

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: Deaconess Hospital		Medicare Provider Number: 15-0082	
Street: 600 Mary Street		Medicaid Provider Number: 5035	
City: Evansville	State: IN	Zip: 47747	
Period Covered by Statement:	From: 10/01/2018	To: 09/30/2019	

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 <small>XXXX XXXX</small>	<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 type="checkbox"/> General Short-Term <small>XXXX XXXX</small>	<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 <small>XXXX XXXX</small>	<input 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)) Deaconess Hospital 5035 for the cost report beginning 10/01/2018 and ending 09/30/2019 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.

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part I-Hospital									
1.	Adults and Pediatrics	456	168,904		121,164	71.74%		32,144	4.46
2.	Psych	16	5,840		3,518	60.24%		405	8.69
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	67	24,455		17,918	73.27%			
6.	Coronary Care Unit	16	5,840		4,418	75.65%			
7.	Other								
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	555	205,039		147,018	71.70%		32,549	4.52
23.	Observation Bed Days				9,822				

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
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part II-Program									
1.	Adults and Pediatrics				579			144	6.21
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				253				
6.	Coronary Care Unit				62				
7.	Other								
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				894	0.61%		144	6.21

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	102,450,181	468,339,955	0.218752	936,741		204,914	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	17,488,446	143,119,766	0.122194	278,124		33,985	
6.	Radiology - Therapeutic	10,587,942	65,602,811	0.161395	16,027		2,587	
7.	Nuclear Medicine	3,136,705	28,460,894	0.110211	35,275		3,888	
8.	Laboratory	48,476,639	233,064,665	0.207997	598,703		124,528	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	2,819,076	7,696,236	0.366293	76,282		27,942	
12.	Respiratory Therapy	7,922,891	91,439,236	0.086647	775,734		67,215	
13.	Physical Therapy	12,028,269	80,221,615	0.149938	282,952		42,425	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	5,706,124	67,740,971	0.084234	107,762		9,077	
17.	EEG							
18.	Med. / Surg. Supplies	10,030,596	39,680,538	0.252784	125,284		31,670	
19.	Drugs Charged to Patients	92,017,377	376,337,819	0.244507	1,229,769		300,687	
20.	Renal Dialysis	1,876,587	10,782,765	0.174036	87,174		15,171	
21.	Ambulance							
22.	Wound Care Center	2,106,908	10,581,025	0.199121	3,732		743	
23.	Family Practice Clinic	1,924,277	4,507,595	0.426897				
24.	Chemo	2,777,119	26,340,525	0.105431				
25.	Primary Care Seniors	1,745,731	2,276,142	0.766969				
26.	Behavioral Health							
27.	OP Psychiatric	1,210,897	4,939,070	0.245167				
28.	Cath Lab	17,029,786	113,053,352	0.150635	434,043		65,382	
29.	Other							
30.	Implant Devices	31,372,748	91,059,721	0.344529	347,268		119,644	
31.	Pain Management	4,575,382	38,643,255	0.118401				
32.	Sleep Center	3,354,782	9,860,355	0.340229				
33.	Hematology	1,010,372	4,018,588	0.251425				
34.	Durable Med Equip	11,739,721	33,506,008	0.350377				
35.	CT Scan	7,520,977	163,828,483	0.045908	362,913		16,661	
36.	MRI	5,293,176	50,173,494	0.105497	103,253		10,893	
37.	Multi Specialty Clinic	828,153	1,280,241	0.646873				
38.	Cardiac Rehab	1,053,964	3,897,511	0.270420				
39.	Pulmonary Rehab	44,747	1,310	34.158015				
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	3,455,440	4,985,038	0.693162				
44.	Emergency	31,539,044	261,509,858	0.120604	548,634		66,167	
45.	Observation	16,332,192	32,781,871	0.498208	23,611		11,763	
46.	Total				6,373,281		1,155,342	

* 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.

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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)	110,548,085	1,921,567		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	130,986	3,518		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	843.97	546.21		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	579			
3.	Program general inpatient routine cost (Line 1c X Line 2)	488,659			
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)	488,659			

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	23,323,828	17,918	1,301.70	253	329,330	
9.	Coronary Care Unit	5,681,781	4,418	1,286.05	62	79,735	
10.	Other						
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						
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)						1,155,342
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)						2,053,066

Hospital Statement of Cost

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

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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.	Other						
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)								

