

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: Riverside Medical Center		Medicare Provider Number: 14-0186	
Street: 350 N. Wall Street		Medicaid Provider Number: 11006	
City: Kankakee	State: Illinois	Zip: 60901	
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"/> 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)) Riverside Medical Center 11006 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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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	210	76,650		31,807	41.50%		6,864	5.29
2.	Psych	64	23,360		12,577	53.84%		2,714	4.63
3.	Rehab	30	10,950		8,323	76.01%		710	11.72
4.	Other (Sub)								
5.	Intensive Care Unit	18	6,570		4,529	68.93%			
6.	Coronary Care Unit	13	4,745						
7.	Other								
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	18	6,570		2,647	40.29%			
22.	Total	353	128,845		59,883	46.48%		10,288	5.56
23.	Observation Bed Days				1,039				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				416			38	10.95
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				416	0.69%		38	10.95

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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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 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	19,757,716	90,165,972	0.219126				
2.	Recovery Room	4,129,561	14,180,186	0.291221				
3.	Delivery and Labor Room	2,230,787	6,398,639	0.504918				
4.	Anesthesiology	2,023,007	31,123,460	0.064999				
5.	Radiology - Diagnostic	10,419,402	63,131,168	0.165044	8,306		1,371	
6.	Radiology - Therapeutic	5,147,735	14,882,793	0.345885				
7.	Nuclear Medicine	944,301	6,125,666	0.154155	6,873		1,060	
8.	Laboratory	13,778,362	114,051,177	0.120809	75,353		9,103	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	3,409,794	6,468,624	0.527128	4,848		2,556	
12.	Respiratory Therapy	4,051,734	23,849,901	0.169885	87,482		14,862	
13.	Physical Therapy	7,105,509	24,202,737	0.293583	652,647		191,606	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	6,143,043	22,672,325	0.270949	4,439		1,203	
17.	EEG							
18.	Med. / Surg. Supplies	1,135,085	11,208,402	0.101271	11,437		1,158	
19.	Drugs Charged to Patients	18,612,733	108,697,480	0.171234	169,018		28,942	
20.	Renal Dialysis	765,562	1,119,111	0.684080	17,040		11,657	
21.	Ambulance	5,027,434	5,648,065	0.890116				
22.	Cardiac Cath Lab	7,281,149	48,235,742	0.150949				
23.	CT Scan	2,268,962	57,324,231	0.039581	23,001		910	
24.	Ultrasound	1,416,006	13,355,405	0.106025	15,911		1,687	
25.	MRI	1,261,181	14,562,564	0.086604	1,000		87	
26.	Cardiac Rehab	845,044	1,162,846	0.726703				
27.	OP Psy/CDU	2,333,310	8,991,445	0.259503				
28.	RIMMS/Occ Health	1,386,840	1,332,875	1.040488				
29.	Diabetes	693,144	733,086	0.945515				
30.	Infusion	1,391,897	878,814	1.583836				
31.	Community Health	2,334,667	5,318,695	0.438955				
32.	RHC	436,678	484,037	0.902158				
33.	Implantable Devices	15,566,638	34,609,864	0.449775				
34.	Wound/Hyperbaric	1,377,853	3,445,999	0.399841				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	9,163,361	74,847,088	0.122428				
45.	Observation	2,547,589	21,668,671	0.117570				
46.	Total				1,077,355		266,202	

* 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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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)	23,713,230	9,898,604	5,900,080	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	32,846	12,577	8,323	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	721.95	787.04	708.89	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			416	
3.	Program general inpatient routine cost (Line 1c X Line 2)			294,898	
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)			294,898	

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	6,871,353	4,529	1,517.19		
9.	Coronary Care Unit					
10.	Other					
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	2,210,957	2,647	835.27		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					266,202
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					561,100

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

Preliminary

Medicare Provider Number: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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.	Other						
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

BHF Page 6(a)

Preliminary

Medicare Provider Number: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	360,480	31,123,460	0.011582				
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	2,443,071	22,672,325	0.107756	4,439		478	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab							
23.	CT Scan							
24.	Ultrasound							
25.	MRI							
26.	Cardiac Rehab							
27.	OP Psy/CDU	72,299	8,991,445	0.008041				
28.	RIMMS/Occ Health	117,970	1,332,875	0.088508				
29.	Diabetes							
30.	Infusion	375	878,814	0.000427				
31.	Community Health	2,716,367	5,318,695	0.510721				
32.	RHC	24,616	484,037	0.050856				
33.	Implantable Devices							
34.	Wound/Hyperbaric							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	94,254	74,847,088	0.001259				
45.	Observation							
46.	Ancillary Total						478	

* 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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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 Per Diem	Program Days Including Private	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P	Outpatient Program Expenses for H B P
		(CMS 2552-10, W/S A-8-2, Col. 4)	(CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	(Col. 1 / Col. 2)	(BHF Pg. 2 Pt. II, Col. 4)		(Col. 3 X Col. 4)	(Col. 3 X Col. 5)
Routine Service Cost Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	86,678	32,846	2.64				
48.	Psych	27,645	12,577	2.20				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
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)						478	
69.	Total (Lines 67-68)						478	

Computation of Lesser of Reasonable Cost or Customary Charge

Preliminary

Medicare Provider Number: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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)	561,100	
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)	478	
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)	128	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	561,706	
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)	1,077,355	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	415,800	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	1,493,155	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		931,449
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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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)	561,706	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	561,706	
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)	561,706	

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.

Preliminary

Medicare Provider Number: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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)	931,449
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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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 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

1. 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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	Period Covered by Statement: From: 01/01/2015 To: 12/31/2015

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	47,934	90,165,972	0.000532				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	28,823	63,131,168	0.000457	8,306		4	
6.	Radiology - Therapeutic	46,681	14,882,793	0.003137				
7.	Nuclear Medicine	57,959	6,125,666	0.009462	6,873		65	
8.	Laboratory	19,111	114,051,177	0.000168	75,353		13	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	57,020	22,672,325	0.002515	4,439		11	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab							
23.	CT Scan	86,156	57,324,231	0.001503	23,001		35	
24.	Ultrasound							
25.	MRI							
26.	Cardiac Rehab							
27.	OP Psy/CDU							
28.	RIMMS/Occ Health							
29.	Diabetes							
30.	Infusion							
31.	Community Health							
32.	RHC							
33.	Implantable Devices							
34.	Wound/Hyperbaric							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Centers								
43.	Clinic							
44.	Emergency	47,307	74,847,088	0.000632				
45.	Observation							
46.	Ancillary Total						128	

* 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: 14-0186	Medicaid Provider Number: 11006
Program: Medicaid Rehab	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	857,025	32,846	26.09				
48.	Psych	273,342	12,577	21.73				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	161,033	4,529	35.56				
52.	Coronary Care Unit							
53.	Other							
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)						128	
69.	Total (Lines 67-68)						128	

