

Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

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: 10/01/2016	To: 09/30/2017

Type of Control

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

Type of Hospital

<input checked="" 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 checked="" type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/>
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/>

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 10/01/2016 and ending 09/30/2017 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.

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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	459	167,535		116,730	69.67%		28,387	4.58
2.	Psych								
3.	Rehab	26	9,490		8,101	85.36%		544	14.89
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,615		13,168	70.74%			
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		4,722	47.91%			
22.	Total	563	205,495		142,721	69.45%		28,931	4.77
23.	Observation Bed Days				8,604				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				3,031			63	48.11
4.	Other (Sub)								
5.	Intensive Care Unit								
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								
22.	Total				3,031	2.12%		63	48.11

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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	49,489,029	353,625,111	0.139948	33,044		4,624	
2.	Recovery Room	6,133,092	59,032,560	0.103893	9,781		1,016	
3.	Delivery and Labor Room	6,765,174	23,203,904	0.291553				
4.	Anesthesiology	4,103,350	210,972,590	0.019450	16,449		320	
5.	Radiology - Diagnostic	44,276,207	429,275,003	0.103142	47,118		4,860	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	40,153,645	489,736,973	0.081990	214,062		17,551	
9.	Blood							
10.	Blood - Administration	7,767,375	17,119,072	0.453726	3,336		1,514	
11.	Intravenous Therapy	2,435,534	3,964,569	0.614325				
12.	Respiratory Therapy	12,040,655	167,503,583	0.071883	341,086		24,518	
13.	Physical Therapy	21,485,390	50,677,907	0.423960	1,009,550		428,009	
14.	Occupational Therapy							
15.	Speech Pathology	1,428,772	5,770,955	0.247580	136,728		33,851	
16.	EKG	10,860,336	167,358,570	0.064893	2,310		150	
17.	EEG	1,051,767	19,219,728	0.054723	1,023		56	
18.	Med. / Surg. Supplies	46,878,825	299,166,090	0.156698	165,332		25,907	
19.	Drugs Charged to Patients	71,134,828	565,885,460	0.125705	403,155		50,679	
20.	Renal Dialysis	3,250,011	12,231,411	0.265710	39,298		10,442	
21.	Ambulance	93,956						
22.	CT Scan	6,868,040	138,887,882	0.049450	50,898		2,517	
23.	MRI	9,207,309	79,363,178	0.116015	10,501		1,218	
24.	Cardiac Catherization	4,629,367	108,175,613	0.042795				
25.								
26.	Implantable Devices	52,578,949	240,730,831	0.218414	35,548		7,764	
27.	Digestive Diseases	6,650,123	61,165,727	0.108723	11,120		1,209	
28.	Enterostomal	619,460	2,215,153	0.279647	12,860		3,596	
29.	Diabetic Service	2,640,284	2,098,609	1.258111				
30.	Wound Care	2,032,732	8,009,468	0.253791				
31.	Psychology	3,863,313	8,082,631	0.477977	32,416		15,494	
32.	Neuro Diagnostic Ctr.	251,306						
33.								
34.	Comp Epilepsy	449,037						
35.	Sleep Disorders	2,350,160	17,250,575	0.136237				
36.	Pain Program	2,035,724	14,442,003	0.140959				
37.	Cardiac Rehab	3,055,654	1,985,399	1.539063				
38.	Lithotripsy	19,711	2,060,344	0.009567				
39.	Kidney Acquisition	3,427,758	3,939,334	0.870136				
40.	Pancreas Acquisition	103,899	261,390	0.397487				
41.								
42.								
Outpatient Service Cost Centers								
43.	Clinic	3,427,405	4,746,576	0.722079				
44.	Emergency	27,651,980	130,354,103	0.212130	79,563		16,878	
45.	Observation	18,095,398	29,289,081	0.617821				
46.	Total				2,655,178		652,173	

