

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: Methodist Medical Center of Illinois		Medicare Provider Number: 14-0209
Street: 221 N E Glen Oak		Medicaid Provider Number: 16006
City: Peoria	State: Illinois	Zip: 61636
Period Covered by Statement:	From: 01/01/2015	To: 12/31/2015

Type of Contrc

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

Type of Hospita

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

Health Care Program

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

☐ Medicaid Hospital	☐ XXXX Medicaid Sub II XXXX 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)) Methodist Medical Center of Illi 16006 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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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	191	69,715		41,241	59.16%		11,476	4.08
2.	Psych	44	16,060		13,011	81.01%		2,238	5.81
3.	Rehab	36	13,140		7,382	56.18%		545	13.54
4.	Other (Sub)								
5.	Intensive Care Unit	12	4,380		2,848	65.02%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		2,769	63.22%			
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	20	7,300		4,759	65.19%			
22.	Total	315	114,975		72,010	62.63%		14,259	4.72
23.	Observation Bed Days				4,664				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				395			27	14.63
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Surgical ICU								
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.	Total				395	0.55%		27	14.63

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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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	34,249,849	147,930,045	0.231527	12,445		2,881	
2	Recovery Room	4,454,556	34,481,624	0.129186	1,260		163	
3	Delivery and Labor Room	3,991,394	14,493,330	0.275395				
4	Anesthesiology	2,618,104	44,134,324	0.059321	4,568		271	
5	Radiology - Diagnostic	10,292,880	46,155,946	0.223002	19,741		4,402	
6	Radiology - Therapeutic	3,144,627	20,967,287	0.149978				
7	Nuclear Medicine	1,431,557	14,116,520	0.101410	5,239		531	
8	Laboratory	18,338,616	180,412,376	0.101648	102,183		10,387	
9	Blood							
10	Blood - Administration	1,469,574	5,539,148	0.265307				
11	Intravenous Therapy	4,642,733	21,438,320	0.216562				
12	Respiratory Therapy	2,728,188	15,394,732	0.177216	20,776		3,682	
13	Physical Therapy	2,441,112	11,668,366	0.209208	492,771		103,092	
14	Occupational Therapy	1,120,235	5,666,260	0.197703				
15	Speech Pathology	752,712	2,742,853	0.274427				
16	EKG	764,536	6,228,277	0.122752				
17	EEG	1,279,921	9,553,113	0.133979				
18	Med. / Surg. Supplies	2,803,256	67,570,908	0.041486	294		12	
19	Drugs Charged to Patients	24,485,761	74,953,766	0.326678	97,358		31,805	
20	Renal Dialysis	517,848	1,307,880	0.395945				
21	Ambulance							
22	Pain Clinic	178,924	1,925	92.947532				
23	Northside Imaging	598,238	2,272,150	0.263292				
24	Northside Mammography	470,634	1,481,056	0.317769				
25	Northside Ultrasound	444,707	1,787,946	0.248725				
26	Implant Devices	10,616,882	47,299,293	0.224462				
27	Pulmonary Function	338,267	3,386,434	0.099889				
28	Cardiac Cath	939,029	28,758,195	0.032653				
29	CT Scan	948,175	54,964,831	0.017251	12,359		213	
30	Northside CT	406,100	8,607,598	0.047179				
31	MRI	1,200,218	22,102,307	0.054303				
32	Northside MRI	487,796	6,503,542	0.075005				
33	Cardiology	1,842,039	12,495,590	0.147415	1,347		199	
34	Psych-Part Hospital	886,342	2,489,243	0.356069				
35	GI	2,398,527	17,941,290	0.133688				
36	Cardiac Rehab	60,186	21,856	2.753752				
37	Hyperbaric Oxygen	440,932	2,808,907	0.156976				
38	Lithotripsy	28,809						
39	Chilli Family Psysic	1,806,506						
40	Physician Offices	31,994,669	14,594,406	2.192256	42		92	
41	Diabetic Care Center	433,463	1,449,201	0.299105	5,270		1,576	
42	Wound Care Center	408,461	913,444	0.447166	753		337	
	Outpatient Service Cost Centers							
43	Clinic	4,809,486	15,614,702	0.308010				
44	Emergency	7,712,333	41,870,084	0.184197				
45	Observation	4,016,357	6,611,041	0.607523				
46	Total				776,406		159,643	

