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
Period Covered by Statement:	**From:** 10/01/2022	**To:** 09/30/2023

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)) Saint Francis Medical Center 16007 for the cost report beginning 10/01/2022 and ending 09/30/2023 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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: 10/01/2022 To: 09/30/2023

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	448	163,520		130,999	80.11%		25,004	5.83
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	75	27,375		14,794	54.04%			
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				2,596				
22.	**Total**	**523**	**190,895**		**148,389**	**77.73%**		**25,004**	**5.83**
23.	Observation Bed Days				18,808				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,496			726	7.37
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				853				
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				1,264				
22.	**Total**				**6,613**	**4.46%**		**726**	**7.37**

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: 10/01/2022 To: 09/30/2023

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	67,590,045	532,317,346	0.126973	8,464,043		1,074,705	
2.	Recovery Room	6,923,847	85,243,115	0.081225	1,108,073		90,003	
3.	Delivery and Labor Room	10,413,509	25,273,810	0.412028	1,634,193		673,333	
4.	Anesthesiology	8,990,908	303,539,406	0.029620	4,485,892		132,872	
5.	Radiology - Diagnostic	64,669,627	521,483,223	0.124011	2,712,678		336,402	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	53,167,952	657,653,739	0.080845	10,207,271		825,207	
9.	Blood							
10.	Blood - Administration	9,710,736	19,810,474	0.490182	821,347		402,610	
11.	Intravenous Therapy	3,419,113	14,278,359	0.239461	110,616		26,488	
12.	Respiratory Therapy	20,385,274	228,189,592	0.089335	5,475,949		489,194	
13.	Physical Therapy	16,230,381	43,519,360	0.372946	450,517		168,019	
14.	Occupational Therapy	4,263,346	17,854,616	0.238781	293,867		70,170	
15.	Speech Pathology	2,595,763	9,231,420	0.281188	252,091		70,885	
16.	EKG	11,098,627	212,217,202	0.052298	1,190,553		62,264	
17.	EEG	3,435,335	33,531,472	0.102451	841,946		86,258	
18.	Med. / Surg. Supplies	131,353,460	455,126,575	0.288609	4,784,325		1,380,799	
19.	Drugs Charged to Patients	94,526,275	760,884,570	0.124232	13,805,755		1,715,117	
20.	Renal Dialysis							
21.	Ambulance							
22.	Digestive Diseases	8,719,897	120,245,155	0.072518	1,030,063		74,698	
23.	Enterostomal	997,911	3,686,705	0.270678				
24.	Diabetic Service	3,111,674	4,344,236	0.716276				
25.	Wound Care	1,896,070	8,890,218	0.213276	25,741		5,490	
26.	Psychology	1,822,901	9,506,791	0.191747				
27.	Sleep Disorders	3,625,339	24,257,421	0.149453				
28.	Pain Program	2,408,049	23,425,173	0.102797				
29.	Cardiac Rehab	2,184,139	4,807,246	0.454343				
30.	Kidney Acquisition	4,702,548	7,320,564	0.642375				
31.	Heart Acquisition	1,563,100	1,071,293	1.459078				
32.	Pancreas Acquisition	240,790	234,742	1.025764				
33.	CT Scan	10,590,304	244,899,751	0.043243	2,527,118		109,280	
34.	MRI	9,789,942	117,775,969	0.083123	918,493		76,348	
35.	Cardiac Cath	5,127,538	132,320,376	0.038751	1,081,876		41,924	
36.	Implants							
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Service Cost Centers							
43.	Clinic	12,497,161	16,906,943	0.739173	333,142		246,250	
44.	Emergency	41,379,070	219,245,063	0.188734	284,331		53,663	
45.	Observation	35,471,454	57,971,934	0.611873	153,049		93,647	
46.	**Total**				**62,992,929**		**8,305,626**	

* 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: 10/01/2022 To: 09/30/2023

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)	217,196,666			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	149,807			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,449.84			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,496			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,518,481			
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)	6,518,481			

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	39,468,603	14,794	2,667.88	853	2,275,702
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	1,610,737	2,596	620.47	1,264	784,274
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					8,305,626
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**17,884,083**

