

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: 01/01/2018	To: 12/31/2018	

Type of Control

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

☐ Medicaid Hospital	☐ Medicaid Sub II Rehab _____	☐ _____
☐ XXXX XXXX Medicaid Sub I Psych _____	☐ Medicaid Sub III Other _____	☐ _____

**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 IL 16006 for the cost report beginning 01/01/2018 and ending 12/31/2018 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-Hospital	Period Covered by Statement:	From: 01/01/2018 To: 12/31/2018

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	174	63,510		40,784	64.22%		12,396	3.73
2.	Psych	44	16,060		13,016	81.05%		2,308	5.64
3.	Rehab	38	13,870		5,501	39.66%		437	12.59
4.	Other (Sub)								
5.	Intensive Care Unit	12	4,380		2,712	61.92%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		2,771	63.26%			
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		3,918	53.67%			
22.	Total	300	109,500		68,702	62.74%		15,141	4.28
23.	Observation Bed Days				4,598				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				3,550			551	6.44
3.	Rehab								
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				3,550	5.17%		551	6.44

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:		Medicaid Provider Number:	
14-0209		16006	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 01/01/2018	To: 12/31/2018

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)		(4)	(5)	(6)	(7)
1.	Operating Room	34,840,197	159,747,500	0.218095	10,140		2,211	
2.	Recovery Room	4,396,883	35,141,842	0.125118	16,169		2,023	
3.	Delivery and Labor Room	3,334,620	10,462,286	0.318728				
4.	Anesthesiology	3,839,600	52,630,934	0.072953	38,519		2,810	
5.	Radiology - Diagnostic	11,918,261	44,835,667	0.265821	36,002		9,570	
6.	Radiology - Therapeutic	4,396,584	20,871,654	0.210649				
7.	Nuclear Medicine	2,561,375	15,346,213	0.166906				
8.	Laboratory	23,454,531	236,101,683	0.099341	782,266		77,711	
9.	Blood							
10.	Blood - Administration	1,237,540	5,331,358	0.232125				
11.	Intravenous Therapy	5,637,734	24,129,750	0.233642	24,613		5,751	
12.	Respiratory Therapy	2,603,371	28,220,911	0.092250	108,065		9,969	
13.	Physical Therapy	3,523,114	11,928,315	0.295357	4,639		1,370	
14.	Occupational Therapy	1,125,805	3,746,643	0.300484	30,651		9,210	
15.	Speech Pathology	929,181	2,734,714	0.339773				
16.	EKG	390,689	7,763,754	0.050322	46,907		2,360	
17.	EEG	1,935,608	11,020,913	0.175630	10,549		1,853	
18.	Med. / Surg. Supplies	2,546,764	72,558,644	0.035099	3,912		137	
19.	Drugs Charged to Patients	24,334,148	74,146,213	0.328191	129,450		42,484	
20.	Renal Dialysis	744,196	2,479,661	0.300120				
21.	Ambulance							
22.	Pain Clinic	217,390	185,216	1.173711				
23.	Northside Imaging	670,295	2,628,366	0.255023				
24.	Northside Mammography	464,778	1,934,058	0.240312				
25.	Northside Ultrasound	210,367	1,103,746	0.190594				
26.	Implant Devices	20,288,711	59,042,068	0.343631				
27.	Pulmonary Function	1,813,451	3,411,571	0.531559	528		281	
28.	Cardiac Cath	1,227,258	33,609,322	0.036515				
29.	CT Scan	1,238,519	69,708,303	0.017767	99,908		1,775	
30.	Northside CT	473,543	8,572,458	0.055240				
31.	MRI	1,165,327	22,858,589	0.050980	6,251		319	
32.	Northside MRI	677,217	8,025,309	0.084385				
33.	Cardiology	1,874,973	15,457,136	0.121301	4,440		539	
34.	Psych-Part Hospital	777,173	3,218,447	0.241475	11,832		2,857	
35.	GI	1,626,762	21,785,706	0.074671	16,850		1,258	
36.	Cardiac Rehab	8,732	1,000	8.732000				
37.	Hyperbaric Oxygen	848,414	1,104,646	0.768042				
38.	Other Clinics	4,532,168	8,577,595	0.528373				
39.	Chilli Family Psysic	2,212,083						
40.	Physician Offices	32,550,405	27,727,459	1.173941				
41.	Endocrinology,Diabetic	677,978	2,650,693	0.255774				
42.	Wound Care Center	1,186,548	4,279,199	0.277283				
Outpatient Service Cost Centers								
43.	Clinic	7,500,159	23,513,731	0.318969	17,435		5,561	
44.	Emergency	10,668,899	82,736,051	0.128951	675,560		87,114	
45.	Observation	4,636,393	7,166,913	0.646916				
46.	Total				2,074,686		267,163	

