

**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: 10/01/2018	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	<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 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 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 10/01/2018 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: 14-0148	Medicaid Provider Number: 19006
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)
<b>Part I-Hospital</b>									
1.	Adults and Pediatrics	341	124,617		90,230	72.41%		21,633	4.76
2.	Psych	36	13,140		10,391	79.08%		1,261	8.24
3.	Rehab	30	10,950		6,049	55.24%		524	11.54
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	22	8,327		2,454	29.47%			
22.	<b>Total</b>	<b>475</b>	<b>173,824</b>		<b>121,775</b>	<b>70.06%</b>		<b>23,418</b>	<b>5.10</b>
23.	Observation Bed Days				1,632				

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)
<b>Part II-Program</b>									
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				406			28	14.50
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.	<b>Total</b>				<b>406</b>	<b>0.33%</b>		<b>28</b>	<b>14.50</b>

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

Preliminary

Medicare Provider Number: <b>14-0148</b>	Medicaid Provider Number: <b>19006</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>10/01/2018</b> To: <b>09/30/2019</b>

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 (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	69,773,563	315,560,881	0.221110				
2.	Recovery Room							
3.	Delivery and Labor Room	3,812,413	11,683,691	0.326302				
4.	Anesthesiology	6,636,615	56,475,940	0.117512				
5.	Radiology - Diagnostic	37,964,777	424,133,494	0.089511	27,733		2,482	
6.	Radiology - Therapeutic	6,045,273	58,540,146	0.103267				
7.	Nuclear Medicine							
8.	Laboratory	38,018,371	215,697,049	0.176258	48,263		8,507	
9.	Blood							
10.	Blood - Administration	4,219,258	14,358,333	0.293854	1,339		393	
11.	Intravenous Therapy							
12.	Respiratory Therapy	8,991,566	75,098,573	0.119730	43,203		5,173	
13.	Physical Therapy	14,548,878	39,665,824	0.366786	285,652		104,773	
14.	Occupational Therapy	3,254,850	12,808,952	0.254107	250,499		63,654	
15.	Speech Pathology	1,445,031	4,220,582	0.342377	88,956		30,456	
16.	EKG	26,689,621	242,639,065	0.109997	9,630		1,059	
17.	EEG	1,748,282	6,054,858	0.288740				
18.	Med. / Surg. Supplies	44,152,370	245,552,170	0.179809	25,431		4,573	
19.	Drugs Charged to Patients	49,613,739	211,999,559	0.234028	80,006		18,724	
20.	Renal Dialysis	2,505,100	13,132,804	0.190751	8,290		1,581	
21.	Ambulance							
22.	GI Diagnostic	6,493,902	31,598,126	0.205515				
23.	Vascular Lab	2,556,126	15,703,749	0.162772	6,166		1,004	
24.	Ambulatory Surgery	10,110,025	48,635,605	0.207873				
25.	Kidney Acquisition	2,094,756	6,273,804	0.333889				
26.	Pancreas Acquisition							
27.	Renal Transplant	770,673	415,974	1.852695				
28.	Cardiac Rehab	2,005,500						
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							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic							
44.	Emergency	29,707,653	135,476,718	0.219282				
45.	Observation	2,887,982	5,878,467	0.491281				
46.	<b>Total</b>				<b>875,168</b>		<b>242,379</b>	

\* 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: 14-0148	Medicaid Provider Number: 19006
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)	96,972,766	10,572,201	4,849,215	
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)	1,055.64	1,017.44	801.66	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			406	
3.	Program general inpatient routine cost (Line 1c X Line 2)			325,474	
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)			325,474	

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	18,585,851	10,640	1,746.79		
9.	Coronary Care Unit					
10.	Burn Unit	3,333,579	2,011	1,657.67		
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	1,623,699	2,454	661.65		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					242,379
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>567,853</b>

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

Preliminary

Medicare Provider Number: <b>14-0148</b>	Medicaid Provider Number: <b>19006</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>10/01/2018</b> To: <b>09/30/2019</b>

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.	<b>Total (Sum of Lines 22 and 26)</b>								

Preliminary

Medicare Provider Number: <b>14-0148</b>	Medicaid Provider Number: <b>19006</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>10/01/2018</b> To: <b>09/30/2019</b>

