

Hospital Statement of Cost

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

General Information Preliminary

Name of Hospital: Trinity Medical Center		Medicare Provider Number: 14-0280
Street: 2701 17th Street		Medicaid Provider Number: 18015
City: Rock Island	State: Illinois	Zip: 61201
Period Covered by Statement:	From: 01/01/2015	To: 12/31/2015

Type of Contrc

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> XXXX XXXX Other (Specify) Community	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospita

<input type="checkbox"/> XXXX XXXX General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

Health Care Program

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

<input type="checkbox"/> XXXX XXXX Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> U of I - Division of Specialized Care for Children

**NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable
By Fine And / Or Imprisonment Under Federal Law**

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Trinity Medical Center 18015 for the cost report beginning 01/01/2015 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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
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	207	75,582		37,214	49.24%		12,156	4.17
2.	Psych	31	11,288		8,280	73.35%		1,751	4.73
3.	Rehab	22	8,030		3,378	42.07%		245	13.79
4.	Other (Sub)								
5.	Intensive Care Unit	20	7,300		4,983	68.26%			
6.	Coronary Care Unit	31	11,315		7,418	65.56%			
7.	NICU	9	3,285		1,128	34.34%			
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	20	7,300		2,958	40.52%			
22.	Total	340	124,100		65,359	52.67%		14,152	4.41
23.	Observation Bed Days				4,699				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				9,134			3,064	3.59
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				678				
6.	Coronary Care Unit				605				
7.	NICU				574				
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				1,341				
22.	Total				12,332	18.87%		3,064	3.59

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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
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)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of 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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	13,083,844	86,344,045	0.151532	3,496,926		529,896	
2.	Recovery Room	5,016,528	10,673,358	0.470005	385,357		181,120	
3.	Delivery and Labor Room	4,334,089	9,906,258	0.437510	3,669,440		1,605,417	
4.	Anesthesiology	433,470	12,104,424	0.035811	441,334		15,805	
5.	Radiology - Diagnostic	5,491,045	27,374,064	0.200593	569,648		114,267	
6.	Radiology - Therapeutic	6,321,978	48,643,565	0.129965				
7.	Nuclear Medicine	647,212	4,500,651	0.143804	54,745		7,873	
8.	Laboratory	11,900,069	52,218,435	0.227890	4,391,402		1,000,757	
9.	Blood							
10.	Blood - Administration	2,418,477	3,386,479	0.714157	163,949		117,085	
11.	Intravenous Therapy	5,804,978	18,102,542	0.320672	742,752		238,180	
12.	Respiratory Therapy	2,053,035	14,746,973	0.139217	1,517,048		211,199	
13.	Physical Therapy	3,966,192	12,799,221	0.309878	246,396		76,353	
14.	Occupational Therapy	1,317,820	5,313,243	0.248026	74,815		18,556	
15.	Speech Pathology	361,285	1,271,973	0.284035	113,742		32,307	
16.	EKG							
17.	EEG	1,316,125	5,839,219	0.225394	115,782		26,097	
18.	Med. / Surg. Supplies	21,759,365	42,307,553	0.514314	1,747,978		899,010	
19.	Drugs Charged to Patients	29,111,512	96,628,585	0.301272	6,432,205		1,937,843	
20.	Renal Dialysis	1,188,070	2,150,054	0.552577	229,251		126,679	
21.	Ambulance							
22.	Gastrointestinal	2,928,157	12,606,695	0.232270	179,439		41,678	
23.	MRI	1,856,340	6,032,138	0.307742	488,466		150,322	
24.	Ultrasound	882,251	7,155,316	0.123300	204,908		25,265	
25.	Implantable Devices	20,029,746	53,423,890	0.374921	1,433,397		537,411	
26.	Cardiology	2,668,543	14,165,849	0.188379	566,269		106,673	
27.	Cardiopulmonary	1,423,911	8,352,425	0.170479	597,893		101,928	
28.	CT Scan	2,122,054	57,284,305	0.037044	1,907,658		70,667	
29.	Cardiac Rehab	1,210,247	2,388,005	0.506803				
30.	Cardiac Cath	7,866,768	62,065,557	0.126749	999,387		126,671	
31.	Hyperbaric Oxygen Therapy	123,126	411,202	0.299429				
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	7,942,143	18,102,882	0.438723	181,535		79,644	
44.	Emergency	14,648,001	52,258,371	0.280300	1,697,404		475,782	
45.	Observation	3,652,942	4,656,853	0.784423	123,966		97,242	
46.	Total				32,773,092		8,951,727	