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: 10/01/2022 To: 09/30/2023

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: 10/01/2022 To: 09/30/2023

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							
5.	Radiology - Diagnostic							
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.	Digestive Diseases							
23.	Enterostomal							
24.	Diabetic Service							
25.	Wound Care							
26.	Psychology							
27.	Sleep Disorders							
28.	Pain Program							
29.	Cardiac Rehab							
30.	Kidney Acquisition							
31.	Heart Acquisition							
32.	Pancreas Acquisition							
33.	CT Scan							
34.	MRI							
35.	Cardiac Cath							
36.	Implants							
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**							

* 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: 10/01/2022 To: 09/30/2023

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Premature ICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

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: 10/01/2022 To: 09/30/2023

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)	17,884,083	
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)		
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)	1,594,435	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**19,478,518**	
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)	62,992,929	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	11,631,727	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	7,588,253	
	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	1,465,690	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	83,678,599	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		64,200,081
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: 10/01/2022 To: 09/30/2023

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)	19,478,518	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	19,478,518	
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)**	**19,478,518**	

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: 10/01/2022 To: 09/30/2023

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)	64,200,081
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
Teaching Physicians / Routine Services Questionnaire

BHF Supplement No. 1

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0067	16007
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 10/01/2022 To: 09/30/2023

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: 10/01/2022 To: 09/30/2023

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	6,349,681	532,317,346	0.011928	8,464,043		100,959	
2.	Recovery Room							
3.	Delivery and Labor Room	1,089,695	25,273,810	0.043116	1,634,193		70,460	
4.	Anesthesiology	345,090	303,539,406	0.001137	4,485,892		5,100	
5.	Radiology - Diagnostic	6,506,877	521,483,223	0.012478	2,712,678		33,849	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	220,519	657,653,739	0.000335	10,207,271		3,419	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,305,765	228,189,592	0.005722	5,475,949		31,333	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,660,591	212,217,202	0.017249	1,190,553		20,536	
17.	EEG	410,192	33,531,472	0.012233	841,946		10,300	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Digestive Diseases	122,939	120,245,155	0.001022	1,030,063		1,053	
23.	Enterostomal							
24.	Diabetic Service							
25.	Wound Care							
26.	Psychology							
27.	Sleep Disorders	164,463	24,257,421	0.006780				
28.	Pain Program							
29.	Cardiac Rehab							
30.	Kidney Acquisition							
31.	Heart Acquisition							
32.	Pancreas Acquisition							
33.	CT Scan	666,007	244,899,751	0.002720	2,527,118		6,874	
34.	MRI	450,975	117,775,969	0.003829	918,493		3,517	
35.	Cardiac Cath							
36.	Implants							
37.								
38.								
39.								
40.								
41.								
42.								
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	11,794,002	219,245,063	0.053794	284,331		15,295	
45.	Observation							
46.	**Ancillary Total**						**302,695**	

* 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: 10/01/2022 To: 09/30/2023

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	27,800,601	149,807	185.58	4,496		834,368	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,539,498	14,794	306.85	853		261,743	
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	401,780	2,596	154.77	1,264		195,629	
67.	**Routine Total (lines 47-66)**						**1,291,740**	
68.	**Ancillary Total (from line 46)**						**302,695**	
69.	**Total (Lines 67-68)**						**1,594,435**	

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: 10/01/2022	To:	09/30/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,740	(391)	5,349
Newborn Days	873	391	1,264
Total Inpatient Revenue	83,678,599		83,678,599
Ancillary Revenue	62,992,929		62,992,929
Routine Revenue	20,685,670		20,685,670
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Split the A&P Total Beds Available and Total Bed Days Available between the Adult and Childrens cost reports based upon the email from the provider dated 4/11/24

BHF Page 2 - Split the Nursery IP Days between the Adult and Childrens cost reports based upon the email from the provider dated 4/11/24

BHF Page 2 - Reclassified the Part II-Program Nursery days to Nursery from ICU

BHF Page 2 - Part II-Program days agree with the IPCR

BHF Page 3 - I/P Charges agree with the IPCR

BHF Page 3 - Combined the Implant costs/charges with Med/Surg Supplies costs/charges as not differentiated on the IPCR

BHF Page 4 - Spread Adults & Peds, ICU and Nursery costs between Acute and Children's Hospitals; see attached spreadsheet

BHF Page 6a & 6b - Adjusted out the Professional fees as none on the IPCR

BHF Page 7 - The routine charges agree with the IPCR; the amount included the Renal Dialysis charges per the IPCR

BHF Supplemental 2a 2b - Spread Adults & Peds, ICU & Nursery costs between Acute and Children's Hospitals; see attached spreadsheet