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: 01/01/2018	To: 12/31/2018

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
	Corporation		Partnership		City		Hospital District
XXXX XXXX	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

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

XXXX XXXX	Medicaid Hospital		Medicaid Sub II Rehab		
	Medicaid Sub I Psych		Medicaid Sub III Other		

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Methodist Medical Center of Il 16006 for the cost report beginning 01/01/2018 and ending 12/31/2018 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):		Signed (Officer or Administrator of Provider(s)):
Name (Typewritten)		Name (Typewritten)
Title	Date	Title
Firm		Date
Telephone Number		Telephone Number
Email Address		Email Address

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

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	174	63,510		40,784	64.22%		12,396	3.73
2.	Psych	44	16,060		13,016	81.05%		2,308	5.64
3.	Rehab	38	13,870		5,501	39.66%		437	12.59
4.	Other (Sub)								
5.	Intensive Care Unit	12	4,380		2,712	61.92%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		2,771	63.26%			
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		3,918	53.67%			
22.	**Total**	**300**	**109,500**		**68,702**	**62.74%**		**15,141**	**4.28**
23.	Observation Bed Days				4,598				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,318			860	1.82
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				244				
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				1,237				
22.	**Total**				**2,799**	**4.07%**		**860**	**1.82**

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 **BHF Page 3**

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	34,840,197	159,747,500	0.218095	2,179,048		475,239	
2.	Recovery Room	4,396,883	35,141,842	0.125118	283,165		35,429	
3.	Delivery and Labor Room	3,334,620	10,462,286	0.318728	1,158,720		369,317	
4.	Anesthesiology	3,839,600	52,630,934	0.072953	592,953		43,258	
5.	Radiology - Diagnostic	11,918,261	44,835,667	0.265821	455,410		121,058	
6.	Radiology - Therapeutic	4,396,584	20,871,654	0.210649	43,807		9,228	
7.	Nuclear Medicine	2,561,375	15,346,213	0.166906	35,320		5,895	
8.	Laboratory	23,454,531	236,101,683	0.099341	2,529,912		251,324	
9.	Blood							
10.	Blood - Administration	1,237,540	5,331,358	0.232125	180,973		42,008	
11.	Intravenous Therapy	5,637,734	24,129,750	0.233642	232,873		54,409	
12.	Respiratory Therapy	2,603,371	28,220,911	0.092250	675,719		62,335	
13.	Physical Therapy	3,523,114	11,928,315	0.295357	73,065		21,580	
14.	Occupational Therapy	1,125,805	3,746,643	0.300484	23,211		6,975	
15.	Speech Pathology	929,181	2,734,714	0.339773	253,829		86,244	
16.	EKG	390,689	7,763,754	0.050322	104,461		5,257	
17.	EEG	1,935,608	11,020,913	0.175630	50,972		8,952	
18.	Med. / Surg. Supplies	2,546,764	72,558,644	0.035099	970,149		34,051	
19.	Drugs Charged to Patients	24,334,148	74,146,213	0.328191	1,741,662		571,598	
20.	Renal Dialysis	744,196	2,479,661	0.300120	135,790		40,753	
21.	Ambulance							
22.	Pain Clinic	217,390	185,216	1.173711				
23.	Northside Imaging	670,295	2,628,366	0.255023				
24.	Northside Mammography	464,778	1,934,058	0.240312				
25.	Northside Ultrasound	210,367	1,103,746	0.190594				
26.	Implant Devices	20,288,711	59,042,068	0.343631	291,817		100,277	
27.	Pulmonary Function	1,813,451	3,411,571	0.531559	71,435		37,972	
28.	Cardiac Cath	1,227,258	33,609,322	0.036515	408,766		14,926	
29.	CT Scan	1,238,519	69,708,303	0.017767	887,809		15,774	
30.	Northside CT	473,543	8,572,458	0.055240				
31.	MRI	1,165,327	22,858,589	0.050980	218,688		11,149	
32.	Northside MRI	677,217	8,025,309	0.084385				
33.	Cardiology	1,874,973	15,457,136	0.121301	271,019		32,875	
34.	Psych-Part Hospital	777,173	3,218,447	0.241475				
35.	GI	1,626,762	21,785,706	0.074671	96,964		7,240	
36.	Cardiac Rehab	8,732	1,000	8.732000				
37.	Hyperbaric Oxygen	848,414	1,104,646	0.768042				
38.	Other Clinics	4,532,168	8,577,595	0.528373				
39.	Chilli Family Psysic	2,212,083						
40.	Physician Offices	32,550,405	27,727,459	1.173941				
41.	Endocrinology,Diabetic	677,978	2,650,693	0.255774				
42.	Wound Care Center	1,186,548	4,279,199	0.277283				
	Outpatient Service Cost Centers							
43.	Clinic	7,500,159	23,513,731	0.318969	362,829		115,731	
44.	Emergency	10,668,899	82,736,051	0.128951	374,232		48,258	
45.	Observation	4,636,393	7,166,913	0.646916	42,364		27,406	
46.	**Total**				**14,746,962**		**2,656,518**	

* 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-Hospital	From:	01/01/2018	To:	12/31/2018

