Hospital Statement of Cost

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

General Information

PRELIMINARY - Revised 12/23/2019

Name of Hospital: St. John's Children's Hospital		**Medicare Provider Number:** 14-0053	
Street: 800 East Carpenter		**Medicaid Provider Number:** 19002	
City: Springfield	**State:** Illinois	**Zip:** 62769	
Period Covered by Statement:	**From:** 07/01/2017	**To:** 06/30/2018	

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		
	Medicaid Sub I Psych		Medicaid Sub III Other		

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 Children's Hospital 19002 for the cost report beginning 07/01/2017 and ending 06/30/2018 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):

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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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	29	10,585		7,003	66.16%		1,906	10.60
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	NICU	43	15,695		13,192	84.05%			
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				177				
22.	**Total**	**72**	**26,280**		**20,372**	**77.52%**		**1,906**	**10.60**
23.	Observation Bed Days				257				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,384			2,368	5.20
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	NICU				7,933				
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				67				
22.	**Total**				**12,384**	**60.79%**		**2,368**	**5.20**

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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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	32,724,311	189,639,065	0.172561	4,864,114		839,356	
2.	Recovery Room	4,725,447	18,588,270	0.254217	419,609		106,672	
3.	Delivery and Labor Room	8,832,344	20,279,852	0.435523				
4.	Anesthesiology	5,510,089	45,140,808	0.122064	813,806		99,336	
5.	Radiology - Diagnostic	9,441,137	76,175,027	0.123940	1,488,596		184,497	
6.	Radiology - Therapeutic	1,637,549	8,087,102	0.202489	10,785		2,184	
7.	Nuclear Medicine	2,538,823	22,234,261	0.114185	23,477		2,681	
8.	Laboratory	20,142,680	124,936,233	0.161224	4,667,814		752,564	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,197,143	45,721,512	0.157413	7,365,169		1,159,373	
13.	Physical Therapy	9,842,203	33,017,044	0.298095	595,374		177,478	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	7,375,878	87,479,208	0.084316	970,676		81,844	
17.	EEG	1,937,215	14,928,475	0.129766	853,020		110,693	
18.	Med. / Surg. Supplies	31,753,681	95,856,647	0.331262	286,300		94,840	
19.	Drugs Charged to Patients	22,715,304	146,432,006	0.155125	5,473,312		849,048	
20.	Renal Dialysis	1,224,539	3,507,891	0.349081	28,086		9,804	
21.	Ambulance							
22.	Gastrodiagnostic Unit	2,520,199	23,342,173	0.107968	760		82	
23.	Pain Management Center							
24.	CT Scan	2,653,944	110,626,664	0.023990	722,911		17,343	
25.	MRI	1,584,327	15,126,889	0.104736	377,041		39,490	
26.	Cardiac Cath Lab	16,666,225	244,404,421	0.068191	148,308		10,113	
27.	Implants	42,831,622	117,297,142	0.365155				
28.	Other Ancilary Services	4,179,948	10,699,081	0.390683	67,096		26,213	
29.	Cardiac Rehab	1,527,028	2,887,617	0.528819				
30.	Hyperbarid Oxygen	1,519,355	4,933,514	0.307966	413		127	
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	16,373,701	91,832,613	0.178299	1,326,558		236,524	
45.	Observation	2,233,834	5,488,137	0.407030				
46.	**Total**				**30,503,225**		**4,800,262**	

* 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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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)	6,467,964			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	7,260			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	890.90			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,384			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,905,706			
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)	3,905,706			

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					
9.	Coronary Care Unit					
10.	NICU	15,120,687	13,192	1,146.20	7,933	9,092,805
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	115,856	177	654.55	67	43,855
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					4,800,262
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**17,842,628**

