

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: 07/01/2014	To: 06/30/2015

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"/> 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 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 checked="" 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 07/01/2014 and ending 06/30/2015 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: 07/01/2014 To: 06/30/2015

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	241	87,965		52,817	60.04%		15,998	4.15
2.	Psych	15	5,475		4,988	91.11%		411	12.14
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	52	18,980		13,594	71.62%			
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				2,685				
22.	Total	308	112,420		74,084	65.90%		16,409	4.35
23.	Observation Bed Days				2,619				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				10,308			2,287	5.19
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,561				
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				1,069				
22.	Total				12,938	17.46%		2,287	5.19

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: 07/01/2014 To: 06/30/2015

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	42,382,853	167,005,188	0.253782	7,642,786		1,939,602	
2.	Recovery Room	4,033,721	16,666,029	0.242033	688,888		166,734	
3.	Delivery and Labor Room	7,206,527	14,924,425	0.482868	4,133,525		1,995,947	
4.	Anesthesiology	4,818,238	30,517,295	0.157885	1,448,459		228,690	
5.	Radiology - Diagnostic	10,268,918	63,068,808	0.162821	2,142,486		348,842	
6.	Radiology - Therapeutic	1,887,663	3,753,090	0.502962	119,256		59,981	
7.	Nuclear Medicine	2,845,426	25,631,777	0.111012	312,554		34,697	
8.	Laboratory	17,461,910	101,003,084	0.172885	7,100,149		1,227,509	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	6,068,671	44,479,831	0.136436	4,417,299		602,679	
13.	Physical Therapy	9,821,481	42,009,647	0.233791	1,002,538		234,384	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	4,489,737	72,626,073	0.061820	2,787,438		172,319	
17.	EEG	1,882,246	10,335,949	0.182107	484,730		88,273	
18.	Med. / Surg. Supplies	23,780,462	82,069,448	0.289760	2,906,096		842,070	
19.	Drugs Charged to Patients	23,778,520	137,243,540	0.173258	11,650,993		2,018,628	
20.	Renal Dialysis	1,049,995	3,172,217	0.330997	131,735		43,604	
21.	Ambulance							
22.	Gastrodiagnostic Unit	3,047,451	26,859,477	0.113459	560,353		63,577	
23.	Pain Management Center	362,163	2,570,910	0.140870				
24.	CT Scan	2,464,279	77,543,113	0.031779	4,040,779		128,412	
25.	MRI	1,486,466	20,584,713	0.072212	1,282,475		92,610	
26.	Cardiac Cath Lab	15,276,895	182,214,951	0.083840	3,732,858		312,963	
27.	Implants	36,230,703	101,325,858	0.357566	2,975,500		1,063,938	
28.	Other Ancillary Services	5,035,675	11,576,750	0.434982	977,271		425,095	
29.	Hyperbaric Oxygen Therapy	1,101,729	3,926,523	0.280586				
30.	Cardiac Rehab	1,295,077	2,215,803	0.584473				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	13,160,506	64,719,799	0.203346	1,763,606		358,622	
45.	Observation	2,201,924	5,849,008	0.376461	48,624		18,305	
46.	Total				62,350,398		12,467,481	

* 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: 07/01/2014 To: 06/30/2015

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)	41,072,574	3,846,809		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	55,436	4,988		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	740.90	771.21		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	10,308			
3.	Program general inpatient routine cost (Line 1c X Line 2)	7,637,197			
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)	7,637,197			

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	16,531,701	13,594	1,216.10	1,561	1,898,332
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	1,801,505	2,685	670.95	1,069	717,246
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					12,467,481
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					22,720,256

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

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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	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: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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	666,457	167,005,188	0.003991	7,642,786		30,502	
2.	Recovery Room							
3.	Delivery and Labor Room	1,886,628	14,924,425	0.126412	4,133,525		522,527	
4.	Anesthesiology	975,008	30,517,295	0.031949	1,448,459		46,277	
5.	Radiology - Diagnostic	4,650	63,068,808	0.000074	2,142,486		159	
6.	Radiology - Therapeutic	724,744	3,753,090	0.193106	119,256		23,029	
7.	Nuclear Medicine							
8.	Laboratory	165,000	101,003,084	0.001634	7,100,149		11,602	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	114,583	44,479,831	0.002576	4,417,299		11,379	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,390,693	72,626,073	0.032918	2,787,438		91,757	
17.	EEG	108,800	10,335,949	0.010526	484,730		5,102	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	37,000	3,172,217	0.011664	131,735		1,537	
21.	Ambulance							
22.	Gastrodiagnostic Unit							
23.	Pain Management Center							
24.	CT Scan							
25.	MRI							
26.	Cardiac Cath Lab	4,443	182,214,951	0.000024	3,732,858		90	
27.	Implants							
28.	Other Ancillary Services							
29.	Hyperbaric Oxygen Therapy	1,340	3,926,523	0.000341				
30.	Cardiac Rehab							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	2,236,346	64,719,799	0.034554	1,763,606		60,940	
45.	Observation							
46.	Ancillary Total						804,901	

* 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: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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	308,476	55,436	5.56	10,308		57,312	
48.	Psych	35,053	4,988	7.03				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	140,084	13,594	10.30	1,561		16,078	
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						73,390	
68.	Ancillary Total (from line 46)						804,901	
69.	Total (Lines 67-68)						878,291	

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

PRELIMINARY

Medicare Provider Number: 14-0053		Medicaid Provider Number: 19007	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2014 To: 06/30/2015	
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)	22,720,256	
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)	878,291	
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)	919,976	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	24,518,523	
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)	62,350,398	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	8,975,678	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,307,651	
	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	895,886	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	76,529,613	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		52,011,090
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: 07/01/2014 To: 06/30/2015

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)	24,518,523	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	24,518,523	
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)	24,518,523	

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.

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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)	52,011,090
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

PRELIMINARY

Medicare Provider Number: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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: 14-0053	Medicaid Provider Number: 19007
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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	5,845,976	167,005,188	0.035005	7,642,786		267,536	
2.	Recovery Room							
3.	Delivery and Labor Room	468,966	14,924,425	0.031423	4,133,525		129,888	
4.	Anesthesiology							
5.	Radiology - Diagnostic	6,186,873	63,068,808	0.098097	2,142,486		210,171	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Gastrodiagnostic Unit							
23.	Pain Management Center							
24.	CT Scan							
25.	MRI							
26.	Cardiac Cath Lab							
27.	Implants							
28.	Other Ancillary Services							
29.	Hyperbaric Oxygen Therapy							
30.	Cardiac Rehab							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	827,804	64,719,799	0.012791	1,763,606		22,558	
45.	Observation							
46.	Ancillary Total						630,153	

* 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: 07/01/2014 To: 06/30/2015

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	232,429	55,436	4.19	10,308		43,191	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,799,143	13,594	132.35	1,561		206,598	
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	100,554	2,685	37.45	1,069		40,034	
67.	Routine Total (lines 47-66)						289,823	
68.	Ancillary Total (from line 46)						630,153	
69.	Total (Lines 67-68)						919,976	

**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: 07/01/2014 To: 06/30/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,869		11,869
Newborn Days	1,069		1,069
Total Inpatient Revenue	76,585,982	(56,369)	76,529,613
Ancillary Revenue	62,406,767	(56,369)	62,350,398
Routine Revenue	14,179,215		14,179,215
Inpatient Received and Receivable			
Outpatient Reconciliation			
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 \$56,369 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.