

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: Franciscan St. Margaret Health- Dyer		Medicare Provider Number: 15-0090	
Street: U.S. Highway 30		Medicaid Provider Number: 4016	
City: Dyer	State: Indiana	Zip: 46311	
Period Covered by Statement:	From: 01/01/2016	To: 12/31/2016	

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"/> Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospita

<input type="checkbox"/> 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"/> 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)) Franciscan St. Margaret Health- I 4016 for the cost report beginning 01/01/2016 and ending 12/31/2016 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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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	111	40,626		18,683	45.99%		4,835	4.51
2.	Psych								
3.	Rehab	30	10,980		7,545	68.72%		638	11.83
4.	Other (Sub)								
5.	Intensive Care Unit	14	5,124		2,444	47.70%			
6.	Coronary Care Unit	7	2,562		690	26.93%			
7.	NICU								
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				797				
22.	Total	162	59,292		30,159	50.87%		5,473	5.36
23.	Observation Bed Days				4,097				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				225				
2.	Psych								
3.	Rehab				18				
4.	Other (Sub)								
5.	Intensive Care Unit				43				
6.	Coronary Care Unit				22				
7.	NICU								
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				138				
22.	Total				446	1.48%			

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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	8,000,259	43,020,203	0.185965	96,946		18,029	
2.	Recovery Room	1,323,787	6,124,133	0.216159	13,440		2,905	
3.	Delivery and Labor Room							
4.	Anesthesiology	4,031,164	17,519,233	0.230099	37,803		8,698	
5.	Radiology - Diagnostic	4,781,561	49,318,626	0.096952	229,226		22,224	
6.	Radiology - Therapeutic	2,041,821	9,664,820	0.211263				
7.	Nuclear Medicine	1,684,373	9,964,844	0.169032	4,740		801	
8.	Laboratory	7,068,796	52,077,941	0.135735	365,860		49,660	
9.	Blood							
10.	Blood - Administration	558,829	2,639,027	0.211756	9,318		1,973	
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,204,957	14,490,075	0.152170	187,501		28,532	
13.	Physical Therapy	8,217,494	19,192,274	0.428167	27,985		11,982	
14.	Occupational Therapy	703,388	2,664,114	0.264023	17,218		4,546	
15.	Speech Pathology	427,314	1,416,939	0.301575	18,111		5,462	
16.	EKG	1,555,183	13,553,620	0.114743	50,518		5,797	
17.	EEG	493,562	1,358,841	0.363223	4,714		1,712	
18.	Med. / Surg. Supplies	6,432,711	27,392,038	0.234839	160,239		37,630	
19.	Drugs Charged to Patients	9,746,422	62,343,957	0.156333	500,820		78,295	
20.	Renal Dialysis							
21.	Ambulance							
22.	Outpatient Surgery	3,011,479	12,695,569	0.237207				
23.	Radiology-Spec Proc	1,947,046	10,227,015	0.190383				
24.	Ultrasound	1,047,705	8,602,968	0.121784				
25.	Pain Clinic	1,663,496	6,459,357	0.257533				
26.	Cath Lab	3,787,597	34,969,251	0.108312	109,331		11,842	
27.	Activity Therapy	3,611,262	5,456,789	0.661792				
28.	Wound Care Cntr	796,172	1,500,784	0.530504				
29.	Bariatric Clinic	916,769	527,474	1.738036				
30.	CV Resource Cntr	144,056						
31.	Anticoagulation Clinic	548,930	1,162,802	0.472075	22,628		10,682	
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							
44.	Emergency	8,781,738	35,472,673	0.247563	5,884		1,457	
45.	Observation	4,301,973	5,826,456	0.738352				
46.	Total				1,862,282		302,227	

* 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 Cc

Preliminary

Medicare Provider Number: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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)	23,919,688		5,655,389	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	22,780		7,545	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,050.03		749.55	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	225		18	
3.	Program general inpatient routine cost (Line 1c X Line 2)	236,257		13,492	
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)	236,257		13,492	

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)	
		(A)	(B)	(C)	(D)	(E)	
8.	Intensive Care Unit	4,512,963	2,444	1,846.55	43	79,402	
9.	Coronary Care Unit	2,037,504	690	2,952.90	22	64,964	
10.	NICU						
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	1,481,742	797	1,859.15	138	256,563	
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)						302,227
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)						952,905

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

Preliminary

Medicare Provider Number: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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	360,666	43,020,203	0.008384	96,946		813	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	14,499	52,077,941	0.000278	365,860		102	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	9,815	14,490,075	0.000677	187,501		127	
13.	Physical Therapy	28,190	19,192,274	0.001469	27,985		41	
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.	Outpatient Surgery	45,480	12,695,569	0.003582				
23.	Radiology-Spec Proc							
24.	Ultrasound							
25.	Pain Clinic							
26.	Cath Lab	280	34,969,251	0.000008	109,331		1	
27.	Activity Therapy							
28.	Wound Care Cntr	3,245	1,500,784	0.002162				
29.	Bariatric Clinic							
30.	CV Resource Cntr							
31.	Anticoagulation Clinic	6,000	1,162,802	0.005160	22,628		117	
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							
44.	Emergency	9,595	35,472,673	0.000270	5,884		2	
45.	Observation							
46.	Ancillary Total						1,203	

* 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

Preliminary

Medicare Provider Number: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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	21,010	22,780	0.92	225		207	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	45,520	2,444	18.63	43		801	
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)						1,008	
68.	Ancillary Total (from line 46)						1,203	
69.	Total (Lines 67-68)						2,211	

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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)	952,905	
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)	2,211	
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)	12,067	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	967,183	
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)	1,862,282	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,005,351	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. NICU		
	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	61,535	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	2,929,168	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,961,985
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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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)	967,183	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	967,183	
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)	967,183	

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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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)		1,961,985
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)
			(1)	(2A)	(2B)	(3A)
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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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

	Adults and	Sub I	Sub II	Sub III
	Pediatrics	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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

Line No.	Cost Centers	G M E	Total Dept.	Ratio of	Inpatient	Outpatient	Inpatient	Outpatient
		Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	G M E Cost to Charges (Col. 1 / Col. 2)	Program Charges (BHF Page 3, 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)
Inpatient Ancillary Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	16,773	43,020,203	0.000390	96,946		38	
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.	Outpatient Surgery							
23.	Radiology-Spec Proc							
24.	Ultrasound							
25.	Pain Clinic							
26.	Cath Lab							
27.	Activity Therapy							
28.	Wound Care Cntr							
29.	Bariatric Clinic							
30.	CV Resource Cntr							
31.	Anticoagulation Clinic							
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	31,150	35,472,673	0.000878	5,884		5	
45.	Observation							
46.	Ancillary Total						43	

* 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: 15-0090	Medicaid Provider Number: 4016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2016 To: 12/31/2016

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	1,217,259	22,780	53.44	225		12,024	
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)						12,024	
68.	Ancillary Total (from line 46)						43	
69.	Total (Lines 67-68)						12,067	

