

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: Union Hospital, Inc.		Medicare Provider Number: 15-0023
Street: 1606 N. 7th Street		Medicaid Provider Number: 20003
City: Terre Haute	State: IN	Zip: 47804
Period Covered by Statement:	From: 01/01/2016	To: 12/31/2016

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" 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 Hospital

<input checked="" 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 checked="" type="checkbox"/> Medicaid Sub II XXXX XXXX	<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)) Union Hospital, Inc. 20003 for the cost report beginning 01/01/2016 and ending 12/31/2016 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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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	191	69,906		48,771	69.77%		14,901	4.09
2.	Psych								
3.	Rehab	22	8,052		3,642	45.23%		267	13.64
4.	Other (Sub)								
5.	Intensive Care Unit	36	13,176		8,314	63.10%			
6.	Coronary Care Unit								
7.	Intensive Care-Nursery	15	5,490		3,852	70.16%			
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	30	10,980		3,565	32.47%			
22.	Total	294	107,604		68,144	63.33%		15,168	4.26
23.	Observation Bed Days				9,247				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Intensive Care-Nursery								
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								

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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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	19,862,225	157,004,486	0.126507				
2.	Recovery Room	2,714,220	5,065,446	0.535830				
3.	Delivery and Labor Room	7,324,481	18,165,230	0.403214				
4.	Anesthesiology							
5.	Radiology - Diagnostic	12,635,791	53,347,399	0.236859				
6.	Radiology - Therapeutic	8,071,356	38,684,121	0.208648				
7.	Nuclear Medicine	1,722,147	9,016,112	0.191008				
8.	Laboratory	11,007,193	92,236,841	0.119336				
9.	Blood							
10.	Blood - Administration	1,435,549	3,216,828	0.446262				
11.	Intravenous Therapy							
12.	Respiratory Therapy	5,598,618	12,153,254	0.460668				
13.	Physical Therapy	3,660,067	11,604,203	0.315409				
14.	Occupational Therapy	1,888,685	7,752,483	0.243623				
15.	Speech Pathology	881,834	2,548,823	0.345977				
16.	EKG	3,101,694	19,601,012	0.158242				
17.	EEG	1,471,861	4,564,027	0.322492				
18.	Med. / Surg. Supplies	1,491,675	2,537,728	0.587799				
19.	Drugs Charged to Patients	51,802,600	246,314,350	0.210311				
20.	Renal Dialysis	1,937,684	3,970,687	0.487997				
21.	Ambulance							
22.	Cardiac Surgery	3,015,120	9,899,097	0.304585				
23.	WVSC	15,806,800	103,895,244	0.152142				
24.	OP Treatment Rm.	5,488,589	2,748,332	1.997062				
25.	Cat Scan	3,540,876	57,501,526	0.061579				
26.	MRI	2,204,972	13,713,140	0.160793				
27.	Cardiac Cath Lab	19,550,064	106,078,215	0.184299				
28.	O/P Psych Therapy	2,419,654	6,812,335	0.355187				
29.	Cardiac Rehab.	966,793	1,421,475	0.680134				
30.	Implant Devices	13,684,826	15,375,112	0.890064				
31.	Patient Nutrition	566,463	223,008	2.540102				
32.	Wound Clinic	1,879,798	5,778,097	0.325332				
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	303,027	797,668	0.379891				
44.	Emergency	14,932,878	124,751,734	0.119701				
45.	Observation	9,646,008	17,837,707	0.540765				
46.	Total							

* 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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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)	60,521,204		3,313,607	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	58,018		3,642	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,043.15		909.83	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)				
3.	Program general inpatient routine cost (Line 1c X Line 2)				
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)				

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	13,167,561	8,314	1,583.78		
9.	Coronary Care Unit					
10.	Intensive Care-Nursery	4,266,074	3,852	1,107.50		
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	1,996,226	3,565	559.95		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					

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

Preliminary

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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.	Intensive Care-Nursery						
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.	Total (Sum of Lines 22 and 26)								

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

Preliminary

Medicare Provider Number:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2016 To: 12/31/2016

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	3,215,946	157,004,486	0.020483				
2.	Recovery Room							
3.	Delivery and Labor Room	1,928,333	18,165,230	0.106155				
4.	Anesthesiology							
5.	Radiology - Diagnostic	503,249	53,347,399	0.009433				
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	11,650	9,016,112	0.001292				
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	103,155	19,601,012	0.005263				
17.	EEG	2,245,015	4,564,027	0.491893				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	424,418	246,314,350	0.001723				
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery	2,808,597	9,899,097	0.283723				
23.	WVSC	926,727	103,895,244	0.008920				
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab	1,796,870	106,078,215	0.016939				
28.	O/P Psych Therapy							
29.	Cardiac Rehab.							
30.	Implant Devices							
31.	Patient Nutrition							
32.	Wound Clinic							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4) (1)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (2)	Professional Component Cost Per Diem (Col. 1 / Col. 2) (3)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4) (4)	Outpatient Program Charges (BHF Page 3, Col. 5) (5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4) (6)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5) (7)
	Routine Service Cost Centers							
47.	Adults and Pediatrics	53,328	58,018	0.92				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	539,067	3,852	139.94				
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 Charge:**

Preliminary

Medicare Provider Number: 15-0023		Medicaid Provider Number: 20003	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2016 To: 12/31/2016	
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)		
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)		
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)		

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)		
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Intensive Care-Nursery		
	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)		
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		
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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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

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.	Balance Due Provider / (State Agency) * (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: 15-0023		Medicaid Provider Number: 20003	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2016 To: 12/31/2016	

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)	
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	Sum of Columns 1 - 4
		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 Charge

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(1)	(2A)	(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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2016 To: 12/31/2016

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of G M E Cost to Charges (Col. 1 / Col. 2) (3)	Inpatient Program Charges (BHF Page 3, Col. 4) (4)	Outpatient Program Charges (BHF Page 3, Col. 5) (5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4) (6)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5) (7)
Inpatient Ancillary Centers								
1.	Operating Room	200,699	157,004,486	0.001278				
2.	Recovery Room							
3.	Delivery and Labor Room	457,408	18,165,230	0.025180				
4.	Anesthesiology							
5.	Radiology - Diagnostic	70,011	53,347,399	0.001312				
6.	Radiology - Therapeutic	32,672	38,684,121	0.000845				
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	70,011	12,153,254	0.005761				
13.	Physical Therapy	4,667	11,604,203	0.000402				
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	4,667	19,601,012	0.000238				
17.	EEG	14,002	4,564,027	0.003068				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	65,344	246,314,350	0.000265				
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery							
23.	WVSC							
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab	23,337	106,078,215	0.000220				
28.	O/P Psych Therapy	149,358	6,812,335	0.021925				
29.	Cardiac Rehab.							
30.	Implant Devices							
31.	Patient Nutrition	9,335	223,008	0.041859				
32.	Wound Clinic	79,346	5,778,097	0.013732				
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Centers								
43.	Clinic	728,120	797,668	0.912811				
44.	Emergency	490,081	124,751,734	0.003928				
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 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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25) (1)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8) (2)	GME Cost Per Diem (Col. 1 / Col. 2) (3)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4) (4)	Outpatient Program Charges (BHF Page 3, Col. 5) (5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4) (6)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5) (7)
47.	Adults and Pediatrics	1,712,949	58,018	29.52				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	42,007	3,852	10.91				
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)							

