

# 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: Rush Copley Memorial Hospital		Medicare Provider Number: 14-0029	
Street: 2000 Ogden Avenue		Medicaid Provider Number: 1007	
City: Aurora	State: IL	Zip: 60504	
Period Covered by Statement:	From: 07/01/2015	To: 06/30/2016	

**Type of Control**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" 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 Hospital**

<input checked="" 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 checked="" 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)) Rush Copley Memorial Hospit 1007 for the cost report beginning 07/01/2015 and ending 06/30/2016 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: <b>14-0029</b>	Medicaid Provider Number: <b>1007</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

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
<b>Part I-Hospital</b>									
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	157	57,462		28,810	50.14%		11,220	3.19
2.	Psych								
3.	Rehab	18	6,588		4,442	67.43%		362	12.27
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,052		4,873	60.52%			
6.	Coronary Care Unit								
7.	NICU	13	4,758		2,107	44.28%			
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	25	9,150		8,426	92.09%			
<b>22.</b>	<b>Total</b>	<b>235</b>	<b>86,010</b>		<b>48,658</b>	<b>56.57%</b>		<b>11,582</b>	<b>3.47</b>
23.	Observation Bed Days				12,493				

<b>Part II-Program</b>		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				6,156			3,493	2.34
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,414				
6.	Coronary Care Unit								
7.	NICU				611				
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				2,444				
<b>22.</b>	<b>Total</b>				<b>10,625</b>	<b>21.84%</b>		<b>3,493</b>	<b>2.34</b>

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: <b>14-0029</b>	Medicaid Provider Number: <b>1007</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

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	20,339,607	190,712,158	0.106651	3,344,284		356,671	
2.	Recovery Room	1,596,901	18,725,347	0.085280	275,114		23,462	
3.	Delivery and Labor Room	11,443,991	49,264,214	0.232298	5,384,854		1,250,891	
4.	Anesthesiology	1,391,257	20,869,344	0.066665	622,193		41,478	
5.	Radiology - Diagnostic	17,853,432	240,266,303	0.074307	2,470,443		183,571	
6.	Radiology - Therapeutic	7,351,601	30,671,028	0.239692	41,953		10,056	
7.	Nuclear Medicine							
8.	Laboratory	13,670,300	146,934,007	0.093037	5,793,439		539,004	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	4,499,217	37,169,014	0.121048	3,990,902		483,091	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,390,970	41,420,678	0.081867	683,497		55,956	
17.	EEG							
18.	Med. / Surg. Supplies	1,166,912	40,462,492	0.028839				
19.	Drugs Charged to Patients	18,619,285	193,427,940	0.096260				
20.	Renal Dialysis	979,920	5,445,410	0.179953	224,913		40,474	
21.	Ambulance							
22.	Same Day Surgery	3,536,027	18,600,418	0.190105	35,550		6,758	
23.	G.I. Lab	4,793,430	21,556,477	0.222366	165,023		36,696	
24.	Cardiac Rehab	3,673,380	3,212,186	1.143576				
25.	Rehab Services	6,138,030	45,668,362	0.134404	1,085,256		145,863	
26.	Implantable Devices	10,749,616	23,552,666	0.456408				
27.	Pancreas Acquisition							
28.	Wound Care Center	1,294,615	2,736,847	0.473032				
29.	MCAI	6,472,826	29,913,954	0.216381				
30.	Vascular Services	11,851,048	69,185,989	0.171293	977,470		167,434	
31.	Diabetic Center	499,702	363,417	1.375010				
32.	Yorkville	9,896,674	69,190,781	0.143035	292,503		41,838	
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic	4,093,584	14,214,643	0.287984	61,287		17,650	
44.	Emergency	15,538,826	165,968,693	0.093625	1,344,391		125,869	
45.	Observation	13,986,913	12,033,109	1.162369				
46.	<b>Total</b>				<b>26,793,072</b>		<b>3,526,762</b>	

\* 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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	46,231,260		3,642,038	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	41,303		4,442	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,119.32		819.91	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	6,156			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,890,534			
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)	6,890,534			

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	6,157,959	4,873	1,263.69	1,414	1,786,858
9.	Coronary Care Unit					
10.	NICU	6,691,658	2,107	3,175.92	611	1,940,487
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		8,426		2,444	
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					3,526,762
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>14,144,641</b>

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

Preliminary

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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.	<b>Total (Sum of Lines 22 and 26)</b>								

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

Preliminary

Medicare Provider Number: <b>14-0029</b>	Medicaid Provider Number: <b>1007</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

