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. Vincent Evansville		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: 07/01/2018	To: 06/30/2019

Type of Control

Voluntary Nonprofit
- [ ] Church
- [XXXX] Corporation
- [ ] Other (Specify) ______

Proprietary
- [ ] Individual
- [ ] Partnership
- [ ] Corporation

Government (Non-Federal)
- [ ] State
- [ ] City
- [ ] County
- [ ] Township
- [ ] Hospital District
- [ ] Other (Specify) ______

Type of Hospital

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

Health Care Program

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

- [XXXX] Medicaid Hospital
- [ ] Medicaid Sub I Psych
- [ ] Medicaid Sub II Rehab
- [ ] 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)) St. Vincent Evansville 5038 for the cost report beginning 07/01/2018 and ending 06/30/2019 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):

Name (Typewritten)

Title

Date

Firm

Telephone Number

Email Address

Signed (Officer or Administrator of Provider(s)):

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:	Medicaid Provider Number:
15-0100	5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	292	106,580		37,935	35.59%		14,970	3.69
2.	Psych	14	5,110		3,994	78.16%		612	6.53
3.	Rehab	24	8,760		4,930	56.28%		387	12.74
4.	Other (Sub)								
5.	Intensive Care Unit	60	21,900		11,094	50.66%			
6.	Coronary Care Unit	8	2,920		1,170	40.07%			
7.	NICU	40	14,600		4,981	34.12%			
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				2,372				
22.	**Total**	**438**	**159,870**		**66,476**	**41.58%**		**15,969**	**4.01**
23.	Observation Bed Days				9,438				

Line No.	**Part II-Program**	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				428			211	4.99
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				150				
6.	Coronary Care Unit				3				
7.	NICU				471				
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				95				
22.	**Total**				**1,147**	**1.73%**		**211**	**4.99**

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: 07/01/2018	To: 06/30/2019

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)*	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	88,526,896	454,583,464	0.194743	1,397,263		272,107	
2.	Recovery Room	3,911,275	28,177,235	0.138810	121,446		16,858	
3.	Delivery and Labor Room	5,437,412	21,114,842	0.257516	184,810		47,592	
4.	Anesthesiology	132,931	36,273,010	0.003665	193,224		708	
5.	Radiology - Diagnostic	10,661,402	67,108,230	0.158869	104,521		16,605	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	4,128,175	34,776,772	0.118705	55,041		6,534	
8.	Laboratory	22,438,785	139,498,396	0.160853	407,574		65,560	
9.	Blood							
10.	Blood - Administration	2,113,175	12,161,460	0.173760	85,506		14,858	
11.	Intravenous Therapy	7,278,033	34,933,967	0.208337	111,900		23,313	
12.	Respiratory Therapy	5,868,955	17,360,958	0.338055	111,536		37,705	
13.	Physical Therapy	6,999,834	17,511,928	0.399718	94,103		37,615	
14.	Occupational Therapy	2,398,749	12,042,228	0.199195	102,940		20,505	
15.	Speech Pathology	873,181	4,322,382	0.202014	36,343		7,342	
16.	EKG	2,799,857	69,181,851	0.040471	215,349		8,715	
17.	EEG	1,182,707	8,372,566	0.141260	22,334		3,155	
18.	Med. / Surg. Supplies	5,976,127	105,598,620	0.056593	418,821		23,702	
19.	Drugs Charged to Patients	68,008,630	245,613,173	0.276893	632,971		175,265	
20.	Renal Dialysis	1,456,091	5,572,982	0.261277	45,280		11,831	
21.	Ambulance	5,231,681	5,019,797	1.042210				
22.	Ultrasound	1,029,085	17,646,692	0.058316	53,828		3,139	
23.	CT Scan	2,742,526	61,136,325	0.044859	175,633		7,879	
24.	Cardiac Cath Lab	5,992,883	155,195,410	0.038615	653,813		25,247	
25.	MRI	1,695,144	20,250,034	0.083711	35,894		3,005	
26.	Cardiac Rehab	1,900,195	1,839,769	1.032844				
27.	Diabetic Education							
28.	Impl.Devices	30,377,845	109,188,602	0.278214	547,829		152,414	
29.	ECT	230,864	2,711,168	0.085153	5,024		428	
30.	Mobile Clininc	946,978	674,607	1.403748	1		1	
31.	Outpatient Psych							
32.	Bariatrics							
33.	Diagn.Treatm. Cntr	4,048,407	28,288,640	0.143111	78,285		11,203	
34.	DME	4,092,328	8,741,733	0.468137	13		6	
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	1,579,873	4,141,242	0.381497	401		153	
44.	Emergency	13,604,757	123,101,589	0.110517	291,849		32,254	
45.	Observation	8,778,189	12,090,642	0.726032	36,389		26,420	
46.	**Total**				**6,219,921**		**1,052,119**	

