

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: 10/01/2017	To: 09/30/2018

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 10/01/2017 and ending 09/30/2018 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: 10/01/2017 To: 09/30/2018

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	466	170,090		127,400	74.90%		28,203	4.97
2.	Psych								
3.	Rehab	26	9,490		8,197	86.38%		508	16.14
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,615		12,896	69.28%			
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		4,900	49.72%			
22.	Total	570	208,050		153,393	73.73%		28,711	5.17
23.	Observation Bed Days				9,831				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				819			42	19.50
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				819	0.53%		42	19.50

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: 10/01/2017 To: 09/30/2018

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	47,109,032	377,591,507	0.124762	22,602		2,820	
2.	Recovery Room	6,172,977	62,228,536	0.099198	6,017		597	
3.	Delivery and Labor Room	7,000,055	26,451,842	0.264634				
4.	Anesthesiology	6,605,495	220,383,293	0.029973	11,546		346	
5.	Radiology - Diagnostic	52,397,513	429,430,626	0.122016	21,876		2,669	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	41,494,009	519,749,579	0.079835	246,317		19,665	
9.	Blood							
10.	Blood - Administration	7,542,533	17,867,300	0.422142	3,781		1,596	
11.	Intravenous Therapy	2,589,410	3,991,571	0.648720				
12.	Respiratory Therapy	13,217,374	190,574,920	0.069355	77,751		5,392	
13.	Physical Therapy	17,205,906	36,936,085	0.465829	568,609		264,875	
14.	Occupational Therapy	3,850,636	15,724,591	0.244880	589,233		144,291	
15.	Speech Pathology	2,129,022	8,618,157	0.247039	218,159		53,894	
16.	EKG	10,587,675	180,425,226	0.058682	946		56	
17.	EEG	1,379,279	23,236,728	0.059358	1,047		62	
18.	Med. / Surg. Supplies	45,167,343	297,264,345	0.151943	99,754		15,157	
19.	Drugs Charged to Patients	83,581,435	642,553,552	0.130077	449,958		58,529	
20.	Renal Dialysis	3,947,475	17,084,158	0.231061	18,816		4,348	
21.	Ambulance	95,436						
22.	CT Scan	7,523,203	157,563,757	0.047747	15,067		719	
23.	MRI	9,815,235	84,525,939	0.116121	6,813		791	
24.	Cardiac Catherization	4,411,772	111,889,233	0.039430				
25.								
26.	Implantable Devices	56,798,188	268,026,230	0.211913				
27.	Digestive Diseases	6,494,407	69,982,798	0.092800				
28.	Enterostomal	629,701	2,880,402	0.218616				
29.	Diabetic Service	2,738,004	2,768,392	0.989023				
30.	Wound Care	2,010,266	7,967,362	0.252313				
31.	Psychology	3,795,436	8,935,951	0.424738	19,771		8,397	
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders	2,811,703	18,385,481	0.152931				
36.	Pain Program	2,123,994	17,942,733	0.118376				
37.	Cardiac Rehab	3,404,458	2,118,422	1.607073				
38.	Lithotripsy							
39.	Kidney Acquisition	3,786,014	4,693,845	0.806591				
40.	Pancreas Acquisition	238,738	261,390	0.913340				
41.								
42.								
Outpatient Service Cost Centers								
43.	Clinic	4,149,417	6,057,109	0.685049				
44.	Emergency	30,994,145	141,071,262	0.219706				
45.	Observation	17,416,291	30,990,992	0.561979	11,713		6,582	
46.	Total				2,389,776		590,786	

* 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: 10/01/2017 To: 09/30/2018

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)	144,338,337		5,899,382	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	137,231		8,197	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,051.79		719.70	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			819	
3.	Program general inpatient routine cost (Line 1c X Line 2)			589,434	
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)			589,434	

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	28,232,590	12,896	2,189.25		
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	6,854,081	4,900	1,398.79		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					590,786
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,180,220

