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: 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: 01/01/2017	To: 12/31/2017

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)

XXXX XXXX	Medicaid Hospital		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 01/01/2017 and ending 12/31/2017 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):

Name (Typewritten)
Title Date
Firm
Telephone Number
Email Address

Signed (Officer or Administrator of Provider(s)):

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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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		40,040	63.05%		12,732	3.54
2.	Psych	44	16,060		13,487	83.98%		2,257	5.98
3.	Rehab	36	13,140		5,533	42.11%		379	14.60
4.	Other (Sub)								
5.	Intensive Care Unit	12	4,380		2,479	56.60%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		2,600	59.36%			
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		3,568	48.88%			
22.	**Total**	**298**	**108,770**		**67,707**	**62.25%**		**15,368**	**4.17**
23.	Observation Bed Days				5,243				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,936			563	3.93
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				276				
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				71				
22.	**Total**				**2,283**	**3.37%**		**563**	**3.93**

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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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	31,128,085	149,048,107	0.208846	3,605,608		753,017	
2.	Recovery Room	3,517,061	29,631,634	0.118693	511,092		60,663	
3.	Delivery and Labor Room	3,237,052	11,510,761	0.281220	1,131,244		318,128	
4.	Anesthesiology	2,631,009	48,121,096	0.054675	913,780		49,961	
5.	Radiology - Diagnostic	10,559,939	44,733,190	0.236065	476,850		112,568	
6.	Radiology - Therapeutic	3,506,574	21,220,931	0.165241	58,655		9,692	
7.	Nuclear Medicine	2,108,794	14,418,729	0.146254	43,486		6,360	
8.	Laboratory	19,086,511	205,128,530	0.093047	2,256,688		209,978	
9.	Blood							
10.	Blood - Administration	1,171,603	5,172,831	0.226492	256,819		58,167	
11.	Intravenous Therapy	4,878,492	24,214,147	0.201473	241,941		48,745	
12.	Respiratory Therapy	2,129,011	19,669,089	0.108241	532,900		57,682	
13.	Physical Therapy	4,153,737	14,063,730	0.295351	142,133		41,979	
14.	Occupational Therapy	521,459	2,019,226	0.258247	36,866		9,521	
15.	Speech Pathology	855,596	2,733,418	0.313013	38,223		11,964	
16.	EKG	387,854	7,071,301	0.054849	117,797		6,461	
17.	EEG	1,485,944	11,484,271	0.129389	28,513		3,689	
18.	Med. / Surg. Supplies	1,952,707	70,955,495	0.027520	1,313,961		36,160	
19.	Drugs Charged to Patients	21,220,038	66,045,856	0.321292	1,952,489		627,319	
20.	Renal Dialysis	585,372	1,938,071	0.302038	95,222		28,761	
21.	Ambulance							
22.	Pain Clinic	125,167	450	278.148889				
23.	Northside Imaging	580,629	2,588,798	0.224285				
24.	Northside Mammography	419,056	1,876,487	0.223319				
25.	Northside Ultrasound	272,040	1,491,913	0.182343				
26.	Implant Devices	18,506,062	57,950,654	0.319342	833,325		266,116	
27.	Pulmonary Function	229,417	3,384,094	0.067793	39,188		2,657	
28.	Cardiac Cath	1,159,724	33,654,945	0.034459	372,116		12,823	
29.	CT Scan	1,108,350	65,364,076	0.016957	735,830		12,477	
30.	Northside CT	414,952	8,063,395	0.051461				
31.	MRI	974,095	20,715,426	0.047023	198,132		9,317	
32.	Northside MRI	574,031	7,425,254	0.077308				
33.	Cardiology	1,994,118	13,763,353	0.144886	244,273		35,392	
34.	Psych-Part Hospital	684,552	3,030,525	0.225886				
35.	GI	2,148,700	18,882,364	0.113794	240,725		27,393	
36.	Cardiac Rehab	6,965	1	###########				
37.	Hyperbaric Oxygen	345,398	2,339,351	0.147647				
38.	Other Clinics	1,454,929	243,718	5.969723				
39.	Chilli Family Psysic	1,954,103						
40.	Physician Offices	34,569,432	26,805,941	1.289618				
41.	Endocrinology,Diabetic	529,218	2,010,163	0.263271				
42.	Wound Care Center	1,672,370	3,739,405	0.447229				
	Outpatient Service Cost Centers							
43.	Clinic	4,948,556	15,803,731	0.313126	302,934		94,857	
44.	Emergency	9,611,616	53,263,509	0.180454	343,372		61,963	
45.	Observation	4,801,644	8,146,660	0.589400	60,421		35,612	
46.	**Total**				**17,124,583**		**3,009,422**	

