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: Children's Hospital of Illinois		Medicare Provider Number: 14-0067	
Street: 530 NE Glen Oak Avenue		Medicaid Provider Number: 16008	
City: Peoria	State: Illinois	Zip: 61637-0001	
Period Covered by Statement:	From: 10/01/2018	To: 09/30/2019	

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

	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation	XXXX XXXX	Other (Specify) Children's Hospital

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)) Children's Hospital of Illinois 16008 for the cost report beginning 10/01/2018 and ending 09/30/2019 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	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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	68	24,820		19,826	79.88%		4,485	7.24
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	16	5,840		4,119	70.53%			
6.	Coronary Care Unit								
7.	Neonatal ICU	28	10,220		8,535	83.51%			
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**	**112**	**40,880**		**32,480**	**79.45%**		**4,485**	**7.24**
23.	Observation Bed Days				2,048				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,027			850	8.42
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				686				
6.	Coronary Care Unit								
7.	Neonatal ICU				443				
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**				**7,156**	**22.03%**		**850**	**8.42**

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	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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	54,054,719	395,831,055	0.136560	3,930,215		536,710	
2.	Recovery Room	6,291,298	67,611,502	0.093051	462,841		43,068	
3.	Delivery and Labor Room	7,173,233	25,557,724	0.280668	9,248		2,596	
4.	Anesthesiology	6,128,426	227,091,890	0.026987	2,105,357		56,817	
5.	Radiology - Diagnostic	53,550,408	458,133,141	0.116888	1,849,224		216,152	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	40,314,719	538,752,282	0.074830	5,633,861		421,582	
9.	Blood							
10.	Blood - Administration	8,048,219	18,611,421	0.432434	527,164		227,964	
11.	Intravenous Therapy	2,544,889	4,680,206	0.543756	53,704		29,202	
12.	Respiratory Therapy	15,651,985	187,037,477	0.083684	13,586,765		1,136,995	
13.	Physical Therapy	15,558,217	40,611,976	0.383094	429,730		164,627	
14.	Occupational Therapy	3,997,073	16,442,787	0.243090	187,336		45,540	
15.	Speech Pathology	2,163,208	8,229,231	0.262869	285,397		75,022	
16.	EKG	8,032,922	182,327,739	0.044058	827,600		36,462	
17.	EEG	1,500,352	25,372,714	0.059132	725,489		42,900	
18.	Med. / Surg. Supplies	39,451,366	209,728,814	0.188107	3,753,307		706,023	
19.	Drugs Charged to Patients	80,410,460	639,921,459	0.125657	11,433,022		1,436,639	
20.	Renal Dialysis	4,195,079	20,447,469	0.205164	370,450		76,003	
21.	Ambulance							
22.	CT Scan	7,028,382	169,526,693	0.041459	334,222		13,857	
23.	MRI	9,760,978	88,618,268	0.110146	295,940		32,597	
24.	Cardiac Catherization	3,885,969	131,854,234	0.029472	158,077		4,659	
25.	Digestive Diseases	6,763,471	77,250,182	0.087553				
26.	Enterostomal	652,078	3,344,939	0.194945				
27.	Diabetic Service	2,894,518	3,936,540	0.735295				
28.	Wound Care	1,991,221	8,152,725	0.244240				
29.	Psychology	4,240,911	10,217,305	0.415071	1,769		734	
30.	Sleep Disorders	2,973,211	19,458,410	0.152798				
31.	Pain Program	2,086,251	19,719,946	0.105794				
32.	Cardiac Rehab	3,595,259	2,984,816	1.204516				
33.	Implant Devices	59,893,573	275,884,674	0.217096				
34.	Kidney Acquisition	3,236,768	4,517,411	0.716510				
35.	Pancreas Acquisition	195,407	390,344	0.500602				
36.								
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Service Cost Centers							
43.	Clinic	4,722,487	6,280,126	0.751973	62,089		46,689	
44.	Emergency	31,629,633	153,667,772	0.205831	75,591		15,559	
45.	Observation	22,030,753	41,775,065	0.527366	80,265		42,329	
46.	**Total**				**47,178,663**		**5,410,726**	

* 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 BHF Page 4

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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)	22,630,775			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	21,874			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,034.60			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,027			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,235,534			
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)	6,235,534			

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	9,585,406	4,119	2,327.12	686	1,596,404
9.	Coronary Care Unit					
10.	Neonatal ICU	17,970,990	8,535	2,105.56	443	932,763
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)					5,410,726
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**14,175,427**

