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: 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:** 10/01/2012	**To:** 09/30/2013

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
XXXX XXXX	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX XXXX	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)

XXXX XXXX	Medicaid Hospital		Medicaid Sub II Rehab		DHS - Office of Rehabilitation Services
	Medicaid Sub I Psych		Medicaid Sub III Other		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)) Saint Francis Medical Center 16007 for the cost report beginning 10/01/2012 and ending 09/30/2013 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

Signed (Officer or Administrator of Provider(s)):

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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

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	447	163,155		119,910	73.49%		30,844	4.35
2.	Psych								
3.	Rehab	26	9,490		8,928	94.08%		605	14.76
4.	Other (Sub)								
5.	Intensive Care Unit	51	18,615		14,221	76.40%			
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**	**524**	**191,260**		**143,059**	**74.80%**		**31,449**	**4.55**
23.	Observation Bed Days				4,017				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				17,973			5,478	3.71
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,324				
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**				**20,297**	**14.19%**		**5,478**	**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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

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	61,437,283	228,981,352	0.268307	11,534,460		3,094,776	
2.	Recovery Room	4,661,186	35,726,666	0.130468	2,411,720		314,652	
3.	Delivery and Labor Room	8,946,829	15,505,614	0.577006	4,714,302		2,720,181	
4.	Anesthesiology	3,343,339	124,594,421	0.026834	7,779,519		208,756	
5.	Radiology - Diagnostic	46,960,909	280,755,330	0.167266	11,385,952		1,904,483	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	38,219,097	414,133,694	0.092287	23,062,217		2,128,343	
9.	Blood							
10.	Blood - Administration	8,592,090	17,284,928	0.497086	1,508,112		749,661	
11.	Intravenous Therapy							
12.	Respiratory Therapy	10,401,104	104,189,702	0.099829	9,722,402		970,578	
13.	Physical Therapy	15,504,108	47,742,549	0.324744	1,835,917		596,203	
14.	Occupational Therapy							
15.	Speech Pathology	1,500,984	4,905,126	0.306003	250,941		76,789	
16.	EKG	5,153,903	59,379,067	0.086797	1,889,949		164,042	
17.	EEG	1,545,347	10,732,353	0.143990	1,941,650		279,578	
18.	Med. / Surg. Supplies	26,310,111	311,065,978	0.084580	22,277,167		1,884,203	
19.	Drugs Charged to Patients	34,531,222	332,755,437	0.103774	29,559,956		3,067,555	
20.	Renal Dialysis	3,272,356	8,787,777	0.372376	699,427		260,450	
21.	Ambulance	12,356,097	29,357,264	0.420887	3,391,805		1,427,567	
22.	CT Scan	7,461,335	151,759,780	0.049165	6,194,227		304,539	
23.	MRI	7,867,425	106,754,957	0.073696	2,975,870		219,310	
24.	Cardiac Catherization	7,079,862	153,149,347	0.046228	2,521,297		116,555	
25.								
26.	Implantable Devices	41,025,547	172,738,690	0.237501	8,645,854		2,053,399	
27.	Digestive Diseases	6,000,795	65,062,288	0.092232	1,540,975		142,127	
28.	Enterostomal	460,089	976,178	0.471317				
29.	Diabetic Service	1,164,684	204,594	5.692660	30,135		171,548	
30.	Wound Care	1,689,167	5,084,819	0.332198	13,514		4,489	
31.	Psychology	1,537,564	2,644,747	0.581365				
32.	Neuro Diagnostic Ctr.	1,512,822	2,163,712	0.699179	8,514		5,953	
33.								
34.	Urological	193,165	642,802	0.300505	5,625		1,690	
35.	Sleep Disorders	3,964,352	16,142,042	0.245592				
36.	Pain Program	1,917,072	6,381,625	0.300405				
37.	Comp Epilepsy	1,867,887	4,508,476	0.414306				
38.	Cardiac Rehab	859,597	1,555,132	0.552749				
39.	Lithotripsy	167,249	2,436,040	0.068656	13,821		949	
40.	Kidney Acquisition	4,079,442	3,707,303	1.100380	7,408		8,152	
41.	Pancreas Acquisition	143,857	124,390	1.156500				
42.								
	Outpatient Service Cost Centers							
43.	Clinic	9,173,479	6,556,647	1.399111	20,554		28,757	
44.	Emergency	26,623,170	119,589,644	0.222621	4,433,436		986,976	
45.	Observation	4,242,428	11,448,807	0.370556	185,962		68,909	
46.	**Total**				**160,562,688**		**23,961,170**	

* 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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