* 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:
15-0100	5038
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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)	44,060,934	2,936,941	4,634,633	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	47,373	3,994	4,930	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	930.09	735.34	940.09	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	428			
3.	Program general inpatient routine cost (Line 1c X Line 2)	398,079			
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)	398,079			

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	16,640,076	11,094	1,499.92	150	224,988
9.	Coronary Care Unit	2,374,487	1,170	2,029.48	3	6,088
10.	NICU	6,460,618	4,981	1,297.05	471	610,911
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	1,598,492	2,372	673.90	95	64,021
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,052,119
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**2,356,206**

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: 07/01/2018 To: 06/30/2019

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.	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 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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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	823,166	454,583,464	0.001811	1,397,263		2,530	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,325,698	36,273,010	0.091685	193,224		17,716	
5.	Radiology - Diagnostic	1,334,154	67,108,230	0.019881	104,521		2,078	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	9,460	34,776,772	0.000272	55,041		15	
8.	Laboratory	340,972	139,498,396	0.002444	407,574		996	
9.	Blood							
10.	Blood - Administration	2,200	12,161,460	0.000181	85,506		15	
11.	Intravenous Therapy	484,632	34,933,967	0.013873	111,900		1,552	
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	89,278	69,181,851	0.001290	215,349		278	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound							
23.	CT Scan	4,100	61,136,325	0.000067	175,633		12	
24.	Cardiac Cath Lab	47,527	155,195,410	0.000306	653,813		200	
25.	MRI							
26.	Cardiac Rehab							
27.	Diabetic Education							
28.	Impl.Devices							
29.	ECT							
30.	Mobile Clininc	185,192	674,607	0.274518	1			
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	200	4,141,242	0.000048	401			
44.	Emergency	4,031,200	123,101,589	0.032747	291,849		9,557	
45.	Observation							
46.	**Ancillary Total**						**34,949**	

* 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: 07/01/2018 To: 06/30/2019

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	1,678,606	47,373	35.43	428		15,164	
48.	Psych	829,524	3,994	207.69				
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)**						**15,164**	
68.	**Ancillary Total (from line 46)**						**34,949**	
69.	**Total (Lines 67-68)**						**50,113**	

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	2,356,206	
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)	50,113	
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)	9,176	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**2,415,495**	
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)	6,219,921	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	413,418	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	215,015	
	F. Coronary Care Unit	28,742	
	G. NICU	81,577	
	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	22,398	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	6,981,071	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		4,565,576
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: 07/01/2018	To: 06/30/2019

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)	2,415,495	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,415,495	
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)**	**2,415,495**	

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.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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)	4,565,576
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)	(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)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(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)**					

Hospital Statement of Cost | **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number: 15-0100	**Medicaid Provider Number:** 5038		
Program: Medicaid Hospital	**Period Covered by Statement:** From: 07/01/2018		To: 06/30/2019

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: 15-0100	Medicaid Provider Number: 5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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							
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:	Medicaid Provider Number:
15-0100	5038
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2018 To: 06/30/2019

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	1,015,723	47,373	21.44	428		9,176	
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)**						**9,176**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**9,176**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,052		1,052
Newborn Days	95		95
Total Inpatient Revenue	6,958,706	22,365	6,981,071
Ancillary Revenue	6,219,954	(33)	6,219,921
Routine Revenue	738,752	22,398	761,150
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Did not include $33 in cardiac rehab as these charges aren't covered by Medicare
Blood reclassed to blood administration

BHF Page 7, Part II, Customary Charges - Provider did not report any customary charges for Nursery although
Nursery Program Days were reported on BHF Page 2. See attached worksheet for allocation.