* 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-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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)	45,760,375	11,713,121	3,494,507	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	45,382	13,016	5,501	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,008.34	899.90	635.25	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		3,550		
3.	Program general inpatient routine cost (Line 1c X Line 2)		3,194,645		
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)		3,194,645		

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	8,019,095	2,712	2,956.89		
9.	Coronary Care Unit					
10.	Surgical ICU	1,134,025	2,771	409.25		
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	2,166,319	3,918	552.91		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					267,163
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,461,808

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

Medicare Provider Number:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2018 To: 12/31/2018

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.	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) (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)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	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:		Medicaid Provider Number:	
14-0209		16006	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 01/01/2018	To: 12/31/2018

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	1,111,194	159,747,500	0.006956	10,140		71	
2.	Recovery Room							
3.	Delivery and Labor Room	1,374,500	10,462,286	0.131377				
4.	Anesthesiology	5,058,697	52,630,934	0.096116	38,519		3,702	
5.	Radiology - Diagnostic	179,662	44,835,667	0.004007	36,002		144	
6.	Radiology - Therapeutic	601,339	20,871,654	0.028811				
7.	Nuclear Medicine							
8.	Laboratory	454,101	236,101,683	0.001923	782,266		1,504	
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							
30.	Northside CT							
31.	MRI							
32.	Northside MRI							
33.	Cardiology							
34.	Psych-Part Hospital							
35.	GI							
36.	Cardiac Rehab	926	1,000	0.926000				
37.	Hyperbaric Oxygen							
38.	Other Clinics	7,654,787	8,577,595	0.892416				
39.	Chilli Family Psysic	1,140,709		#DIV/0!				
40.	Physician Offices	33,207,773	27,727,459	1.197649				
41.	Endocrinology,Diabetic	577,910	2,650,693	0.218022				
42.	Wound Care Center	388,377	4,279,199	0.090759				
	Outpatient Ancillary Cost Centers							
43.	Clinic	177,041	23,513,731	0.007529	17,435		131	
44.	Emergency	7,186,072	82,736,051	0.086855	675,560		58,676	
45.	Observation							
46.	Ancillary Total						64,228	

* 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-Hospital	Period Covered by Statement:	From: 01/01/2018 To: 12/31/2018

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	866,386	45,382	19.09				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,222	2,712	0.45				
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	902,978	3,918	230.47				
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)						64,228	
69.	Total (Lines 67-68)						64,228	

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

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0209		Medicaid Provider Number: 16006	
Program: Medicaid-Hospital		Period Covered by Statement: From: 01/01/2018 To: 12/31/2018	
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)	3,461,808	
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)	64,228	
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)	142,418	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	3,668,454	
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)	2,074,686	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	8,130,079	
	C. Rehab		
	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)	10,204,765	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		6,536,311
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-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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)	3,668,454	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,668,454	
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)	3,668,454	

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-Hospital	Period Covered by Statement:	From: 01/01/2018 To: 12/31/2018

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)	6,536,311
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)	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-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

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

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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2018 To: 12/31/2018

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	464,767	159,747,500	0.002909	10,140		29	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	91,215	44,835,667	0.002034	36,002		73	
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	65,154	185,216	0.351773				
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	62,114	21,785,706	0.002851	16,850		48	
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Other Clinics							
39.	Chilli Family Psysic							
40.	Physician Offices	4,838,787	27,727,459	0.174512				
41.	Endocrinology,Diabetic							
42.	Wound Care Center	13,031	4,279,199	0.003045				
	Outpatient Ancillary Centers							
43.	Clinic	4,195,932	23,513,731	0.178446	17,435		3,111	
44.	Emergency	430,018	82,736,051	0.005197	675,560		3,511	
45.	Observation							
46.	Ancillary Total						6,772	

* 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-Hospital	Period Covered by Statement:	From: 01/01/2018 To: 12/31/2018

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	1,128,906	45,382	24.88				
48.	Psych	497,344	13,016	38.21	3,550		135,646	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	395,269	2,712	145.75				
52.	Coronary Care Unit							
53.	Surgical ICU	18,243	2,771	6.58				
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	25,193	3,918	6.43				
67.	Routine Total (lines 47-66)						135,646	
68.	Ancillary Total (from line 46)						6,772	
69.	Total (Lines 67-68)						142,418	

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2018 To: 12/31/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,550		3,550
Newborn Days			
Total Inpatient Revenue	10,204,765		10,204,765
Ancillary Revenue	2,074,686		2,074,686
Routine Revenue	8,130,079		8,130,079
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 7 - Combined A&P, Psych and ICU customary charges into Psych customary charges