* 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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
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)	31,241,923	6,171,907	2,634,283	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	41,913	8,280	3,378	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	745.40	745.40	779.84	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	9,134			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,808,484			
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)	6,808,484			

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	7,351,003	4,983	1,475.22	678	1,000,199	
9.	Coronary Care Unit	6,252,940	7,418	842.94	605	509,979	
10.	NICU	2,165,722	1,128	1,919.97	574	1,102,063	
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Other						
22.	Other						
23.	Nursery	1,726,628	2,958	583.71	1,341	782,755	
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)						8,951,727
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)						19,155,207

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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
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.	NICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	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 (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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
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	18,061	86,344,045	0.000209	3,496,926		731	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	715,765	12,104,424	0.059133	441,334		26,097	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic	751	48,643,565	0.000015				
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	162	18,102,542	0.000009	742,752		7	
12.	Respiratory Therapy	905	14,746,973	0.000061	1,517,048		93	
13.	Physical Therapy	73,625	12,799,221	0.005752	246,396		1,417	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	18,181	5,839,219	0.003114	115,782		361	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Gastrointestinal	130	12,606,695	0.000010	179,439		2	
23.	MRI							
24.	Ultrasound							
25.	Implantable Devices							
26.	Cardiology	325,269	14,165,849	0.022961	566,269		13,002	
27.	Cardiopulmonary							
28.	CT Scan							
29.	Cardiac Rehab	20,467	2,388,005	0.008571				
30.	Cardiac Cath	1,089,313	62,065,557	0.017551	999,387		17,540	
31.	Hyperbaric Oxygen Therapy							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	276,148	18,102,882	0.015254	181,535		2,769	
44.	Emergency	2,537,189	52,258,371	0.048551	1,697,404		82,411	
45.	Observation							
46.	Ancillary Total						144,430	

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(b)

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

Line No.	Cost Centers	Professional Component	Total Days Including Private	Professional Component Cost	Program Days	Outpatient Program	Inpatient Program	Outpatient Program
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Per Diem (Col. 1 / Col. 2)	Including Private (BHF Pg. 2 Pt. II, Col. 4)	Charges (BHF Page 3, Col. 5)	Expenses for H B P (Col. 3 X Col. 4)	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	8,962,391	41,913	213.83	9,134		1,953,123	
48.	Psych	1,770,539	8,280	213.83				
49.	Rehab	95,250	3,378	28.20				
50.	Other (Sub)							
51.	Intensive Care Unit	1,459,121	4,983	292.82	678		198,532	
52.	Coronary Care Unit							
53.	NICU	1,210,724	1,128	1,073.34	574		616,097	
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)						2,767,752	
68.	Ancillary Total (from line 46)						144,430	
69.	Total (Lines 67-68)						2,912,182	

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number: 14-0280		Medicaid Provider Number: 18015	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2015 To: 12/31/2015	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	19,155,207	
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)	2,912,182	
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)	22,067,389	
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	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	32,773,092	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	7,918,853	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,576,470	
	F. Coronary Care Unit	972,417	
	G. NICU	817,728	
	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	1,217,628	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	45,276,188	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		23,208,799
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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
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)	22,067,389	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	22,067,389	
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)	22,067,389	

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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
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)	23,208,799
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 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	Sub I	Sub II	Sub III
	Service	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)				

Part C. Program Cost	General	Sub I	Sub II	Sub III
	Service	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

1. Gross Routine Revenues	Adults and	Sub I	Sub II	Sub III
	Pediatrics	Psych	Rehab	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: 14-0280	Medicaid Provider Number: 18015
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.	Gastrointestinal							
23.	MRI							
24.	Ultrasound							
25.	Implantable Devices							
26.	Cardiology							
27.	Cardiopulmonary							
28.	CT Scan							
29.	Cardiac Rehab							
30.	Cardiac Cath							
31.	Hyperbaric Oxygen Therapy							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

Line No.	Cost Centers	G M E	Total Days	GME	Program	Outpatient	Inpatient	Outpatient
		Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Including Private (CMS 2552-10, W/S S-3, Pt. 1 Col. 8)	Cost Per Diem (Col. 1 / Col. 2)	Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Program Charges (BHF Page 3, Col. 5)	Program Expenses for G M E (Col. 3 X Col. 4)	Program Expenses for G M E (Col. 3 X Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

