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. Marys Medical Center		**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:** 07/01/2015	**To:** 06/30/2016	

Type of Contro

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

Type of Hospita

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

Health Care Program

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

XXXX XXXX	Medicaid Hospital		Medicaid Sub II Rehab		DHS - Office of Rehabilitation Services
	Medicaid Sub I Psych		Medicaid Sub III Other		U of I - Division of Specialized Care for Children

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. Marys Medical Center 5038 for the cost report beginning 07/01/2015 and ending 06/30/2016 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

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

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

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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	294	107,604		49,598	46.09%		16,542	4.28
2.	Psych	14	5,124		3,398	66.32%		560	6.07
3.	Rehab	24	8,784		4,750	54.08%		367	12.94
4.	Other (Sub)								
5.	Intensive Care Unit	62	22,692		13,828	60.94%			
6.	Coronary Care Unit	9	3,294		1,457	44.23%			
7.	NICU	40	14,640		5,937	40.55%			
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				3,061				
22.	**Total**	**443**	**162,138**		**82,029**	**50.59%**		**17,469**	**4.52**
23.	Observation Bed Days				6,990				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				641				
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				185				
6.	Coronary Care Unit				6				
7.	NICU				825				
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				143				
22.	**Total**				**1,800**	**2.19%**			

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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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	67,775,004	254,243,352	0.266575	900,314		240,001	
2.	Recovery Room	3,155,633	29,400,083	0.107334	68,728		7,377	
3.	Delivery and Labor Room	5,405,009	12,336,250	0.438140	702,287		307,700	
4.	Anesthesiology	240,352	19,661,385	0.012225	72,444		886	
5.	Radiology - Diagnostic	9,446,394	72,735,001	0.129874	151,432		19,667	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	2,765,050	37,201,063	0.074327	35,297		2,624	
8.	Laboratory	18,721,353	102,158,590	0.183258	566,486		103,813	
9.	Blood							
10.	Blood - Administration	2,007,792	8,184,416	0.245319	128,187		31,447	
11.	Intravenous Therapy	4,816,447	19,546,003	0.246416	252,623		62,250	
12.	Respiratory Therapy	4,898,553	11,416,923	0.429061	457,950		196,488	
13.	Physical Therapy	4,769,694	18,217,768	0.261815	71,693		18,770	
14.	Occupational Therapy	2,042,703	11,202,329	0.182346	110,550		20,158	
15.	Speech Pathology	690,353	3,714,964	0.185830	74,183		13,785	
16.	EKG	4,178,257	57,771,227	0.072324	203,527		14,720	
17.	EEG	1,609,394	8,758,452	0.183753	8,754		1,609	
18.	Med. / Surg. Supplies	11,107,578	132,598,567	0.083768	265,316		22,225	
19.	Drugs Charged to Patients	31,677,453	157,297,529	0.201386	1,157,470		233,098	
20.	Renal Dialysis	1,575,577	3,700,694	0.425752	13,630		5,803	
21.	Ambulance	7,256,241	11,290,556	0.642682				
22.	Ultrasound	1,100,821	17,760,039	0.061983	110,230		6,832	
23.	CT Scan	2,305,335	54,150,217	0.042573	156,910		6,680	
24.	Cardiac Cath Lab	3,796,512	79,284,944	0.047884	333,391		15,964	
25.	MRI	1,137,348	18,185,504	0.062541	55,599		3,477	
26.	Cardiac Rehab	1,251,580	1,151,040	1.087347				
27.	Diabetic Education	1,110,401	204,756	5.423045				
28.	Impl.Devices	20,324,804	102,662,594	0.197977				
29.	ECT	207,722	2,863,562	0.072540				
30.	Mobile Clininc	1,295,257	656,053	1.974318				
31.	Outpatient Psych	671,401	395,481	1.697682				
32.	Bariatrics	413,195						
33.	Diagn.Treatm. Cntr	3,697,129	28,199,173	0.131108	180,396		23,651	
34.	DME	3,167,543	5,965,616	0.530967				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	1,243,374	3,439,518	0.361497				
44.	Emergency	14,302,464	136,345,221	0.104899	330,599		34,680	
45.	Observation	5,820,363	8,943,381	0.650801				
46.	**Total**				**6,407,996**		**1,393,705**	

