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: Methodist Medical Center of Illinois			**Medicare Provider Number:** 14-0209
Street: 221 N E Glen Oak			**Medicaid Provider Number:** 16006
City: Peoria	**State:** Illinois	**Zip:** 61636	
Period Covered by Statement:	**From:** 01/01/2013	**To:** 12/31/2013	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
XXXX XXXX	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)

	Medicaid Hospital		Medicaid Sub II Rehab		DHS - Office of Rehabilitation Services
XXXX XXXX	Medicaid Sub I Psych		Medicaid Sub III Other		U of I - Division of Specialized Care for Children

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Methodist Medical Center of | 16006 for the cost report beginning 01/01/2013 and ending 12/31/2013 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

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

Name (Typewritten)

Title

Date

Telephone Number

Email Address

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	156	56,873		35,413	62.27%		11,186	3.64
2.	Psych	67	24,455		20,220	82.68%		2,947	6.86
3.	Rehab	26	9,490		8,497	89.54%		660	12.87
4.	Other (Sub)								
5.	Intensive Care Unit	12	4,380		3,536	80.73%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		1,760	40.18%			
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	20	7,300		4,290	58.77%			
22.	**Total**	**293**	**106,878**		**73,716**	**68.97%**		**14,793**	**4.69**
23.	Observation Bed Days				4,578				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				8,499			1,154	7.36
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Surgical ICU								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**8,499**	**11.53%**		**1,154**	**7.36**

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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	37,106,935	120,849,603	0.307051	171,548		52,674	
2.	Recovery Room	4,026,354	24,373,797	0.165192				
3.	Delivery and Labor Room	4,244,834	7,283,065	0.582836				
4.	Anesthesiology	2,754,928	46,253,284	0.059562	45,581		2,715	
5.	Radiology - Diagnostic	10,850,519	56,765,378	0.191147	267,272		51,088	
6.	Radiology - Therapeutic	3,057,665	21,057,028	0.145209				
7.	Nuclear Medicine	944,111	5,625,410	0.167830				
8.	Laboratory	15,432,532	152,998,690	0.100867	1,367,308		137,916	
9.	Blood							
10.	Blood - Administration	1,452,888	7,118,012	0.204114				
11.	Intravenous Therapy	1,100,245	5,267,909	0.208858				
12.	Respiratory Therapy	1,798,921	14,855,778	0.121092	262,009		31,727	
13.	Physical Therapy	2,030,137	10,075,306	0.201496	154,174		31,065	
14.	Occupational Therapy	1,054,779	6,017,843	0.175275				
15.	Speech Pathology	533,311	2,267,506	0.235197				
16.	EKG	450,173	6,619,826	0.068004				
17.	EEG	1,172,735	9,913,843	0.118293	12,991		1,537	
18.	Med. / Surg. Supplies	4,952,146	65,309,862	0.075825	22,249		1,687	
19.	Drugs Charged to Patients	21,565,821	76,815,757	0.280747	455,446		127,865	
20.	Renal Dialysis	438,095	1,216,824	0.360032				
21.	Ambulance							
22.	Lithotripsy	117,485	502,520	0.233792				
23.	Pain Clinic	1,318,255	7,099,420	0.185685				
24.	PET Scan							
25.	Psych-Partial Hospitalization	795,731	2,464,734	0.322847				
26.	Endoscopy							
27.	Chillicothe Family	1,613,386	3,439,720	0.469046				
28.	Physician Offices	28,316,741	65,631,926	0.431448				
29.								
30.	Diabetic Care Center	269,997	462,536	0.583732				
31.	Wound Care Center	364,172	281,715	1.292697				
32.	Hyperbaric Oxygen Therapy	972,042	3,298,625	0.294681				
33.	CT Scan	1,537,222	62,331,155	0.024662				
34.	MRI	1,264,950	20,011,033	0.063213				
35.	Cardiac Rehab	3,850,195	35,095,221	0.109707				
36.	Other Northside Cost Centers(6)	3,387,311	22,854,725	0.148211				
37.	Radioisotope	51,284	18,748	2.735438				
38.	Cardiac Cath	421,793	12,593,462	0.033493				
39.	Implant Devices	7,877,067	63,998,755	0.123082				
40.	Gastro Intestinal	2,159,727	14,661,506	0.147306				
41.								
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	3,160,492	9,502,049	0.332612				
44.	Emergency	9,165,311	47,203,234	0.194167	1,006,765		195,481	
45.	Observation	4,090,351	5,242,033	0.780299				
46.	**Total**				**3,765,343**		**633,755**	

* 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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	34,989,882	15,954,248	5,923,602	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	39,991	20,220	8,497	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	874.94	789.03	697.14	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		8,499		
3.	Program general inpatient routine cost (Line 1c X Line 2)		6,705,966		
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)		6,705,966		

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	6,486,900	3,536	1,834.53		
9.	Coronary Care Unit					
10.	Surgical ICU	1,209,678	1,760	687.32		
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	1,494,328	4,290	348.33		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					633,755
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**7,339,721**

