

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: Adventist Glenoaks Hospital		Medicare Provider Number: 14-0292
Street: 701 Winthrop Avenue		Medicaid Provider Number: 7074
City: Glendale Heights	State: Illinois	Zip: 60139
Period Covered by Statement:	From: 01/01/2015	To: 12/31/2015

Type of Contrc

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☐ XXXX XXXX Church	☐ Individual	☐ State ☐ Township
☐ 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)) Adventist Glenoaks Hospital 7074 for the cost report beginning 01/01/2015 and ending 12/31/2015 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:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

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	67	24,470		8,081	33.02%		3,330	3.12
2.	Psych	66	24,075		18,079	75.09%		4,216	4.29
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	10	3,650		2,309	63.26%			
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				697				
22.	Total	143	52,195		29,166	55.88%		7,546	3.77
23.	Observation Bed Days				4,076				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				675			339	2.51
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				176				
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				434				
22.	Total				1,285	4.41%		339	2.51

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:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

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	4,151,612	15,002,773	0.276723	636,092		176,021	
2	Recovery Room	509,569	2,467,905	0.206478	66,540		13,739	
3	Delivery and Labor Room	1,704,713	1,287,642	1.323903	427,571		566,063	
4	Anesthesiology	195,820	3,694,410	0.053004	178,265		9,449	
5	Radiology - Diagnostic	2,182,200	14,700,207	0.148447	290,877		43,180	
6	Radiology - Therapeutic							
7	Nuclear Medicine	439,835	3,274,650	0.134315	87,329		11,730	
8	Laboratory	4,089,232	33,398,115	0.122439	1,449,042		177,419	
9	Blood							
10	Blood - Administration							
11	Intravenous Therapy							
12	Respiratory Therapy	1,311,687	6,884,619	0.190524	313,009		59,636	
13	Physical Therapy	1,363,642	3,790,474	0.359755	29,277		10,533	
14	Occupational Therapy	59,701	245,929	0.242757	10,899		2,646	
15	Speech Pathology	28,331	248,871	0.113838	4,553		518	
16	EKG	927,642	8,096,465	0.114574	205,771		23,576	
17	EEG	54,032	203,000	0.266167	11,250		2,994	
18	Med. / Surg. Supplies	1,484,617	4,718,025	0.314669	146,926		46,233	
19	Drugs Charged to Patients	4,676,710	21,730,166	0.215217	597,007		128,486	
20	Renal Dialysis	233,025	607,150	0.383801	7,750		2,974	
21	Ambulance							
22	CT Scan	1,214,762	22,545,640	0.053880	548,403		29,548	
23	MRI	466,385	4,624,150	0.100859	122,290		12,334	
24	Cardiac Cath	1,453,326	5,984,015	0.242868	229,829		55,818	
25	Implants Charged	3,310,306	8,387,107	0.394690	57,921		22,861	
26	Wound Care	913,146	1,371,692	0.665708				
27	Other							
28	Other							
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 Service Cost Centers								
43	Clinic	495,334	1,755,657	0.282136	1,550		437	
44	Emergency	5,408,951	36,766,846	0.147115	565,487		83,192	
45	Observation	3,224,279	4,436,029	0.726839	466,574		339,124	
46	Total				6,454,212		1,818,511	

* 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: 14-0292	Medicaid Provider Number: 7074
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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)	7,583,192	16,877,523		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	12,157	18,079		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	623.77	933.54		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	675			
3.	Program general inpatient routine cost (Line 1c X Line 2)	421,045			
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)	421,045			

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	4,140,650	2,309	1,793.27	176	315,616
9.	Coronary Care Unit					
10.	Other					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	884,247	697	1,268.65	434	550,594
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,818,511
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,105,766

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

Preliminary

Medicare Provider Number:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

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							
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	51,040	8,096,465	0.006304	205,771		1,297	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath	26,967	5,984,015	0.004507	229,829		1,036	
25.	Implants Charged							
26.	Wound Care							
27.	Other							
28.	Other							
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	252,692	1,755,657	0.143930	1,550		223	
44.	Emergency							
45.	Observation							
46.	Ancillary Total						2,556	

* 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:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)						2,556	
69.	Total (Lines 67-68)						2,556	

Hospital Statement of Cost

BHF Page 7

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
14-0292		7074	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2015	To: 12/31/2015
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)	3,105,766	
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)	2,556	
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)	3,108,322	
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)	6,454,212	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	993,587	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	405,269	
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	421,513	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	8,274,581	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,166,259
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: 14-0292	Medicaid Provider Number: 7074
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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)	3,108,322	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,108,322	
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)	3,108,322	

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:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

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)	5,166,259
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			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)	(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: 14-0292	Medicaid Provider Number: 7074
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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

1. Gross Routine Revenues	Adults and Pediatrics	Sub i Psych	Sub II Rehab	Sub III Other (Sub)
(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:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

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.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Implants Charged							
26.	Wound Care							
27.	Other							
28.	Other							
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							
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:	14-0292	Medicaid Provider Number:	7074
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2015 To: 12/31/2015

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.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 14-0292	Medicaid Provider Number: 7074
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	851		851
Newborn Days	434		434
Total Inpatient Revenue	8,274,581		8,274,581
Ancillary Revenue	6,454,212		6,454,212
Routine Revenue	1,820,369		1,820,369
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Total Beds/Bed Days Available for Adults & Peds and Psych were adjusted to prior year and W/S S-3..
BHF Page 2 - Removed Labor & Delivery and Hospice days from filed Medicaid report.
BHF Page 3 - Total costs/total charges agree with as filed W/S C
BHF Page 4 - Adults & Peds costs were split between Psych and Acute based on percentage of patient days (see attached spreadsheet)