

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: 01/01/2019	To: 12/31/2019	

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	☐ XXXX XXXX Medicaid Sub II Rehab _____	☐ _____ _____
☐ 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 01/01/2019 and ending 12/31/2019 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: 01/01/2019 To: 12/31/2019

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		44,472	70.02%		12,595	3.98
2.	Psych	44	16,060		14,285	88.95%		2,239	6.38
3.	Rehab	38	13,870		5,233	37.73%		406	12.89
4.	Other (Sub)								
5.	Intensive Care Unit	12	4,380		2,888	65.94%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		2,751	62.81%			
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	19	6,935		4,788	69.04%			
22.	Total	299	109,135		74,417	68.19%		15,240	4.57
23.	Observation Bed Days				5,532				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				172			10	17.20
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				172	0.23%		10	17.20

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:	01/01/2019	To: 12/31/2019

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	31,688,227	167,028,532	0.189717				
2.	Recovery Room	4,647,180	39,745,004	0.116925				
3.	Delivery and Labor Room	3,971,077	13,672,980	0.290432				
4.	Anesthesiology	4,715,938	82,886,513	0.056896				
5.	Radiology - Diagnostic	11,743,889	45,101,798	0.260386	6,884		1,792	
6.	Radiology - Therapeutic	4,052,638	29,160,167	0.138979				
7.	Nuclear Medicine	2,422,563	15,119,743	0.160225	2,995		480	
8.	Laboratory	26,689,862	155,363,707	0.171790	67,539		11,603	
9.	Blood							
10.	Blood - Administration	1,475,365	5,837,937	0.252720	5,701		1,441	
11.	Intravenous Therapy	5,224,464	26,868,988	0.194442				
12.	Respiratory Therapy	2,636,810	31,133,796	0.084693	51,447		4,357	
13.	Physical Therapy	2,137,490	8,609,136	0.248282	129,652		32,190	
14.	Occupational Therapy	1,004,533	4,238,559	0.236999	104,335		24,727	
15.	Speech Pathology	947,725	3,184,520	0.297604	24,418		7,267	
16.	EKG	402,874	8,558,252	0.047074	414		19	
17.	EEG	1,581,123	9,553,784	0.165497				
18.	Med. / Surg. Supplies	1,922,934	78,297,680	0.024559	34,208		840	
19.	Drugs Charged to Patients	20,082,901	77,923,077	0.257727	26,225		6,759	
20.	Renal Dialysis	906,046	3,213,271	0.281970				
21.	Ambulance							
22.	Pain Clinic	276,119	1,526,576	0.180875				
23.	Northside Imaging	719,478	3,200,042	0.224834				
24.	Northside Mammography	410,668	1,963,383	0.209163				
25.	Northside Ultrasound	169,426	1,132,138	0.149651				
26.	Implant Devices	23,160,760	54,146,460	0.427743	6,336		2,710	
27.	Pulmonary Function	242,238	3,652,813	0.066315	366		24	
28.	Cardiac Cath	1,390,540	36,752,839	0.037835				
29.	CT Scan	1,342,831	79,459,243	0.016900	3,470		59	
30.	Northside CT	482,189	9,311,786	0.051783				
31.	MRI	1,149,973	24,668,592	0.046617	5,453		254	
32.	Northside MRI	766,635	8,961,192	0.085551				
33.	Cardiology	1,796,334	17,180,655	0.104556				
34.	Psych-Part Hospital	1,196,498	3,298,549	0.362735				
35.	GI	1,847,542	27,519,463	0.067136				
36.	Cardiac Rehab	14,606	13,708	1.065509				
37.	Hyperbaric Oxygen	1,229,302	1,667,270	0.737314				
38.	Other Clinics	7,690,272	28,772,692	0.267277				
39.	Chilli Family Psysic	1,874	315	5.949206				
40.	Physician Offices	21,575,829	56,989,622	0.378592				
41.	Endocrinology,Diabetic	866,540	4,105,532	0.211066				
42.	Wound Care Center	936,937	4,533,934	0.206650				
Outpatient Service Cost Centers								
43.	Clinic	6,417,609	26,085,694	0.246020	8,958		2,204	
44.	Emergency	11,703,953	111,295,674	0.105161				
45.	Observation	5,051,103	9,493,252	0.532073				
46.	Total				478,401		96,726	