* 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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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)	41,468,305	10,566,843	3,313,127	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	45,283	13,487	5,533	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	915.76	783.48	598.79	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,936			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,772,911			
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)	1,772,911			

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	7,220,259	2,479	2,912.57	276	803,869
9.	Coronary Care Unit					
10.	Surgical ICU	831,182	2,600	319.69		
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	2,405,705	3,568	674.24	71	47,871
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					3,009,422
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**5,634,073**

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: 01/01/2017 To: 12/31/2017

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Surgical ICU						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

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

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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	423,750	149,048,107	0.002843	3,605,608		10,251	
2.	Recovery Room							
3.	Delivery and Labor Room	1,219,622	11,510,761	0.105955	1,131,244		119,861	
4.	Anesthesiology							
5.	Radiology - Diagnostic	128,330	44,733,190	0.002869	476,850		1,368	
6.	Radiology - Therapeutic	243,373	21,220,931	0.011469	58,655		673	
7.	Nuclear Medicine							
8.	Laboratory	400,553	205,128,530	0.001953	2,256,688		4,407	
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							
37.	Hyperbaric Oxygen							
38.	Other Clinics							
39.	Chilli Family Psysic							
40.	Physician Offices	5,758,922	26,805,941	0.214838				
41.	Endocrinology,Diabetic							
42.	Wound Care Center							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	4,707,949	53,263,509	0.088390	343,372		30,351	
45.	Observation							
46.	**Ancillary Total**						**166,911**	

* 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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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	1,097,148	45,283	24.23	1,936		46,909	
48.	Psych							
49.	Rehab	6,000	5,533	1.08				
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	540,000	3,568	151.35	71		10,746	
67.	**Routine Total (lines 47-66)**						**57,655**	
68.	**Ancillary Total (from line 46)**						**166,911**	
69.	**Total (Lines 67-68)**						**224,566**	

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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)	5,634,073	
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)	224,566	
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)	220,010	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**6,078,649**	
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)	17,124,583	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,486,752	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,304,406	
	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	109,006	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	22,024,747	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		15,946,098
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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	6,078,649	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,078,649	
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)**	**6,078,649**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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)	15,946,098
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)	(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: 14-0209	Medicaid Provider Number: 16006
Program: Medicaid-Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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

	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: 01/01/2017 To: 12/31/2017

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	612,323	149,048,107	0.004108	3,605,608		14,812	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	50,872	44,733,190	0.001137	476,850		542	
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							
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	48,560	18,882,364	0.002572	240,725		619	
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Other Clinics							
39.	Chilli Family Psysic							
40.	Physician Offices	3,794,177	26,805,941	0.141542				
41.	Endocrinology,Diabetic							
42.	Wound Care Center							
	Outpatient Ancillary Centers							
43.	Clinic	4,042,067	15,803,731	0.255767	302,934		77,481	
44.	Emergency	416,231	53,263,509	0.007815	343,372		2,683	
45.	Observation							
46.	**Ancillary Total**						**96,137**	

* 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: 01/01/2017 To: 12/31/2017

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	1,416,110	45,283	31.27	1,936		60,539	
48.	Psych	332,985	13,487	24.69				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	568,849	2,479	229.47	276		63,334	
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							
67.	**Routine Total (lines 47-66)**						**123,873**	
68.	**Ancillary Total (from line 46)**						**96,137**	
69.	**Total (Lines 67-68)**						**220,010**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 01/01/2017 To: 12/31/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,212		2,212
Newborn Days	71		71
Total Inpatient Revenue	22,024,747		22,024,747
Ancillary Revenue	17,124,583		17,124,583
Routine Revenue	4,900,164		4,900,164
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

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

Professional fees were allowed based on those reported on pg 6a & 6b instead of as reported on Sched A-8-2 of Medicare rpt.
(These fees tied as reported in 2011-14 & not reported prior to 2011)