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)	45,760,375	11,713,121	3,494,507	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	45,382	13,016	5,501	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,008.34	899.90	635.25	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,318			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,328,992			
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)	1,328,992			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	8,019,095	2,712	2,956.89	244	721,481
9.	Coronary Care Unit					
10.	Surgical ICU	1,134,025	2,771	409.25		
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	2,166,319	3,918	552.91	1,237	683,950
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,656,518
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**5,390,941**

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

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	1,111,194	159,747,500	0.006956	2,179,048		15,157	
2.	Recovery Room							
3.	Delivery and Labor Room	1,374,500	10,462,286	0.131377	1,158,720		152,229	
4.	Anesthesiology	5,058,697	52,630,934	0.096116	592,953		56,992	
5.	Radiology - Diagnostic	179,662	44,835,667	0.004007	455,410		1,825	
6.	Radiology - Therapeutic	601,339	20,871,654	0.028811	43,807		1,262	
7.	Nuclear Medicine							
8.	Laboratory	454,101	236,101,683	0.001923	2,529,912		4,865	
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.	Pain Clinic							
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	Implant Devices							
27.	Pulmonary Function							
28.	Cardiac Cath							
29.	CT Scan							
30.	Northside CT							
31.	MRI							
32.	Northside MRI							
33.	Cardiology							
34.	Psych-Part Hospital							
35.	GI							
36.	Cardiac Rehab	926	1,000	0.926000				
37.	Hyperbaric Oxygen							
38.	Other Clinics	7,654,787	8,577,595	0.892416				
39.	Chilli Family Psysic	1,140,709		#DIV/0!				
40.	Physician Offices	33,207,773	27,727,459	1.197649				
41.	Endocrinology,Diabetic	577,910	2,650,693	0.218022				
42.	Wound Care Center	388,377	4,279,199	0.090759				
	Outpatient Ancillary Cost Centers							
43.	Clinic	177,041	23,513,731	0.007529	362,829		2,732	
44.	Emergency	7,186,072	82,736,051	0.086855	374,232		32,504	
45.	Observation							
46.	**Ancillary Total**						**267,566**	

* 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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	866,386	45,382	19.09	1,318		25,161	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,222	2,712	0.45	244		110	
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	902,978	3,918	230.47	1,237		285,091	
67.	**Routine Total (lines 47-66)**						**310,362**	
68.	**Ancillary Total (from line 46)**						**267,566**	
69.	**Total (Lines 67-68)**						**577,928**	

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charges

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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)	5,390,941	
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)	577,928	
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)	150,540	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**6,119,409**	
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)	14,746,962	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,686,145	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,139,094	
	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	1,768,082	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	20,340,283	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		14,220,874
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: 14-0209	Medicaid Provider Number: 16006	
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018	To: 12/31/2018

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)	6,119,409	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,119,409	
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)**	**6,119,409**	

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: 14-0209	Medicaid Provider Number: 16006	
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018	To: 12/31/2018

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)	14,220,874
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended to (1)	to (2)	to (3)	Current Cost Reporting Period (4)	Sum of Columns 1 - 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) (1)	Inpatient Ratio (2A)	Inpatient Amount (Col. 1x2A) (2B)	Outpatient Ratio (3A)	Outpatient Amount (Col. 1x3A) (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: **14-0209**	**Medicaid Provider Number:** **16006**
Program: **Medicaid-Hospital**	**Period Covered by Statement:** **From: 01/01/2018 To: 12/31/2018**

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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	464,767	159,747,500	0.002909	2,179,048		6,339	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	91,215	44,835,667	0.002034	455,410		926	
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.	Pain Clinic	65,154	185,216	0.351773				
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	Implant Devices							
27.	Pulmonary Function							
28.	Cardiac Cath							
29.	CT Scan							
30.	Northside CT							
31.	MRI							
32.	Northside MRI							
33.	Cardiology							
34.	Psych-Part Hospital							
35.	GI	62,114	21,785,706	0.002851	96,964		276	
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Other Clinics							
39.	Chilli Family Psysic							
40.	Physician Offices	4,838,787	27,727,459	0.174512				
41.	Endocrinology,Diabetic							
42.	Wound Care Center	13,031	4,279,199	0.003045				
	Outpatient Ancillary Centers							
43.	Clinic	4,195,932	23,513,731	0.178446	362,829		64,745	
44.	Emergency	430,018	82,736,051	0.005197	374,232		1,945	
45.	Observation							
46.	**Ancillary Total**						**74,231**	

* 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: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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	1,128,906	45,382	24.88	1,318		32,792	
48.	Psych	497,344	13,016	38.21				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	395,269	2,712	145.75	244		35,563	
52.	Coronary Care Unit							
53.	Surgical ICU	18,243	2,771	6.58				
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	25,193	3,918	6.43	1,237		7,954	
67.	**Routine Total (lines 47-66)**						**76,309**	
68.	**Ancillary Total (from line 46)**						**74,231**	
69.	**Total (Lines 67-68)**						**150,540**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue
PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,562		1,562
Newborn Days	1,237		1,237
Total Inpatient Revenue	20,340,283		20,340,283
Ancillary Revenue	14,746,962		14,746,962
Routine Revenue	5,593,321		5,593,321
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes: