

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: Memorial Medical Center		Medicare Provider Number: 14-0148
Street: 701 North First Street		Medicaid Provider Number: 19006
City: Springfield	State: Illinois	Zip: 62781
Period Covered by Statement:	From: 10/01/2017	To: 09/30/2018

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 type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> XXXX XXXX Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> XXXX XXXX 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"/> XXXX XXXX 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)) Memorial Medical Center 19006 for the cost report beginning 10/01/2017 and ending 09/30/2018 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)
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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	351	127,933		90,230	70.53%		21,630	4.76
2.	Psych	36	13,140		10,391	79.08%		1,306	7.96
3.	Rehab	30	10,950		6,049	55.24%		540	11.20
4.	Other (Sub)								
5.	Intensive Care Unit	37	13,505		10,640	78.79%			
6.	Coronary Care Unit								
7.	Burn Unit	9	3,285		2,011	61.22%			
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	24	8,696		2,454	28.22%			
22.	Total	487	177,509		121,775	68.60%		23,476	5.08
23.	Observation Bed Days				1,632				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				941			74	12.72
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Burn Unit								
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				941	0.77%		74	12.72

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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	65,630,816	313,436,711	0.209391	4,465		935	
2.	Recovery Room							
3.	Delivery and Labor Room	4,063,606	11,312,181	0.359224				
4.	Anesthesiology	6,383,697	53,397,001	0.119552	2,167		259	
5.	Radiology - Diagnostic	35,793,294	396,514,811	0.090270	95,814		8,649	
6.	Radiology - Therapeutic	6,703,102	57,220,559	0.117145	106,490		12,475	
7.	Nuclear Medicine							
8.	Laboratory	35,295,232	205,000,798	0.172171	97,008		16,702	
9.	Blood							
10.	Blood - Administration	4,372,758	14,719,307	0.297076	2,392		711	
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,978,705	72,096,037	0.110668	179,671		19,884	
13.	Physical Therapy	13,882,060	37,431,576	0.370865	726,307		269,362	
14.	Occupational Therapy	3,081,888	11,687,440	0.263692	648,599		171,030	
15.	Speech Pathology	1,368,605	3,681,636	0.371738	187,255		69,610	
16.	EKG	25,710,732	211,303,774	0.121677	3,416		416	
17.	EEG	1,538,962	5,070,709	0.303500	4,795		1,455	
18.	Med. / Surg. Supplies	43,898,676	216,419,704	0.202840	60,432		12,258	
19.	Drugs Charged to Patients	48,476,075	200,971,441	0.241209	203,304		49,039	
20.	Renal Dialysis	2,608,146	13,398,772	0.194656	9,211		1,793	
21.	Ambulance							
22.	GI Diagnostic	6,265,396	30,622,950	0.204598				
23.	Vascular Lab	2,357,717	15,055,928	0.156597	11,452		1,793	
24.	Ambulatory Surgery	8,495,999	46,973,356	0.180868				
25.	Kidney Acquisition	1,649,172						
26.	Pancreas Acquisition							
27.	Renal Transplant	655,248	455,887	1.437304				
28.	Cardiac Rehab							
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							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	27,484,904	130,423,319	0.210736				
45.	Observation	1,575,239	3,343,542	0.471129				
46.	Total				2,342,778		636,371	

* 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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	88,509,220	10,535,773	4,308,036	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	91,862	10,391	6,049	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	963.50	1,013.93	712.19	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			941	
3.	Program general inpatient routine cost (Line 1c X Line 2)			670,171	
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)			670,171	

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	17,306,433	10,640	1,626.54		
9.	Coronary Care Unit					
10.	Burn Unit	3,241,984	2,011	1,612.13		
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	1,515,519	2,454	617.57		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					636,371
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,306,542

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

Preliminary

Medicare Provider Number: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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.	Burn Unit						
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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	252,754	313,436,711	0.000806	4,465		4	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	13,086,893	53,397,001	0.245087	2,167		531	
5.	Radiology - Diagnostic	462,093	396,514,811	0.001165	95,814		112	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	309,273	205,000,798	0.001509	97,008		146	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,614	72,096,037	0.000133	179,671		24	
13.	Physical Therapy	1,867	37,431,576	0.000050	726,307		36	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	324,171	211,303,774	0.001534	3,416		5	
17.	EEG	178	5,070,709	0.000035	4,795			
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	8,200	13,398,772	0.000612	9,211		6	
21.	Ambulance							
22.	GI Diagnostic	1,325	30,622,950	0.000043				
23.	Vascular Lab	819	15,055,928	0.000054	11,452		1	
24.	Ambulatory Surgery							
25.	Kidney Acquisition							
26.	Pancreas Acquisition							
27.	Renal Transplant	672	455,887	0.001474				
28.	Cardiac Rehab							
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							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	179	130,423,319	0.000001				
45.	Observation							
46.	Ancillary Total						865	

* 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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	90,107	91,862	0.98				
48.	Psych	17,000	10,391	1.64				
49.	Rehab	406	6,049	0.07	941		66	
50.	Other (Sub)							
51.	Intensive Care Unit	1,646,654	10,640	154.76				
52.	Coronary Care Unit							
53.	Burn Unit							
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	5,423	2,454	2.21				
67.	Routine Total (lines 47-66)						66	
68.	Ancillary Total (from line 46)						865	
69.	Total (Lines 67-68)						931	

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

Preliminary

Medicare Provider Number: 14-0148		Medicaid Provider Number: 19006	
Program: Medicaid Hospital		Period Covered by Statement: From: 10/01/2017 To: 09/30/2018	
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)	1,306,542	
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)	931	
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)	5,084	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,312,557	
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)	2,342,778	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	1,223,477	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Burn Unit		
	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)	3,566,255	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,253,698
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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	1,312,557	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,312,557	
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)	1,312,557	

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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	2,253,698
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 (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.	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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	3,558,397	313,436,711	0.011353	4,465		51	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	707,748	396,514,811	0.001785	95,814		171	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	108,129	72,096,037	0.001500	179,671		270	
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.	GI Diagnostic							
23.	Vascular Lab							
24.	Ambulatory Surgery							
25.	Kidney Acquisition							
26.	Pancreas Acquisition							
27.	Renal Transplant							
28.	Cardiac Rehab							
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							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	872,047	130,423,319	0.006686				
45.	Observation							
46.	Ancillary Total						492	

* 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: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	6,076,394	91,862	66.15				
48.	Psych	984,387	10,391	94.73				
49.	Rehab	29,489	6,049	4.88	941		4,592	
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn Unit							
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)						4,592	
68.	Ancillary Total (from line 46)						492	
69.	Total (Lines 67-68)						5,084	

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

Preliminary

Medicare Provider Number: 14-0148	Medicaid Provider Number: 19006
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	941		941
Newborn Days			
Total Inpatient Revenue	3,566,255		3,566,255
Ancillary Revenue	2,342,778		2,342,778
Routine Revenue	1,223,477		1,223,477
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 agree with as filed W/S S-3 (Provider included Labor & Delivery Days)
- BHF Page 2, Part I - Adjusted Total Adults & Peds, ICU, Burn Unit, and Nursery days to account for days in Children's Hospital.
- BHF Page 3 - Adjusted total costs in Column 1 to agree with as filed W/S C Part 1, column 1.
- BHF Page 3 - Reclassified Blood to Blood Administration
- BHF Page 7, Part II, line 10a - combined line 10a and 10b
- BHF Page 6 (a) - Anesthesiology - Column 1 includes CRNA costs from W/S A-8, lines 38.03, 38.04, 38.05, and 38.07.
- BHF Page 3 Kidney Acquisition Dept. Charges reported were offset since not found on Medicare Worksheet C part I.
- BHF Page 2 - Adjusted A&P Discharges to agree with filed W/S S-3

Costs for Adults & Peds, ICU, Burn Unit, and Nursery are allocated between Acute Hospital and Children's Hospital for:
costs on BHF page 4, costs on BHF page 6, and for GME costs on BHF Supplement No. 2(b)