

**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: Genesis Medical Center		Medicare Provider Number: 16-0033	
Street: 1227 E. Rusholme Street		Medicaid Provider Number: 4031	
City: Davenport	State: Iowa	Zip: 52803	
Period Covered by Statement:	From: 07/01/2015	To: 06/30/2016	

**Type of Contrc**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation XXXX XXXX	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

**Type of Hospita**

<input type="checkbox"/> General Short-Term XXXX XXXX	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

**Health Care Program**

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab _____	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I Psych _____	<input type="checkbox"/> Medicaid Sub III Other _____	<input type="checkbox"/> U of I - Division of Specialized Care for Children

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

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):**

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Genesis Medical Center 4031 for the cost report beginning 07/01/2015 and ending 06/30/2016 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

\_\_\_\_\_  
 Name (Typewritten)  
 Title \_\_\_\_\_ Date \_\_\_\_\_  
 Firm \_\_\_\_\_  
 Telephone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_

\_\_\_\_\_  
 Name (Typewritten)  
 Title \_\_\_\_\_  
 Date \_\_\_\_\_  
 Telephone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_

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

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	198	72,468		49,671	68.54%		15,950	3.62
2.	Psych	23	8,418		5,496	65.29%		1,237	4.44
3.	Rehab	34	12,444		6,511	52.32%		488	13.34
4.	Other (Sub)								
5.	Intensive Care Unit	30	10,980		5,399	49.17%			
6.	Coronary Care Unit								
7.	NICU	20	7,320		2,681	36.63%			
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	7,320		4,009	54.77%			
22.	<b>Total</b>	<b>325</b>	<b>118,950</b>		<b>73,767</b>	<b>62.02%</b>		<b>17,675</b>	<b>3.95</b>
23.	Observation Bed Days				4,386				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				67			10	6.70
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	NICU								
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.	<b>Total</b>				<b>67</b>	<b>0.09%</b>		<b>10</b>	<b>6.70</b>

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: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Line No.	Ancillary Service Cost Centers	Total Dept. Costs	Total Dept. Charges	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program	Total Billed O/P Charges (Gross) for Health Care Program	I/P Expenses Applicable to Health Care Program	O/P Expenses Applicable to Health Care Program
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S C, Pt. 1, Col. 8)*		(4)	(5)	(Col. 3 X 4)	(Col. 3 X 5)
		(1)	(2)		(3)	(6)	(7)	
1.	Operating Room	24,561,339	95,986,350	0.255884				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	27,921,317	135,728,576	0.205714	201		41	
6.	Radiology - Therapeutic	17,642,481	43,779,299	0.402987				
7.	Nuclear Medicine							
8.	Laboratory	12,854,168	61,697,305	0.208342	9,276		1,933	
9.	Blood							
10.	Blood - Administration	2,101,009	2,595,404	0.809511				
11.	Intravenous Therapy							
12.	Respiratory Therapy	4,096,276	25,917,580	0.158050	379		60	
13.	Physical Therapy	20,181,772	38,968,528	0.517899	7,170		3,713	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	5,197,268	22,391,362	0.232110				
17.	EEG	1,673,641	6,859,687	0.243982				
18.	Med. / Surg. Supplies	20,048,281	68,334,732	0.293383	6,420		1,884	
19.	Drugs Charged to Patients	23,856,893	82,069,875	0.290690	12,736		3,702	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath	10,504,483	121,496,424	0.086459				
23.	Implantable Devices	34,309,384	90,956,527	0.377206				
24.	OP Institutes	3,044,382	14,074,268	0.216308				
25.	Clinical Psych	246,531	494,027	0.499023				
26.	Bariatric Clinic	597,062	372,283	1.603785				
27.	Pain Management	1,293,979	4,589,644	0.281935				
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic							
44.	Emergency	11,910,259	61,208,038	0.194587				
45.	Observation	3,623,889	6,877,830	0.526894				
46.	<b>Total</b>				<b>36,182</b>		<b>11,333</b>	

\* 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 Cc

Preliminary

Medicare Provider Number: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	44,664,147	5,185,173	4,024,230	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	54,057	5,496	6,511	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	826.24	943.44	618.07	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		67		
3.	Program general inpatient routine cost (Line 1c X Line 2)		63,210		
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)		63,210		

