

Hospital Statement of Cost

BHF Page 1

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information Preliminary

Name of Hospital: Trinity Medical Center	Medicare Provider Number: 14-0280	
Street: 2701 17th Street	Medicaid Provider Number: 18015	
City: Rock Island	State: Illinois	Zip: 61201
Period Covered by Statement:	From: 01/01/2014	To: 12/31/2014

Type of Control

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

Type of Hospital

☐ 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)) Trinity Medical Center 18015 for the cost report beginning 01/01/2014 and ending 12/31/2014 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

Name (Typewritten)

Title	Date
Firm	
Telephone Number	
Email Address	

Name (Typewritten)

Title
Date
Telephone Number
Email Address

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

Hospital Statement of Cost / Statistical Data

BHF Page 2

Preliminary

Medicare Provider Number:	14-0280	Medicaid Provider Number:	18015
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

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	208	75,759		35,749	47.19%		11,605	4.16
2.	Psych	31	11,315		7,954	70.30%		1,692	4.70
3.	Rehab	22	8,030		4,090	50.93%		279	14.66
4.	Other (Sub)								
5.	Intensive Care Unit	20	7,300		4,560	62.47%			
6.	Coronary Care Unit	31	11,315		7,230	63.90%			
7.	NICU	9	3,285		751	22.86%			
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	20	7,300		2,861	39.19%			
22.	Total	341	124,304		63,195	50.84%		13,576	4.44
23.	Observation Bed Days				4,811				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,320			1,763	3.07
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				496				
6.	Coronary Care Unit				587				
7.	NICU				3				
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				585				
22.	Total				5,991	9.48%		1,763	3.07

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

BHF Page 3

Preliminary

Medicare Provider Number:	14-0280	Medicaid Provider Number:	18015
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (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.	Operating Room	14,805,596	83,982,325	0.176294	4,505,736		794,334	
2.	Recovery Room	4,296,406	10,485,262	0.409757	281,565		115,373	
3.	Delivery and Labor Room	4,474,214	10,800,878	0.414245	4,344,803		1,799,813	
4.	Anesthesiology	434,672	11,463,332	0.037918	310,740		11,783	
5.	Radiology - Diagnostic	5,909,088	26,036,924	0.226950	375,614		85,246	
6.	Radiology - Therapeutic	6,129,494	40,634,746	0.150844	53,842		8,122	
7.	Nuclear Medicine	714,942	4,040,860	0.176928	59,929		10,603	
8.	Laboratory	11,161,062	47,059,774	0.237168	2,838,175		673,124	
9.	Blood							
10.	Blood - Administration	2,825,022	3,737,344	0.755890				
11.	Intravenous Therapy	4,112,203	16,237,821	0.253248	730		185	
12.	Respiratory Therapy	1,865,436	12,656,745	0.147387	2,779,578		409,674	
13.	Physical Therapy	3,663,590	11,748,308	0.311840	273,657		85,337	
14.	Occupational Therapy	1,316,631	5,175,881	0.254378				
15.	Speech Pathology	366,091	1,262,056	0.290075				
16.	EKG							
17.	EEG	1,334,702	6,603,611	0.202117				
18.	Med. / Surg. Supplies	14,223,157	44,915,048	0.316668				
19.	Drugs Charged to Patients	26,458,933	101,096,914	0.261719	5,257,283		1,375,931	
20.	Renal Dialysis	837,476	1,550,099	0.540273				
21.	Ambulance	719,147						
22.	Gastrointestinal	2,308,036	10,631,278	0.217099	202,192		43,896	
23.	MRI	1,992,928	6,271,870	0.317757	558,253		177,389	
24.	Ultrasound	936,491	6,231,148	0.150292	211,463		31,781	
25.	Implantable Devices	26,350,959	52,445,576	0.502444				
26.	Cardiology	2,131,168	12,990,034	0.164062	722,111		118,471	
27.	Pulmonary Function	1,452,278	8,155,737	0.178068				
28.	CT Scan	2,331,763	55,076,540	0.042337	2,017,541		85,417	
29.	Cardiac Rehab	778,305	2,291,406	0.339663				
30.	Cardiac Cath	5,617,338	56,273,785	0.099822	1,314,136		131,180	
31.	Hyperbaric Oxygen Therapy	276,282	921,436	0.299839				
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	6,673,464	16,234,462	0.411068	4,334		1,782	
44.	Emergency	12,188,123	47,328,365	0.257523	1,641,348		422,685	
45.	Observation	3,215,480	5,119,091	0.628135				
46.	Total				27,753,030		6,382,126	