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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical 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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
1.	Operating Room	3,829,041	120,849,603	0.031684	171,548		5,435	
2.	Recovery Room							
3.	Delivery and Labor Room	1,545,991	7,283,065	0.212272				
4.	Anesthesiology	4,564,202	46,253,284	0.098678	45,581		4,498	
5.	Radiology - Diagnostic	219,996	56,765,378	0.003876	267,272		1,036	
6.	Radiology - Therapeutic	137,652	21,057,028	0.006537				
7.	Nuclear Medicine							
8.	Laboratory	441,739	152,998,690	0.002887	1,367,308		3,947	
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.	Lithotripsy							
23.	Pain Clinic							
24.	PET Scan							
25.	Psych-Partial Hospitalization	182,948	2,464,734	0.074226				
26.	Endoscopy							
27.	Chillicothe Family	902,277	3,439,720	0.262311				
28.	Physician Offices	22,293,963	65,631,926	0.339682				
29.								
30.	Diabetic Care Center	70,507	462,536	0.152436				
31.	Wound Care Center	644,699	281,715	2.288479				
32.	Hyperbaric Oxygen Therapy							
33.	CT Scan	51,457	62,331,155	0.000826				
34.	MRI							
35.	Cardiac Rehab							
36.	Other Northside Cost Centers(6)							
37.	Radioisotope							
38.	Cardiac Cath							
39.	Implant Devices							
40.	Gastro Intestinal							
41.								
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	411,522	9,502,049	0.043309				
44.	Emergency	1,972,848	47,203,234	0.041795	1,006,765		42,078	
45.	Observation							
46.	**Ancillary Total**						**56,994**	

* 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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	54,070	39,991	1.35				
48.	Psych	31,200	20,220	1.54	8,499		13,088	
49.	Rehab	111,425	8,497	13.11				
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Surgical 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	167,993	4,290	39.16				
67.	**Routine Total (lines 47-66)**						**13,088**	
68.	**Ancillary Total (from line 46)**						**56,994**	
69.	**Total (Lines 67-68)**						**70,082**	

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	7,339,721	
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)	70,082	
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)	232,892	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**7,642,695**	
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)	3,765,343	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	15,918,627	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Surgical ICU		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	19,683,970	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		12,041,275
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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	7,642,695	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	7,642,695	
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)**	**7,642,695**	

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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	12,041,275
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	Sum of Columns 1 - 4
		to	to	to		
		(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		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	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:**
14-0209	**16006**
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	**From: 01/01/2013 To: 12/31/2013**

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
6.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7.	Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))**				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	**Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)**				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
1.	Operating Room	254,360	120,849,603	0.002105	171,548		361	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	39,854	56,765,378	0.000702	267,272		188	
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.	Lithotripsy							
23.	Pain Clinic	79,708	7,099,420	0.011227				
24.	PET Scan							
25.	Psych-Partial Hospitalization							
26.	Endoscopy							
27.	Chillicothe Family							
28.	Physician Offices	2,780,611	65,631,926	0.042367				
29.								
30.	Diabetic Care Center							
31.	Wound Care Center							
32.	Hyperbaric Oxygen Therapy							
33.	CT Scan							
34.	MRI							
35.	Cardiac Rehab							
36.	Other Northside Cost Centers(6)							
37.	Radioisotope							
38.	Cardiac Cath							
39.	Implant Devices							
40.	Gastro Intestinal	157,071	14,661,506	0.010713				
41.								
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	2,100,523	9,502,049	0.221060				
44.	Emergency	305,936	47,203,234	0.006481	1,006,765		6,525	
45.	Observation							
46.	**Ancillary Total**						**7,074**	

* 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:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 01/01/2013 To: 12/31/2013

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	1,442,879	39,991	36.08				
48.	Psych	537,145	20,220	26.57	8,499		225,818	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	577,175	3,536	163.23				
52.	Coronary Care Unit							
53.	Surgical ICU	8,205	1,760	4.66				
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	13,363	4,290	3.11				
67.	**Routine Total (lines 47-66)**						**225,818**	
68.	**Ancillary Total (from line 46)**						**7,074**	
69.	**Total (Lines 67-68)**						**232,892**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
14-0209	**16006**
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	**From: 01/01/2013 To: 12/31/2013**

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	8,499		8,499
Newborn Days			
Total Inpatient Revenue	19,683,970		19,683,970
Ancillary Revenue	3,765,343		3,765,343
Routine Revenue	15,918,627		15,918,627
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2- Received info from corporate HQ regarding split of total Hospital days in Acute and Psych Units.
Total Hospital and Medicaid Psych Days, Charges, & Discharges came from filed hospital report.
Adjusted the Days available and utilized To the allocate the Adolescent Psych Days to the Medicaid Psych report.
Allocation of Routine Service and GME Costs(from W/S B, Pt. I, Col. 25) to Psych done.

BHF page 3- Per instructions from UnityPoint Health, all Medicaid charges should be I/P.