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: 10/01/2017 To: 09/30/2018

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: 10/01/2017 To: 09/30/2018

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	81,114	26,451,842	0.003066				
4.	Anesthesiology							
5.	Radiology - Diagnostic	2,755,471	429,430,626	0.006417	21,876		140	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,128,595	519,749,579	0.002171	246,317		535	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	62,889	3,991,571	0.015755				
12.	Respiratory Therapy	45,522	190,574,920	0.000239	77,751		19	
13.	Physical Therapy	170,528	36,936,085	0.004617	568,609		2,625	
14.	Occupational Therapy							
15.	Speech Pathology	40	8,618,157	0.000005	218,159		1	
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI	5,259	84,525,939	0.000062	6,813			
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases	98,583	69,982,798	0.001409				
28.	Enterostomal							
29.	Diabetic Service	89,538	2,768,392	0.032343				
30.	Wound Care	90,518	7,967,362	0.011361				
31.	Psychology	61,756	8,935,951	0.006911	19,771		137	
32.	Neuro Diagnostic Ctr.							
33.								
34.	Comp Epilepsy							
35.	Sleep Disorders							
36.	Pain Program	523,464	17,942,733	0.029174				
37.	Cardiac Rehab	169,827	2,118,422	0.080167				
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition							
41.								
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	62,328	6,057,109	0.010290				
44.	Emergency	14,518,421	141,071,262	0.102916				
45.	Observation							
46.	Ancillary Total						3,457	

* 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: 10/01/2017 To: 09/30/2018

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	13,765,756	137,231	100.31				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	41,680	12,896	3.23				
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)						3,457	
69.	Total (Lines 67-68)						3,457	

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: 10/01/2017 To: 09/30/2018	
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)	1,180,220	
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)	3,457	
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)	4,156	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,187,833	
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)	2,389,776	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	1,104,623	
	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)	3,494,399	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,306,566
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: 10/01/2017 To: 09/30/2018

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)	1,187,833	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,187,833	
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)	1,187,833	

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: 10/01/2017 To: 09/30/2018

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)	2,306,566
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	Sum of Columns 1 - 4
		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)
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: 10/01/2017 To: 09/30/2018

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: 10/01/2017 To: 09/30/2018

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	8,297,922	377,591,507	0.021976	22,602		497	
2.	Recovery Room							
3.	Delivery and Labor Room	1,582,478	26,451,842	0.059825				
4.	Anesthesiology	350,566	220,383,293	0.001591	11,546		18	
5.	Radiology - Diagnostic	5,584,847	429,430,626	0.013005	21,876		284	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	246,562	519,749,579	0.000474	246,317		117	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	216,974	180,425,226	0.001203	946		1	
17.	EEG	462,640	23,236,728	0.019910	1,047		21	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	491,330	157,563,757	0.003118	15,067		47	
23.	MRI	627,612	84,525,939	0.007425	6,813		51	
24.	Cardiac Catherization	2,999,087	111,889,233	0.026804				
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	41,243	18,385,481	0.002243				
36.	Pain Program							
37.	Cardiac Rehab							
38.	Lithotripsy							
39.	Kidney Acquisition							
40.	Pancreas Acquisition							
41.								
42.								
	Outpatient Ancillary Centers							
43.	Clinic	1,782,417	6,057,109	0.294269				
44.	Emergency	10,234,551	141,071,262	0.072549				
45.	Observation							
46.	Ancillary Total						1,036	

* 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: 10/01/2017 To: 09/30/2018

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	23,597,814	137,231	171.96				
48.	Psych							
49.	Rehab	31,268	8,197	3.81	819		3,120	
50.	Other (Sub)							
51.	Intensive Care Unit	3,679,664	12,896	285.33				
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)						3,120	
68.	Ancillary Total (from line 46)						1,036	
69.	Total (Lines 67-68)						4,156	

