

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: St. Marys Medical Center		Medicare Provider Number: 15-0100
Street: 3700 Washington Ave.		Medicaid Provider Number: 5038
City: Evansville	State: Indiana	Zip: 47714-0541
Period Covered by Statement:	From: 07/01/2016	To: 06/30/2017

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	<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	<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 Rehab	<input type="checkbox"/> _____
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> _____

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)) St. Marys Medical Center 5038 for the cost report beginning 07/01/2016 and ending 06/30/2017 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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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	294	107,310		47,893	44.63%		15,992	4.23
2.	Psych	14	5,110		4,296	84.07%		702	6.12
3.	Rehab	24	8,760		5,121	58.46%		373	13.73
4.	Other (Sub)								
5.	Intensive Care Unit	62	22,630		12,783	56.49%			
6.	Coronary Care Unit	9	3,285		1,241	37.78%			
7.	NICU	40	14,600		5,703	39.06%			
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				2,686				
22.	Total	443	161,695		79,723	49.30%		17,067	4.51
23.	Observation Bed Days				7,228				

Part II-Program									
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				31				
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.	Total				31	0.04%			

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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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	84,807,644	291,876,964	0.290560				
2.	Recovery Room	3,553,716	30,198,091	0.117680				
3.	Delivery and Labor Room	5,579,371	11,810,217	0.472419				
4.	Anesthesiology	168,993	20,445,309	0.008266				
5.	Radiology - Diagnostic	11,271,772	72,790,459	0.154852	447		69	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	4,084,071	37,794,860	0.108059				
8.	Laboratory	20,489,424	103,047,717	0.198834	2,059		409	
9.	Blood							
10.	Blood - Administration	2,173,147	7,596,356	0.286078	983		281	
11.	Intravenous Therapy	6,035,835	20,926,675	0.288428	1,176		339	
12.	Respiratory Therapy	5,448,696	13,838,502	0.393735	3,140		1,236	
13.	Physical Therapy	5,623,595	17,968,153	0.312976	20,435		6,396	
14.	Occupational Therapy	2,466,812	11,194,764	0.220354	22,025		4,853	
15.	Speech Pathology	789,911	4,085,484	0.193346	14,177		2,741	
16.	EKG	2,606,435	62,117,393	0.041960				
17.	EEG	1,372,294	10,560,821	0.129942				
18.	Med. / Surg. Supplies	11,758,881	115,899,259	0.101458	2,607		265	
19.	Drugs Charged to Patients	35,631,273	176,655,463	0.201699	16,777		3,384	
20.	Renal Dialysis	1,620,697	3,762,411	0.430760				
21.	Ambulance	8,036,029	17,601,442	0.456555				
22.	Ultrasound	1,185,258	17,956,294	0.066008	1,174		77	
23.	CT Scan	2,601,951	57,026,491	0.045627				
24.	Cardiac Cath Lab	5,244,845	92,818,026	0.056507				
25.	MRI	1,375,378	19,653,745	0.069980				
26.	Cardiac Rehab	1,685,825	1,329,916	1.267618				
27.	Diabetic Education	420,192						
28.	Impl.Devices	21,926,460	130,493,776	0.168027				
29.	ECT	230,658	2,899,953	0.079539				
30.	Mobile Clinic	1,636,116	837,262	1.954127				
31.	Outpatient Psych							
32.	Bariatrics							
33.	Diagn.Treatm. Cntr	4,038,786	27,400,821	0.147397				
34.	DME	4,443,211	7,813,400	0.568665				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	1,542,525	5,520,770	0.279404				
44.	Emergency	14,901,502	135,182,187	0.110233				
45.	Observation	6,230,608	11,536,398	0.540083				
46.	Total				85,000		20,050	

* 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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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)	47,514,890	4,359,754	5,437,460	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	55,121	4,296	5,121	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	862.01	1,014.84	1,061.80	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			31	
3.	Program general inpatient routine cost (Line 1c X Line 2)			32,916	
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)			32,916	

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	17,786,574	12,783	1,391.42		
9.	Coronary Care Unit	2,610,812	1,241	2,103.80		
10.	NICU	6,472,836	5,703	1,134.99		
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	1,511,161	2,686	562.61		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					20,050
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					52,966

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

Preliminary

Medicare Provider Number: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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.	Total (Sum of Lines 22 and 26)								

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

Preliminary

Medicare Provider Number: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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	588,624	291,876,964	0.002017				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,822,914	20,445,309	0.186982				
5.	Radiology - Diagnostic	1,009,861	72,790,459	0.013874	447		6	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	12,298	37,794,860	0.000325				
8.	Laboratory	340,974	103,047,717	0.003309	2,059		7	
9.	Blood							
10.	Blood - Administration	2,640	7,596,356	0.000348	983			
11.	Intravenous Therapy	517,109	20,926,675	0.024711	1,176		29	
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	93,156	62,117,393	0.001500				
17.	EEG	27,200	10,560,821	0.002576				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	3,212	17,601,442	0.000182				
22.	Ultrasound							
23.	CT Scan	9,046	57,026,491	0.000159				
24.	Cardiac Cath Lab	36,843	92,818,026	0.000397				
25.	MRI							
26.	Cardiac Rehab							
27.	Diabetic Education							
28.	Impl.Devices							
29.	ECT							
30.	Mobile Clininc	100,919	837,262	0.120535				
31.	Outpatient Psych							
32.	Bariatrics							
33.	Diagn.Treatm. Cntr							
34.	DME							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	31,923	5,520,770	0.005782				
44.	Emergency	4,185,875	135,182,187	0.030965				
45.	Observation							
46.	Ancillary Total						42	

* 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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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	241,120	5,121	47.08	31		1,459	
50.	Other (Sub)							
51.	Intensive Care Unit							
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.	Routine Total (lines 47-66)						1,459	
68.	Ancillary Total (from line 46)						42	
69.	Total (Lines 67-68)						1,501	

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

Preliminary

Medicare Provider Number: 15-0100		Medicaid Provider Number: 5038	
Program: Medicaid Hospital		Period Covered by Statement: From: 07/01/2016 To: 06/30/2017	
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)	52,966	
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)	1,501	
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)	54,467	
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)	85,000	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	30,132	
	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.	Total Charges for Patient Services (Sum of Lines 9 through 11)	115,132	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		60,665
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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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)	54,467	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	54,467	
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)	54,467	

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.

Preliminary

Medicare Provider Number: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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)	60,665
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)		
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)
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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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							
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.	Ultrasound							
23.	CT Scan							
24.	Cardiac Cath Lab							
25.	MRI							
26.	Cardiac Rehab							
27.	Diabetic Education							
28.	Impl.Devices							
29.	ECT							
30.	Mobile Clininc							
31.	Outpatient Psych							
32.	Bariatrics							
33.	Diagn.Treatm. Cntr							
34.	DME							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary 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 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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

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	698,088	55,121	12.66				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
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.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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

Preliminary

Medicare Provider Number: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2016 To: 06/30/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	31		31
Newborn Days			
Total Inpatient Revenue	115,132		115,132
Ancillary Revenue	85,000		85,000
Routine Revenue	30,132		30,132
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Total costs/total charges agree with as filed W/S C
GME costs were adjusted to agree with as filed W/S B Part 1, column 25