* 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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Rehab	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)	39,324,644	9,917,440	5,796,225	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	45,905	13,011	7,382	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	856.65	762.24	785.18	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			395	
3.	Program general inpatient routine cost (Line 1c X Line 2)			310,146	
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)			310,146	

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	11,139,885	2,848	3,911.48		
9.	Coronary Care Unit					
10.	Surgical ICU	569,075	2,769	205.52		
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	2,440,403	4,759	512.80		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					159,643
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					469,789

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

PRELIMINARY

Medicare Provider Number:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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.	Surgical ICU						
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	Outpatient	Inpatient	Outpatient
						(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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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	1,562,159	14,493,330	0.107785				
4.	Anesthesiology							
5.	Radiology - Diagnostic	182,986	46,155,946	0.003965	19,741		78	
6.	Radiology - Therapeutic	137,652	20,967,287	0.006565				
7.	Nuclear Medicine							
8.	Laboratory	574,407	180,412,376	0.003184	102,183		325	
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.	Pain Clinic							
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	Implant Devices							
27.	Pulmonary Function							
28.	Cardiac Cath							
29.	CT Scan	200	54,964,831	0.000004	12,359			
30.	Northside CT							
31.	MRI							
32.	Northside MRI							
33.	Cardiology							
34.	Psych-Part Hospital							
35.	GI							
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Lithotripsy							
39.	Chilli Family Psysic							
40.	Physician Offices	220,467	14,594,406	0.015106	42		1	
41.	Diabetic Care Center							
42.	Wound Care Center							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	2,153,392	41,870,084	0.051430				
45.	Observation							
46.	Ancillary Total						404	

* 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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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	306,095	45,905	6.67				
48.	Psych							
49.	Rehab	67,240	7,382	9.11	395		3,598	
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Surgical ICU							
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	86,663	4,759	18.21				
67.	Routine Total (lines 47-66)						3,598	
68.	Ancillary Total (from line 46)						404	
69.	Total (Lines 67-68)						4,002	

Hospital Statement of Cost

BHF Page 7

Computation of Lesser of Reasonable Cost or Customary Charge

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0209		16006	
Program:		Period Covered by Statement:	
Medicaid-Rehab		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)	469,789	
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)	4,002	
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)	64	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	473,855	
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)	776,406	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	528,914	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Surgical ICU		
	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)	1,305,320	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		831,465
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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Rehab	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)	473,855	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	473,855	
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)	473,855	

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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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)	831,465
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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Rehab	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)	

	General Service	Sub I	Sub II	Sub III
		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)				

	General Service	Sub I	Sub II	Sub III
		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 Pediatrics	Sub I	Sub II	Sub III
		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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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	332,681	147,930,045	0.002249	12,445		28	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	39,255	46,155,946	0.000850	19,741		17	
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.	Pain Clinic	85,052	1,925	44.182857				
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	Implant Devices							
27.	Pulmonary Function							
28.	Cardiac Cath							
29.	CT Scan							
30.	Northside CT							
31.	MRI							
32.	Northside MRI							
33.	Cardiology							
34.	Psych-Part Hospital							
35.	GI	90,939	17,941,290	0.005069				
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Lithotripsy							
39.	Chilli Family Psysic							
40.	Physician Offices	3,845,295	14,594,406	0.263477	42		11	
41.	Diabetic Care Center							
42.	Wound Care Center	9,813	913,444	0.010743	753		8	
	Outpatient Ancillary Centers							
43.	Clinic	3,297,370	15,614,702	0.211171				
44.	Emergency	271,510	41,870,084	0.006485				
45.	Observation							
46.	Ancillary Total						64	

* 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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Rehab	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	2,934,921	45,905	63.93				
48.	Psych	160,943	13,011	12.37				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	13,412	2,848	4.71				
52.	Coronary Care Unit							
53.	Surgical ICU	13,412	2,769	4.84				
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	19,627	4,759	4.12				
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)						64	
69.	Total (Lines 67-68)						64	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Rehab	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	395		395
Newborn Days			
Total Inpatient Revenue	1,305,320		1,305,320
Ancillary Revenue	776,406		776,406
Routine Revenue	528,914		528,914
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Total Hospital and Medicaid Psych Days, Charges, & Discharges came from filed hospital report.

Allocation of Routine Service and GME Costs(from W/S B, Pt. I, Col. 25) to Psych done.

BHF page 3- Per instructions from UnityPoint Health, all Medicaid charges should be as per worksheet submitted by Unity on 09/21/2015.