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

Line No.	Cost Centers	Professional Component	Total Dept. Charges	Ratio of Professional	Inpatient Program	Outpatient Program	Inpatient Program	Outpatient Program
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S C, Pt. 1, Col. 8)*	to Charges (Col. 1 / Col. 2)	Charges (BHF Page 3, Col. 4)	Charges (BHF Page 3, Col. 5)	Expenses for H B P (Col. 3 X Col. 4)	Expenses for H B P (Col. 3 X Col. 5)
Inpatient Ancillary Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	13,960,170	468,339,955	0.029808	936,741		27,922	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	142,592	233,064,665	0.000612	598,703		366	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	35,096	91,439,236	0.000384	775,734		298	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	597,483	67,740,971	0.008820	107,762		950	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Wound Care Center	214,735	10,581,025	0.020294	3,732		76	
23.	Family Practice Clinic	172,832	4,507,595	0.038342				
24.	Chemo							
25.	Primary Care Seniors	1,205,118	2,276,142	0.529456				
26.	Behavioral Health							
27.	OP Psychiatric							
28.	Cath Lab							
29.	Other							
30.	Implant Devices							
31.	Pain Management	627,622	38,643,255	0.016241				
32.	Sleep Center	1,252,514	9,860,355	0.127025				
33.	Hematology	9,636	4,018,588	0.002398				
34.	Durable Med Equip							
35.	CT Scan							
36.	MRI							
37.	Multi Specialty Clinic	228,384	1,280,241	0.178391				
38.	Cardiac Rehab							
39.	Pulmonary Rehab							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic	152,954	4,985,038	0.030683				
44.	Emergency	12,189,837	261,509,858	0.046613	548,634		25,573	
45.	Observation							
46.	Ancillary Total						55,185	

* 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.

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

Line No.	Cost Centers	Professional Component	Total Days Including Private	Professional Component Cost Per Diem	Program Days Including Private	Outpatient Program Charges	Inpatient Program Expenses	Outpatient Program Expenses
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	(Col. 1 / Col. 2)	(BHF Pg. 2 Pt. II, Col. 4)	(BHF Page 3, Col. 5)	for H B P (Col. 3 X Col. 4)	for H B P (Col. 3 X Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	24,616,649	130,986	187.93	579		108,811	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
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)						108,811	
68.	Ancillary Total (from line 46)						55,185	
69.	Total (Lines 67-68)						163,996	

Computation of Lesser of Reasonable Cost or Customary Charges

PRELIMINARY

Medicare Provider Number: 15-0082		Medicaid Provider Number: 5035	
Program: Medicaid-Hospital		Period Covered by Statement: From: 10/01/2018 To: 09/30/2019	
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)	2,053,066	
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)	163,996	
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)	12,746	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	2,229,808	
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)	6,373,281	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	777,630	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	992,374	
	F. Coronary Care Unit	261,588	
	G. Other		
	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)	8,404,873	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		6,175,065
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)		

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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)	2,229,808	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,229,808	
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)	2,229,808	

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: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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)	6,175,065
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)
			(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

Teaching Physicians / Routine Services Questionnaire

PRELIMINARY

Medicare Provider Number: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

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	392,498	468,339,955	0.000838	936,741		785	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	33,125	143,119,766	0.000231	278,124		64	
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.	Wound Care Center							
23.	Family Practice Clinic	1,563,238	4,507,595	0.346801				
24.	Chemo							
25.	Primary Care Seniors	74,391	2,276,142	0.032683				
26.	Behavioral Health							
27.	OP Psychiatric							
28.	Cath Lab	66,527	113,053,352	0.000588	434,043		255	
29.	Other							
30.	Implant Devices							
31.	Pain Management	24,427	38,643,255	0.000632				
32.	Sleep Center							
33.	Hematology							
34.	Durable Med Equip							
35.	CT Scan							
36.	MRI							
37.	Multi Specialty Clinic							
38.	Cardiac Rehab							
39.	Pulmonary Rehab							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	288,868	261,509,858	0.001105	548,634		606	
45.	Observation							
46.	Ancillary Total						1,710	

* 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: 15-0082	Medicaid Provider Number: 5035
Program: Medicaid-Hospital	Period Covered by Statement: From: 10/01/2018 To: 09/30/2019

Line No.	Cost Centers	G M E	Total Days	GME	Program	Outpatient	Inpatient	Outpatient
		Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	Cost Per Diem (Col. 1 / Col. 2)	Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Program Charges (BHF Page 3, Col. 5)	Program Expenses for G M E (Col. 3 X Col. 4)	Program Expenses for G M E (Col. 3 X Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	2,261,075	130,986	17.26	579		9,994	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	73,836	17,918	4.12	253		1,042	
52.	Coronary Care Unit							
53.	Other							
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)						11,036	
68.	Ancillary Total (from line 46)						1,710	
69.	Total (Lines 67-68)						12,746	