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	8,378,123	5,399	1,551.79		
9.	Coronary Care Unit					
10.	NICU	2,148,833	2,681	801.50		
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	3,284,212	4,009	819.21		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					11,333
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>74,543</b>

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

Preliminary

Medicare Provider Number: <b>16-0033</b>	Medicaid Provider Number: <b>4031</b>
Program: <b>Medicaid Psych</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	<b>Total (Sum of Lines 22 and 26)</b>								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	955,988	95,986,350	0.009960				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic	21,188	43,779,299	0.000484				
7.	Nuclear Medicine							
8.	Laboratory	42,200	61,697,305	0.000684	9,276		6	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	38	25,917,580	0.000001	379			
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	444,526	22,391,362	0.019853				
17.	EEG	98,225	6,859,687	0.014319				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath	206,251	121,496,424	0.001698				
23.	Implantable Devices							
24.	OP Institutes	247,386	14,074,268	0.017577				
25.	Clinical Psych							
26.	Bariatric Clinic	390,845	372,283	1.049860				
27.	Pain Management							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency	1,491,849	61,208,038	0.024373				
45.	Observation							
46.	<b>Ancillary Total</b>						6	

\* 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: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	439,363	5,399	81.38				
52.	Coronary Care Unit							
53.	NICU							
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>						6	
69.	<b>Total (Lines 67-68)</b>						6	

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	74,543	
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)	6	
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)	1,266	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>75,815</b>	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	36,182	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	70,350	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. NICU		
	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.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>106,532</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		30,717
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: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	75,815	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	75,815	
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.	<b>Total Allowable Cost</b> (Sum of Lines 3 and 4, Plus or Minus Line 5)	<b>75,815</b>	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	<b>Balance Due Provider / (State Agency) *</b> (Line 6 Minus Line 8)		

\* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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

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)	30,717
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 Charge

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			(1)	(2A)	(2B)	(3A)
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: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

**Part I - Apportionment of Cost for the Services of Teaching Physician**

**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: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Line No.	Cost Centers	G M E	Total Dept.	Ratio of	Inpatient	Outpatient	Inpatient	Outpatient
		Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	G M E Cost to Charges (Col. 1 / Col. 2)	Program Charges (BHF Page 3, Col. 4)	Program Charges (BHF Page 3, Col. 5)	Program Expenses for G M E (Col. 3 X Col. 4)	Program Expenses for G M E (Col. 3 X Col. 5)
Inpatient Ancillary Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	123,278	95,986,350	0.001284				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	81,085	135,728,576	0.000597	201			
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	40,189	61,697,305	0.000651	9,276		6	
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	62,936	82,069,875	0.000767	12,736		10	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath							
23.	Implantable Devices							
24.	OP Institutes							
25.	Clinical Psych							
26.	Bariatric Clinic							
27.	Pain Management							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Ancillary Centers</b>								
43.	Clinic							
44.	Emergency	215,678	61,208,038	0.003524				
45.	Observation							
46.	<b>Ancillary Total</b>						16	

\* 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: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	2,233,740	54,057	41.32				
48.	Psych	102,535	5,496	18.66	67		1,250	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	131,292	5,399	24.32				
52.	Coronary Care Unit							
53.	NICU	121,864	2,681	45.45				
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.	<b>Routine Total (lines 47-66)</b>						1,250	
68.	<b>Ancillary Total (from line 46)</b>							16
69.	<b>Total (Lines 67-68)</b>						1,266	

**Hospital Statement of Cost  
Reconciliation of Patient Days and Revenue**

Preliminary

Medicare Provider Number: 16-0033	Medicaid Provider Number: 4031
Program: Medicaid Psych	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	67		67
Newborn Days			
Total Inpatient Revenue	106,532		106,532
Ancillary Revenue	36,182		36,182
Routine Revenue	70,350		70,350
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

- BHF Page 2- Adjusted Observation Bed days to W/S S-3, col. 8, line 28.
- BHF Supp. No. 2 GME costs were adjusted to as filed W/S B Part 1, col. 25
- BHF Page 2-Removed Medicaid Psych (67) and Rehab (93) days from this report.
- BHF Page 3 - Radiology Diagnostic included CT Scan and MRI costs & charges from W/S C.
- BHF Page 3 - Reclassified Blood as Blood Admin.