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	77,619	315,560,881	0.000246				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	18,084,734	56,475,940	0.320220				
5.	Radiology - Diagnostic	460,350	424,133,494	0.001085	27,733		30	
6.	Radiology - Therapeutic	729	58,540,146	0.000012				
7.	Nuclear Medicine							
8.	Laboratory	629,864	215,697,049	0.002920	48,263		141	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,458	75,098,573	0.000019	43,203		1	
13.	Physical Therapy	84,335	39,665,824	0.002126	285,652		607	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	32,055	242,639,065	0.000132	9,630		1	
17.	EEG	16,048	6,054,858	0.002650				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	GI Diagnostic							
23.	Vascular Lab	9,910	15,703,749	0.000631	6,166		4	
24.	Ambulatory Surgery							
25.	Kidney Acquisition	12,180	6,273,804	0.001941				
26.	Pancreas Acquisition							
27.	Renal Transplant							
28.	Cardiac Rehab	9,017		#DIV/0!				
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	38,413	135,476,718	0.000284				
45.	Observation							
46.	Ancillary Total						784	

\* 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: 14-0148	Medicaid Provider Number: 19006
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. 4)	for H B P (Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	71,136	91,862	0.77				
48.	Psych	16,198	10,391	1.56				
49.	Rehab	604	6,049	0.10	406		41	
50.	Other (Sub)							
51.	Intensive Care Unit	1,983,878	10,640	186.45				
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	9,114	2,454	3.71				
67.	<b>Routine Total (lines 47-66)</b>						41	
68.	<b>Ancillary Total (from line 46)</b>						784	
69.	<b>Total (Lines 67-68)</b>						825	

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

<b>Medicare Provider Number:</b> 14-0148		<b>Medicaid Provider Number:</b> 19006	
<b>Program:</b> Medicaid Hospital		<b>Period Covered by Statement:</b> 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)	567,853	
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)	825	
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)	2,799	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>571,477</b>	
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)	875,168	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	556,213	
	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.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>1,431,381</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		859,904
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: 14-0148	Medicaid Provider Number: 19006
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)	571,477	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	571,477	
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.	<b>Total Allowable Cost</b> (Sum of Lines 3 and 4, Plus or Minus Line 5)	571,477	

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.	<b>Balance Due Provider / (State Agency) *</b> (Line 6 Minus Line 8)		

\* Line 9 DOES NOT APPLY to the Medicaid program.

Preliminary

Medicare Provider Number: 14-0148	Medicaid Provider Number: 19006
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)	859,904
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.	<b>Total (Sum of Lines 1 - 3)</b>					

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number: 14-0148	Medicaid Provider Number: 19006
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	Sub I	Sub II	Sub III
	Service	Psych	Rehab	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	Sub I	Sub II	Sub III
	Service	Psych	Rehab	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	Sub I	Sub II	Sub III
	Pediatrics	Psych	Rehab	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: 10/01/2018 To: 09/30/2019

Line No.	Cost Centers	G M E	Total Dept.	Ratio of	Inpatient	Outpatient	Inpatient	Outpatient
		Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	G M E Cost to Charges (Col. 1 / Col. 2)	Program Charges (BHF Page 3, 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)
Inpatient Ancillary Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	2,848,902	315,560,881	0.009028				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	767,272	424,133,494	0.001809	27,733		50	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	12,157	215,697,049	0.000056	48,263		3	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	40,525	75,098,573	0.000540	43,203		23	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	63,489	242,639,065	0.000262	9,630		3	
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	1,110,383	135,476,718	0.008196				
45.	Observation							
46.	Ancillary Total						79	

\* 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: 10/01/2018 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	6,509,104	91,862	70.86				
48.	Psych	810,498	10,391	78.00				
49.	Rehab	40,525	6,049	6.70	406		2,720	
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.	<b>Routine Total (lines 47-66)</b>						2,720	
68.	<b>Ancillary Total (from line 46)</b>						79	
69.	<b>Total (Lines 67-68)</b>						2,799	

**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: 10/01/2018 To: 09/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	406		406
Newborn Days			
Total Inpatient Revenue	1,431,381		1,431,381
Ancillary Revenue	875,168		875,168
Routine Revenue	556,213		556,213
Inpatient Received and Receivable			
<b>Outpatient Reconciliation</b>			
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 - Radiology Diagnostic includes Radiology Diagnostic, CT Scab & MRI
- BHF Page 3 - Med/Surgical Supplies includes Medical Supplies Charged to Patient and Implantable Devices
- 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 10c - combined line 10b and 10c
- 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.
- 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)