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

PRELIMINARY - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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.	NICU						
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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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	1,314,000	20,279,852	0.064793				
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	23,291	45,721,512	0.000509	7,365,169		3,749	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	2,363,875	87,479,208	0.027022	970,676		26,230	
17.	EEG	37,000	14,928,475	0.002478	853,020		2,114	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	37,000	3,507,891	0.010548	28,086		296	
21.	Ambulance							
22.	Gastrodiagnostic Unit							
23.	Pain Management Center							
24.	CT Scan							
25.	MRI							
26.	Cardiac Cath Lab							
27.	Implants							
28.	Other Ancilary Services							
29.	Cardiac Rehab							
30.	Hyperbarid Oxygen							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	4,172,136	91,832,613	0.045432	1,326,558		60,268	
45.	Observation							
46.	**Ancillary Total**						**92,657**	

* 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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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	436,991	7,260	60.19	4,384		263,873	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU	93,600	13,192	7.10	7,933		56,324	
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)**						**320,197**	
68.	**Ancillary Total (from line 46)**						**92,657**	
69.	**Total (Lines 67-68)**						**412,854**	

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

PRELIMINARY - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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)	17,842,628	
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)	412,854	
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)	1,118,625	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**19,374,107**	
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)	30,503,225	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	8,486,079	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. NICU	24,931,899	
	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	63,126	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	63,984,329	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		44,610,222
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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:		
14-0053	19002		
Program:	Period Covered by Statement:		
Medicaid-Hospital	From: 07/01/2017	To:	06/30/2018

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)	19,374,107	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	19,374,107	
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)**	**19,374,107**	

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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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)	44,610,222
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 - Revised 12/23/2019

Medicare Provider Number:	**Medicaid Provider Number:**
14-0053	**19002**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 07/01/2017 To: 06/30/2018**

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)

PRELIMINARY - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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	7,493,451	189,639,065	0.039514	4,864,114		192,201	
2.	Recovery Room							
3.	Delivery and Labor Room	649,076	20,279,852	0.032006				
4.	Anesthesiology	60,401	45,140,808	0.001338	813,806		1,089	
5.	Radiology - Diagnostic	352,307	76,175,027	0.004625	1,488,596		6,885	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	31,977	22,234,261	0.001438	23,477		34	
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,496	45,721,512	0.000033	7,365,169		243	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	2,244	14,928,475	0.000150	853,020		128	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Gastrodiagnostic Unit							
23.	Pain Management Center							
24.	CT Scan	8,789	110,626,664	0.000079	722,911		57	
25.	MRI	43,758	15,126,889	0.002893	377,041		1,091	
26.	Cardiac Cath Lab	11,220	244,404,421	0.000046	148,308		7	
27.	Implants							
28.	Other Ancilary Services							
29.	Cardiac Rehab							
30.	Hyperbarid Oxygen							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	2,071,395	91,832,613	0.022556	1,326,558		29,922	
45.	Observation							
46.	**Ancillary Total**						**231,657**	

* 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 - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

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	923,507	7,260	127.20	4,384		557,645	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU	533,323	13,192	40.43	7,933		320,731	
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	22,698	177	128.24	67		8,592	
67.	**Routine Total (lines 47-66)**						**886,968**	
68.	**Ancillary Total (from line 46)**						**231,657**	
69.	**Total (Lines 67-68)**						**1,118,625**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY - Revised 12/23/2019

Medicare Provider Number:	Medicaid Provider Number:
14-0053	19002
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2017 To: 06/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	12,317		12,317
Newborn Days	685	(618)	67
Total Inpatient Revenue	64,575,885	(591,556)	63,984,329
Ancillary Revenue	30,503,225		30,503,225
Routine Revenue	34,072,660	(591,556)	33,481,104
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 spilt between Acute Hospital and Children's Hospital.

BHF Supplement No 2(a) and 2(b), Column 1 adjusted to agree with W/S B, Part I, Column 25.

Preliminary revised due to reallocation of nursery program days (BHF Page 2) and nursery charges (BHF Page 7).
Provider reported more program Nursery Days on their Children's Cost Report than available nursery days.
Reallocated nursery program days using historical data and then reallocated charges based upon new program days.