* 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: 01/01/2019 To: 12/31/2019

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)	45,657,251	12,382,922	4,385,058	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	50,004	14,285	5,233	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	913.07	866.85	837.96	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			172	
3.	Program general inpatient routine cost (Line 1c X Line 2)			144,129	
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)			144,129	

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	7,365,027	2,888	2,550.22		
9.	Coronary Care Unit					
10.	Surgical ICU	750,785	2,751	272.91		
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	2,407,888	4,788	502.90		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					96,726
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					240,855

**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: 01/01/2019 To: 12/31/2019

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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2019 To: 12/31/2019

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	1,188,246	167,028,532	0.007114				
2.	Recovery Room							
3.	Delivery and Labor Room	1,374,500	13,672,980	0.100527				
4.	Anesthesiology	5,465,920	82,886,513	0.065945				
5.	Radiology - Diagnostic	153,996	45,101,798	0.003414	6,884		24	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	567,517	155,363,707	0.003653	67,539		247	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	1,440	26,868,988	0.000054				
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	5,744	3,298,549	0.001741				
35.	GI							
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Other Clinics	6,259,706	28,772,692	0.217557				
39.	Chilli Family Psysic							
40.	Physician Offices	21,256,822	56,989,622	0.372995				
41.	Endocrinology, Diabetic	515,366	4,105,532	0.125530				
42.	Wound Care Center	315,159	4,533,934	0.069511				
	Outpatient Ancillary Cost Centers							
43.	Clinic	166,207	26,085,694	0.006372	8,958		57	
44.	Emergency	7,996,043	111,295,674	0.071845				
45.	Observation							
46.	Ancillary Total						328	

* 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: 01/01/2019 To: 12/31/2019

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	822,639	50,004	16.45				
48.	Psych							
49.	Rehab	73,409	5,233	14.03	172		2,413	
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	1,035,500	4,788	216.27				
67.	Routine Total (lines 47-66)						2,413	
68.	Ancillary Total (from line 46)						328	
69.	Total (Lines 67-68)						2,741	

**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: 01/01/2019 To: 12/31/2019	
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)	240,855	
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)	2,741	
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)	1,452	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	245,048	
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)	478,401	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	279,672	
	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)	758,073	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		513,025
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: 01/01/2019 To: 12/31/2019

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)	245,048	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	245,048	
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)	245,048	

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: 01/01/2019 To: 12/31/2019

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)	513,025
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: 01/01/2019 To: 12/31/2019

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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 01/01/2019 To: 12/31/2019

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	432,198	167,028,532	0.002588				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	295,876	45,101,798	0.006560	6,884		45	
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	13,150	1,526,576	0.008614				
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	91,174	27,519,463	0.003313				
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Other Clinics							
39.	Chilli Family Psysic							
40.	Physician Offices	5,039,539	56,989,622	0.088429				
41.	Endocrinology,Diabetic							
42.	Wound Care Center							
	Outpatient Ancillary Centers							
43.	Clinic	4,098,434	26,085,694	0.157114	8,958		1,407	
44.	Emergency	475,594	111,295,674	0.004273				
45.	Observation							
46.	Ancillary Total						1,452	

* 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: 01/01/2019 To: 12/31/2019

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	1,181,751	50,004	23.63				
48.	Psych	382,228	14,285	26.76				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	478,224	2,888	165.59				
52.	Coronary Care Unit							
53.	Surgical ICU	18,410	2,751	6.69				
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	25,862	4,788	5.40				
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)						1,452	
69.	Total (Lines 67-68)						1,452	

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	172		172
Newborn Days			
Total Inpatient Revenue	758,073		758,073
Ancillary Revenue	478,401		478,401
Routine Revenue	279,672		279,672
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

This image shows a full page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.