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)	127,034,386		6,441,683	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	123,927		8,928	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,025.07		721.51	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	17,973			
3.	Program general inpatient routine cost (Line 1c X Line 2)	18,423,583			
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)	18,423,583			

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	28,709,691	14,221	2,018.82	2,324	4,691,738
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					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					23,961,170
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**47,076,491**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	417,499	124,594,421	0.003351	7,779,519		26,069	
5.	Radiology - Diagnostic	1,558,213	280,755,330	0.005550	11,385,952		63,192	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy	748,736	47,742,549	0.015683	1,835,917		28,793	
14.	Occupational Therapy							
15.	Speech Pathology	11,400	4,905,126	0.002324	250,941		583	
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI	5,485	106,754,957	0.000051	2,975,870		152	
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.	806,148	2,163,712	0.372576	8,514		3,172	
33.								
34.	Urological							
35.	Sleep Disorders	800,128	16,142,042	0.049568				
36.	Pain Program	532,481	6,381,625	0.083440				
37.	Comp Epilepsy	978,079	4,508,476	0.216942				
38.	Cardiac Rehab	114,155	1,555,132	0.073405				
39.	Lithotripsy							
40.	Kidney Acquisition							
41.	Pancreas Acquisition							
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	638,437	6,556,647	0.097372	20,554		2,001	
44.	Emergency	9,118,563	119,589,644	0.076249	4,433,436		338,045	
45.	Observation	79,536	11,448,807	0.006947	185,962		1,292	
46.	**Ancillary Total**						**463,299**	

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

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	526,907	123,927	4.25	17,973		76,385	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	9,312	14,221	0.65	2,324		1,511	
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)**						**77,896**	
68.	**Ancillary Total (from line 46)**						**463,299**	
69.	**Total (Lines 67-68)**						**541,195**	

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	47,076,491	
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)	541,195	
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)	4,496,260	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**52,113,946**	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	160,562,688	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	25,099,667	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	9,516,127	
	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)**	195,178,482	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		143,064,536
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:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	52,113,946	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	52,113,946	
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)**	**52,113,946**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

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)	143,064,536
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(1)	(2)	(3)	(4)	(5)
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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
14-0067	**16007**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 10/01/2012 To: 09/30/2013**

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)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

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	7,434,129	228,981,352	0.032466	11,534,460		374,478	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	390,640	124,594,421	0.003135	7,779,519		24,389	
5.	Radiology - Diagnostic	7,146,722	280,755,330	0.025455	11,385,952		289,829	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	64,783	414,133,694	0.000156	23,062,217		3,598	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	78,996	59,379,067	0.001330	1,889,949		2,514	
17.	EEG	313,140	10,732,353	0.029177	1,941,650		56,652	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Catherization	52,664	153,149,347	0.000344	2,521,297		867	
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.							
33.								
34.	Urological							
35.	Sleep Disorders							
36.	Pain Program	26,332	6,381,625	0.004126				
37.	Comp Epilepsy							
38.	Cardiac Rehab							
39.	Lithotripsy							
40.	Kidney Acquisition							
41.	Pancreas Acquisition							
42.								
	Outpatient Ancillary Centers							
43.	Clinic	1,840,841	6,556,647	0.280760	20,554		5,771	
44.	Emergency	7,898,529	119,589,644	0.066047	4,433,436		292,815	
45.	Observation							
46.	**Ancillary Total**						**1,050,913**	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

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	20,370,883	123,927	164.38	17,973		2,954,402	
48.	Psych							
49.	Rehab	1,463,367	8,928	163.91				
50.	Other (Sub)							
51.	Intensive Care Unit	3,004,216	14,221	211.25	2,324		490,945	
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)**						**3,445,347**	
68.	**Ancillary Total (from line 46)**						**1,050,913**	
69.	**Total (Lines 67-68)**						**4,496,260**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2012 To: 09/30/2013

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	20,297		20,297
Newborn Days			
Total Inpatient Revenue	195,208,749	(30,267)	195,178,482
Ancillary Revenue	160,592,955	(30,267)	160,562,688
Routine Revenue	34,615,794		34,615,794
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Total costs & Charges agree with as filed W/S C Part 1, cols. 1 and 8.
BHF Page 3 - Clinic costs & charges include all Clinic data, W/S C lines 90.01-90.07.
BHF Page 3- Removed Cardiac Rehab charges of $30,267 as this is non-covered by Illinois Medicaid.

BHF Supp No. 2(a)- Removed amounts from Col. 1 for Cardiac Rehab and Lithotripsy as not supported by W/S B, Col. 25. Part I,

Spread Adults & Peds and ICU costs between Acute and Children's Hospitals.