764	
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services</b> <b>(Sum of Lines 9 through 11)</b>	<b>62,186,435</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		45,181,290
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

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	17,005,145	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	17,005,145	
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.	<b>Total Allowable Cost</b> (Sum of Lines 3 and 4, Plus or Minus Line 5)	17,005,145	

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.	<b>Balance Due Provider / (State Agency) *</b> (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: 07/01/2015 To: 06/30/2016

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charge

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)	45,181,290
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 Charge

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)
			(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: 07/01/2015 To: 06/30/2016

**Part I - Apportionment of Cost for the Services of Teaching Physician**

**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	Sub I	Sub II	Sub III
	Service	Psych	Rehab	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	Sub I	Sub II	Sub III
	Service	Psych	Rehab	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	Sub I	Sub II	Sub III
	Pediatrics	Psych	Rehab	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: 07/01/2015 To: 06/30/2016

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	2,026,256	187,009,882	0.010835	9,171,407		99,372	
2.	Recovery Room							
3.	Delivery and Labor Room	201,684	16,430,323	0.012275	3,088,370		37,910	
4.	Anesthesiology	64,860	35,827,854	0.001810	1,377,241		2,493	
5.	Radiology - Diagnostic	551,167	66,385,155	0.008303	1,830,176		15,196	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	33,325	23,989,948	0.001389	194,465		270	
8.	Laboratory	10,628	111,504,670	0.000095	5,870,006		558	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	6,527	45,882,115	0.000142	2,966,932		421	
13.	Physical Therapy	51,692	34,936,282	0.001480	674,527		998	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	4,563	70,632,146	0.000065	2,087,986		136	
17.	EEG	89,984	11,968,226	0.007519	281,705		2,118	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Gastrodiagnostic Unit	243,903	22,370,151	0.010903	650,430		7,092	
23.	Pain Management Center							
24.	CT Scan	55,561	90,195,944	0.000616	3,322,713		2,047	
25.	MRI	57,756	19,181,247	0.003011	1,011,312		3,045	
26.	Cardiac Cath Lab							
27.	Implants							
28.	Other Ancillary Services	37,830	12,993,600	0.002911	44,198		129	
29.	Cardiac Rehab							
30.	Hyperbarid Oxygen	1,097	5,325,702	0.000206				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic							
44.	Emergency	942,405	74,294,165	0.012685	1,563,010		19,827	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>191,612</b>	

\* 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: 07/01/2015 To: 06/30/2016

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	6,509,289	57,380	113.44	5,638		639,575	
48.	Psych	363,574	4,524	80.37				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,160,203	13,232	87.68	1,279		112,143	
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	16,225	2,721	5.96	194		1,156	
67.	<b>Routine Total (lines 47-66)</b>						752,874	
68.	<b>Ancillary Total (from line 46)</b>						191,612	
69.	<b>Total (Lines 67-68)</b>						944,486	

**Hospital Statement of Cost  
Reconciliation of Patient Days and Revenue**

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	6,917		6,917
Newborn Days	194		194
Total Inpatient Revenue	62,250,749	(64,314)	62,186,435
Ancillary Revenue	50,785,520	(64,314)	50,721,206
Routine Revenue	11,465,229		11,465,229
Inpatient Received and Receivable			
<b>Outpatient Reconciliation</b>			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

- Split of Adults & Peds and Nursery days came from Hospital personnel.
- Adults & Peds and Nursery Costs are split between Acute and Children's Hospital.
- Adults & Peds Observation Bed Days are split between Acute and Children's Hospital.
- Adults & Peds GME and Professional Component Costs are split between Acute and Children's Hospital.
- Nursery GME Costs are split between Acute and Children's Hospital.
- BHF Page 3 Costs/Charges match with filed W/S C.
- BHF Page 6(b) - Adults & Peds Pro Fee costs split between Acute Hospital and Children's Hospital.
- Removed \$64,314 of Medicaid Cardiac Rehab charges since non-covered by IL Medicaid.
- BHF Supplement No 2(a) and 2(b), Column 1 adjusted to agree with W/S B, Part I, Column 25.