* 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

BHF Page 4

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2014 To: 12/31/2014

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)	27,090,396	5,312,549	2,862,226	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	40,560	7,954	4,090	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	667.91	667.91	699.81	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,320			
3.	Program general inpatient routine cost (Line 1c X Line 2)	2,885,371			
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)	2,885,371			

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	6,403,562	4,560	1,404.29	496	696,528
9.	Coronary Care Unit	5,264,497	7,230	728.15	587	427,424
10.	NICU	1,672,701	751	2,227.30	3	6,682
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	1,561,430	2,861	545.76	585	319,270
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					6,382,126
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					10,717,401

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

Medicare Provider Number:	14-0280	Medicaid Provider Number:	18015
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45) (5A) (5B)		Program Expenses (Col. 4 X Cols. 5A-B) (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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	14-0280	Medicaid Provider Number:	18015
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	689,276	11,463,332	0.060129	310,740		18,684	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic	25	40,634,746	0.000001	53,842			
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	1,837	16,237,821	0.000113	730			
12.	Respiratory Therapy							
13.	Physical Therapy	25,254	11,748,308	0.002150	273,657		588	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	22,680	6,603,611	0.003434				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Gastrointestinal							
23.	MRI							
24.	Ultrasound							
25.	Implantable Devices							
26.	Cardiology	318,098	12,990,034	0.024488	722,111		17,683	
27.	Pulmonary Function							
28.	CT Scan							
29.	Cardiac Rehab							
30.	Cardiac Cath	717,580	56,273,785	0.012752	1,314,136		16,758	
31.	Hyperbaric Oxygen Therapy							
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	229,272	16,234,462	0.014123	4,334		61	
44.	Emergency	7,994,633	47,328,365	0.168918	1,641,348		277,253	
45.	Observation							
46.	Ancillary Total						331,027	

* 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

BHF Page 6(b)

Preliminary

Medicare Provider Number:	14-0280	Medicaid Provider Number:	18015
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

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	5,561,243	40,560	137.11	4,320		592,315	
48.	Psych	1,090,585	7,954	137.11				
49.	Rehab	36,150	4,090	8.84				
50.	Other (Sub)							
51.	Intensive Care Unit	393,238	4,560	86.24	496		42,775	
52.	Coronary Care Unit							
53.	NICU	1,122,393	751	1,494.53	3		4,484	
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)						639,574	
68.	Ancillary Total (from line 46)						331,027	
69.	Total (Lines 67-68)						970,601	

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0280		Medicaid Provider Number: 18015	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2014 To: 12/31/2014	
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)	10,717,401	
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)	970,601	
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)		
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	11,688,002	
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)	27,753,030	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,403,694	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,133,659	
	F. Coronary Care Unit	957,804	
	G. NICU	3,797	
	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	665,435	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	34,917,419	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		23,229,417
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

BHF Page 8

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2014 To: 12/31/2014

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)	11,688,002	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	11,688,002	
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)	11,688,002	

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

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2014 To: 12/31/2014

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)	23,229,417
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2014 To: 12/31/2014

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

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

Part C. Program Cost

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:	14-0280	Medicaid Provider Number:	18015
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

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.	Gastrointestinal							
23.	MRI							
24.	Ultrasound							
25.	Implantable Devices							
26.	Cardiology							
27.	Pulmonary Function							
28.	CT Scan							
29.	Cardiac Rehab							
30.	Cardiac Cath							
31.	Hyperbaric Oxygen Therapy							
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							
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:	14-0280	Medicaid Provider Number:	18015
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2014 To: 12/31/2014

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							
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)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2014 To: 12/31/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,406		5,406
Newborn Days	585		585
Total Inpatient Revenue	34,937,720	(20,301)	34,917,419
Ancillary Revenue	27,773,331	(20,301)	27,753,030
Routine Revenue	7,164,389		7,164,389
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]