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)
	<b>Inpatient Ancillary Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
1.	Operating Room	332,250	190,712,158	0.001742	3,344,284		5,826	
2.	Recovery Room							
3.	Delivery and Labor Room	1,172,623	49,264,214	0.023803	5,384,854		128,176	
4.	Anesthesiology							
5.	Radiology - Diagnostic	98,750	240,266,303	0.000411	2,470,443		1,015	
6.	Radiology - Therapeutic	425	30,671,028	0.000014	41,953		1	
7.	Nuclear Medicine							
8.	Laboratory	70,600	146,934,007	0.000480	5,793,439		2,781	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	4,780	37,169,014	0.000129	3,990,902		515	
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.	Same Day Surgery							
23.	G.I. Lab							
24.	Cardiac Rehab	553,720	3,212,186	0.172381				
25.	Rehab Services							
26.	Implantable Devices							
27.	Pancreas Acquisition							
28.	Wound Care Center							
29.	MCAI							
30.	Vascular Services							
31.	Diabetic Center							
32.	Yorkville	663,867	69,190,781	0.009595	292,503		2,807	
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency	575,731	165,968,693	0.003469	1,344,391		4,664	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>145,785</b>	

\* 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: <b>14-0029</b>	Medicaid Provider Number: <b>1007</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

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)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
47.	Adults and Pediatrics	28,840	41,303	0.70	6,156		4,309	
48.	Psych							
49.	Rehab	113,349	4,442	25.52				
50.	Other (Sub)							
51.	Intensive Care Unit	711,657	4,873	146.04	1,414		206,501	
52.	Coronary Care Unit							
53.	NICU	99,531	2,107	47.24	611		28,864	
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.	<b>Routine Total (lines 47-66)</b>						<b>239,674</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>145,785</b>	
69.	<b>Total (Lines 67-68)</b>						<b>385,459</b>	

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

Preliminary

<b>Medicare Provider Number:</b> 14-0029	<b>Medicaid Provider Number:</b> 1007
<b>Program:</b> Medicaid Hospital	<b>Period Covered by Statement:</b> From: 07/01/2015 To: 06/30/2016

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)	14,144,641	
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)	385,459	
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)	211,497	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>14,741,597</b>	
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)	26,793,072	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,665,308	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	458,203	
	F. Coronary Care Unit		
	G. NICU	10,646,903	
	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.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>42,563,486</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		27,821,889
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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	14,741,597	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	14,741,597	
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.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	<b>14,741,597</b>	

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.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>		

\* Line 9 DOES NOT APPLY to the Medicaid program.

Preliminary

Medicare Provider Number: <b>14-0029</b>	Medicaid Provider Number: <b>1007</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

**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)	27,821,889
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 (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.	Cost Report Period ended		
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	<b>Total (Sum of Lines 1 - 3)</b>					

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

BHF Supplement No. 1

**Preliminary**

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

**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: <b>14-0029</b>	Medicaid Provider Number: <b>1007</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

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)
	<b>Inpatient Ancillary Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
1.	Operating Room	47,567	190,712,158	0.000249	3,344,284		833	
2.	Recovery Room							
3.	Delivery and Labor Room	107,026	49,264,214	0.002172	5,384,854		11,696	
4.	Anesthesiology							
5.	Radiology - Diagnostic	35,676	240,266,303	0.000148	2,470,443		366	
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	35,676	5,445,410	0.006552	224,913		1,474	
21.	Ambulance							
22.	Same Day Surgery							
23.	G.I. Lab	11,892	21,556,477	0.000552	165,023		91	
24.	Cardiac Rehab	95,134	3,212,186	0.029617				
25.	Rehab Services							
26.	Implantable Devices							
27.	Pancreas Acquisition							
28.	Wound Care Center							
29.	MCAI							
30.	Vascular Services							
31.	Diabetic Center							
32.	Yorkville							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic							
44.	Emergency	95,134	165,968,693	0.000573	1,344,391		770	
45.	Observation							
46.	<b>Ancillary Total</b>						<b>15,230</b>	

\* 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: <b>14-0029</b>	Medicaid Provider Number: <b>1007</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2015</b> To: <b>06/30/2016</b>

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)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
47.	Adults and Pediatrics	1,201,065	41,303	29.08	6,156		179,016	
48.	Psych							
49.	Rehab	190,268	4,442	42.83				
50.	Other (Sub)							
51.	Intensive Care Unit	59,459	4,873	12.20	1,414		17,251	
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.	<b>Routine Total (lines 47-66)</b>						<b>196,267</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>15,230</b>	
69.	<b>Total (Lines 67-68)</b>						<b>211,497</b>	

**Hospital Statement of Cost  
Reconciliation of Patient Days and Revenue**

Preliminary

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,181		8,181
Newborn Days	2,444		2,444
Total Inpatient Revenue	42,563,486		42,563,486
Ancillary Revenue	26,793,072		26,793,072
Routine Revenue	15,770,414		15,770,414
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

BHF Page 2 - Total Bed Days Available/Utilized were adjusted to as filed W/S S-3

BHF page 2-Observation Bed Days adjusted to W/S S-3, col. 8, line 28.

BHF page 3 - Costs/charges agree with as filed W/S C Part I, col. 1