* 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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)	128,358,953		6,605,955	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	125,334		8,101	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,024.14		815.45	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			3,031	
3.	Program general inpatient routine cost (Line 1c X Line 2)			2,471,629	
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)			2,471,629	

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	28,737,681	13,168	2,182.39		
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	6,163,371	4,722	1,305.25		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					652,173
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,123,802

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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)	
						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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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	33,588	353,625,111	0.000095	33,044		3	
2.	Recovery Room							
3.	Delivery and Labor Room	36,000	23,203,904	0.001551				
4.	Anesthesiology							
5.	Radiology - Diagnostic	3,440,955	429,275,003	0.008016	47,118		378	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,134,520	489,736,973	0.002317	214,062		496	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	39,384	3,964,569	0.009934				
12.	Respiratory Therapy	25,116	167,503,583	0.000150	341,086		51	
13.	Physical Therapy	859,875	50,677,907	0.016967	1,009,550		17,129	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	417		#DIV/0!				
22.	CT Scan							
23.	MRI	5,024	79,363,178	0.000063	10,501		1	
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service	69,270	2,098,609	0.033008				
30.	Wound Care							
31.	Psychology	87,696	8,082,631	0.010850	32,416		352	
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders							
36.	Pain Program	515,885	14,442,003	0.035721				
37.	Cardiac Rehab	138,163	1,985,399	0.069590				
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition	4,025	261,390	0.015398				
41.								
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	92,526	4,746,576	0.019493				
44.	Emergency	13,551,962	130,354,103	0.103963	79,563		8,272	
45.	Observation	247,944	29,289,081	0.008465				
46.	Ancillary Total						26,682	

* 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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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	754,935	125,334	6.02				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	930,244	13,168	70.64				
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)						26,682	
69.	Total (Lines 67-68)						26,682	

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

Medicare Provider Number: 14-0067		Medicaid Provider Number: 16007	
Program: Medicaid Hospital		Period Covered by Statement: From: 10/01/2016 To: 09/30/2017	
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)	3,123,802	
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)	26,682	
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)	9,082	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	3,159,566	
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)	2,655,178	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	1,032,323	
	D. Other (Sub)		
	E. Intensive Care Unit		
	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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	3,687,501	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		527,935
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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)	3,159,566	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,159,566	
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)	3,159,566	

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.

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)	527,935
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			1.	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

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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)

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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	7,762,034	353,625,111	0.021950	33,044		725	
2.	Recovery Room							
3.	Delivery and Labor Room	1,949,392	23,203,904	0.084011				
4.	Anesthesiology	646,751	210,972,590	0.003066	16,449		50	
5.	Radiology - Diagnostic	5,806,549	429,275,003	0.013526	47,118		637	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	185,801	489,736,973	0.000379	214,062		81	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	678,226	167,358,570	0.004053	2,310		9	
17.	EEG	404,093	19,219,728	0.021025	1,023		22	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	682,287	138,887,882	0.004913	50,898		250	
23.	MRI	558,420	79,363,178	0.007036	10,501		74	
24.	Cardiac Catherization	3,315,998	108,175,613	0.030654				
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders	309,669	17,250,575	0.017951				
36.	Pain Program							
37.	Cardiac Rehab							
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition							
41.								
42.								
	Outpatient Ancillary Centers							
43.	Clinic	2,208,295	4,746,576	0.465240				
44.	Emergency	11,056,709	130,354,103	0.084821	79,563		6,749	
45.	Observation							
46.	Ancillary Total						8,597	

* 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)

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2016 To: 09/30/2017

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	24,953,042	125,334	199.09				
48.	Psych							
49.	Rehab	1,269	8,101	0.16	3,031		485	
50.	Other (Sub)							
51.	Intensive Care Unit	4,111,253	13,168	312.22				
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)						485	
68.	Ancillary Total (from line 46)						8,597	
69.	Total (Lines 67-68)						9,082	