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	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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.	Neonatal 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 **BHF Page 6(a)**

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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	616,748	395,831,055	0.001558	3,930,215		6,123	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	48,234	458,133,141	0.000105	1,849,224		194	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	41,323	538,752,282	0.000077	5,633,861		434	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,008	187,037,477	0.000005	13,586,765		68	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,626	182,327,739	0.000036	827,600		30	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Catherization							
25.	Digestive Diseases							
26.	Enterostomal							
27.	Diabetic Service							
28.	Wound Care							
29.	Psychology							
30.	Sleep Disorders	263	19,458,410	0.000014				
31.	Pain Program							
32.	Cardiac Rehab	37	2,984,816	0.000012				
33.	Implant Devices							
34.	Kidney Acquisition							
35.	Pancreas Acquisition							
36.								
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**						**6,849**	

* 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 BHF Page 6(b)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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	1,349,535	21,874	61.70	6,027		371,866	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Neonatal 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)**						**371,866**	
68.	**Ancillary Total (from line 46)**						**6,849**	
69.	**Total (Lines 67-68)**						**378,715**	

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Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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)	14,175,427	
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)	378,715	
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)	1,278,042	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**15,832,184**	
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)	47,178,663	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	20,997,923	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	2,390,008	
	F. Coronary Care Unit		
	G. Neonatal ICU	1,543,401	
	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)**	72,109,995	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		56,277,811
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)		

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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)	15,832,184	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	15,832,184	
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)**	**15,832,184**	

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.

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Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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)	56,277,811
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	**16008**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 10/01/2018 To: 09/30/2019**

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	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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	7,639,966	395,831,055	0.019301	3,930,215		75,857	
2.	Recovery Room							
3.	Delivery and Labor Room	1,524,653	25,557,724	0.059655	9,248		552	
4.	Anesthesiology	324,496	227,091,890	0.001429	2,105,357		3,009	
5.	Radiology - Diagnostic	5,058,316	458,133,141	0.011041	1,849,224		20,417	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	229,851	538,752,282	0.000427	5,633,861		2,406	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	969,511	187,037,477	0.005184	13,586,765		70,434	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	483,563	182,327,739	0.002652	827,600		2,195	
17.	EEG	241,781	25,372,714	0.009529	725,489		6,913	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	644,617	169,526,693	0.003802	334,222		1,271	
23.	MRI	579,797	88,618,268	0.006543	295,940		1,936	
24.	Cardiac Catherization	3,300,631	131,854,234	0.025032	158,077		3,957	
25.	Digestive Diseases							
26.	Enterostomal							
27.	Diabetic Service							
28.	Wound Care							
29.	Psychology							
30.	Sleep Disorders	156,680	19,458,410	0.008052				
31.	Pain Program							
32.	Cardiac Rehab							
33.	Implant Devices							
34.	Kidney Acquisition							
35.	Pancreas Acquisition							
36.								
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Ancillary Centers							
43.	Clinic	307,794	6,280,126	0.049011	62,089		3,043	
44.	Emergency	8,939,541	153,667,772	0.058174	75,591		4,397	
45.	Observation							
46.	**Ancillary Total**						**196,387**	

* 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	16008
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2018 To: 09/30/2019

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	2,959,966	21,874	135.32	6,027		815,574	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,144,796	4,119	277.93	686		190,660	
52.	Coronary Care Unit							
53.	Neonatal ICU	1,453,073	8,535	170.25	443		75,421	
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)**						**1,081,655**	
68.	**Ancillary Total (from line 46)**						**196,387**	
69.	**Total (Lines 67-68)**						**1,278,042**	

Hospital Statement of Cost

Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:		
14-0067	16008		
Program:	Period Covered by Statement:		
Medicaid Hospital	From: 10/01/2018	To:	09/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,156		7,156
Newborn Days			
Total Inpatient Revenue	72,109,995		72,109,995
Ancillary Revenue	47,178,663		47,178,663
Routine Revenue	24,931,332		24,931,332
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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

BHF Page 2 - # of Discharges Col 7 adjusted to agree with W/S S-3 col 15

Revised by taking Medicare S-3 total of 32,739/(27,243+4324) on Medicaid Acute and Children's times 4,324 = 4,485

BHF 6a and 6b - used provider totals as they didn't agree to Worksheet A-8-2. See allocation for Acute/Children's

breakdown

BHF Page 3 - Costs and Charges agreed to Medicare Report Worksheet C columns 1 & 8