* 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 Cc

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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)	47,119,306	3,173,102	4,763,876	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	56,588	3,398	4,750	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	832.67	933.81	1,002.92	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	641			
3.	Program general inpatient routine cost (Line 1c X Line 2)	533,741			
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)	533,741			

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	17,693,732	13,828	1,279.56	185	236,719
9.	Coronary Care Unit	2,713,254	1,457	1,862.22	6	11,173
10.	NICU	7,224,072	5,937	1,216.79	825	1,003,852
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	1,693,021	3,061	553.09	143	79,092
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,393,705
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**3,258,282**

Hospital Statement of Cos

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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	646,107	254,243,352	0.002541	900,314		2,288	
2.	Recovery Room							
3.	Delivery and Labor Room	1,300	12,336,250	0.000105	702,287		74	
4.	Anesthesiology	3,743,168	19,661,385	0.190382	72,444		13,792	
5.	Radiology - Diagnostic	1,008,636	72,735,001	0.013867	151,432		2,100	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	11,352	37,201,063	0.000305	35,297		11	
8.	Laboratory	341,906	102,158,590	0.003347	566,486		1,896	
9.	Blood							
10.	Blood - Administration	2,640	8,184,416	0.000323	128,187		41	
11.	Intravenous Therapy	369,032	19,546,003	0.018880	252,623		4,770	
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	104,419	57,771,227	0.001807	203,527		368	
17.	EEG	17,000	8,758,452	0.001941	8,754		17	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	3,385	11,290,556	0.000300				
22.	Ultrasound							
23.	CT Scan	5,764	54,150,217	0.000106	156,910		17	
24.	Cardiac Cath Lab	46,247	79,284,944	0.000583	333,391		194	
25.	MRI							
26.	Cardiac Rehab							
27.	Diabetic Education							
28.	Impl.Devices							
29.	ECT							
30.	Mobile Clininc	103,423	656,053	0.157644				
31.	Outpatient Psych	4,500	395,481	0.011379				
32.	Bariatrics	88,015		#DIV/0!				
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	246,234	3,439,518	0.071590				
44.	Emergency	4,131,709	136,345,221	0.030303	330,599		10,018	
45.	Observation							
46.	**Ancillary Total**						**35,586**	

* 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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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	3,600	56,588	0.06	641		38	
48.	Psych							
49.	Rehab	171,912	4,750	36.19				
50.	Other (Sub)							
51.	Intensive Care Unit	1,299,268	13,828	93.96	185		17,383	
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)**						**17,421**	
68.	**Ancillary Total (from line 46)**						**35,586**	
69.	**Total (Lines 67-68)**						**53,007**	

Hospital Statement of Cost

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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)	3,258,282	
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)	53,007	
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)	9,769	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**3,321,058**	
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)	6,407,996	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	688,423	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	353,056	
	F. Coronary Care Unit	11,468	
	G. NICU	1,190,585	
	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)**	8,651,528	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,330,470
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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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)	3,321,058	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,321,058	
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)**	**3,321,058**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	**Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)**		

* Line 9 DOES NOT APPLY to the Medicaid program.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charge

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)	5,330,470
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 Charge

Line No.	Description	Prior Cost Reporting Period Ended to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

Part I - Apportionment of Cost for the Services of Teaching Physician

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:	Medicaid Provider Number:
15-0100	5038
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2015 To: 06/30/2016

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	862,513	56,588	15.24	641		9,769	
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)**						**9,769**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**9,769**	

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: 07/01/2015 To: 06/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,658	(1)	1,657
Newborn Days	143		143
Total Inpatient Revenue	8,651,528		8,651,528
Ancillary Revenue	6,407,996		6,407,996
Routine Revenue	2,243,532		2,243,532
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Total costs/total charges agree with as filed W/S C

GME costs were adjusted to agree with as filed W/S B Part 1, column 25