

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 University Medical Center		Medicare Provider Number: 14-0119	
Street: 1753 West Congress Parkway		Medicaid Provider Number: 3048	
City: Chicago	State: Illinois	Zip: 60612	
Period Covered by Statement:	From: 07/01/2015	To: 06/30/2016	

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)) Rush University Medical Cente 3048 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: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	354	128,517	94,604	98,164	76.38%		27,341	4.71
2.	Psych	67	24,522	14,060	14,607	59.57%		1,472	9.92
3.	Rehab	54	19,764	8,567	11,847	59.94%		1,008	11.75
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Surgical ICU	54	19,188		15,157	78.99%			
8.	Medical ICU	52	18,934		15,535	82.05%			
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	6,588		3,135	47.59%			
22.	Total	599	217,513	117,231	158,445	72.84%		29,821	5.21
23.	Observation Bed Days				7,894				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab			675	869			58	14.98
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Surgical ICU								
8.	Medical ICU								
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			675	869	0.55%		58	14.98

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:	14-0119	Medicaid Provider Number:	3048
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

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 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	57,461,166	376,689,752	0.152542	16,100		2,456	
2.	Recovery Room	10,985,237	30,495,242	0.360228	8,041		2,897	
3.	Delivery and Labor Room	10,764,259	21,346,365	0.504267				
4.	Anesthesiology	10,703,836	97,774,775	0.109474	3,967		434	
5.	Radiology - Diagnostic	38,692,146	291,139,697	0.132899	142,863		18,986	
6.	Radiology - Therapeutic	13,805,944	100,483,467	0.137395	58,648		8,058	
7.	Nuclear Medicine	3,641,543	26,323,075	0.138340				
8.	Laboratory	84,374,184	479,897,679	0.175817	253,648		44,596	
9.	Blood							
10.	Blood - Administration	14,473,892	58,590,829	0.247033	9,845		2,432	
11.	Intravenous Therapy	1,027,029	32,767,490	0.031343	29,261		917	
12.	Respiratory Therapy	14,234,464	47,560,235	0.299293	9,784		2,928	
13.	Physical Therapy	7,811,126	29,785,033	0.262250	479,779		125,822	
14.	Occupational Therapy	5,972,386	19,541,425	0.305627	459,291		140,372	
15.	Speech Pathology	3,966,019	9,861,954	0.402153	200,888		80,788	
16.	EKG	11,434,915	84,545,445	0.135252	20,546		2,779	
17.	EEG	2,396,618	18,123,894	0.132235	8,475		1,121	
18.	Med. / Surg. Supplies	33,092,340	106,701,269	0.310140				
19.	Drugs Charged to Patients	150,095,741	616,031,900	0.243649	337,478		82,226	
20.	Renal Dialysis	4,499,336	13,433,820	0.334926	28,384		9,507	
21.	Ambulance							
22.	Implant Devices	77,942,255	234,143,771	0.332882				
23.	OP Renal Dialysis	1,272,445	2,563,943	0.496284				
24.	Day Hospital	4,846,406	8,548,311	0.566943				
25.	Heart Acquisitions							
26.	Kidney Acquisitions	7,694,771	8,190,000	0.939532				
27.	Liver Acquisitions	2,320,214	1,786,050	1.299076				
28.	Pancreas Acquisitions	770,825	604,800	1.274512				
29.	Other							
30.	Other							
31.	Other							
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	58,541,765	161,618,278	0.362222	1,618		586	
44.	Emergency	29,518,973	158,849,406	0.185830	86		16	
45.	Observation	10,161,772	20,233,640	0.502222				
46.	Total				2,068,702		526,921	

* 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: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	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)	114,203,586	16,073,599	12,888,555	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	106,058	14,607	11,847	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,076.80	1,100.40	1,087.92	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			869	
3.	Program general inpatient routine cost (Line 1c X Line 2)			945,402	
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)			675	
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)			945,402	

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					
9.	Coronary Care Unit					
10.	Surgical ICU	28,418,536	15,157	1,874.94		
11.	Medical ICU	29,931,762	15,535	1,926.73		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,331,509	3,135	1,381.66		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					526,921
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,472,323

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

PRELIMINARY

Medicare Provider Number: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	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.	Surgical ICU						
9.	Medical ICU						
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: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implant Devices							
23.	OP Renal Dialysis							
24.	Day Hospital							
25.	Heart Acquisitions							
26.	Kidney Acquisitions							
27.	Liver Acquisitions							
28.	Pancreas Acquisitions							
29.	Other							
30.	Other							
31.	Other							
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							
45.	Observation							
46.	Ancillary Total							

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

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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Surgical ICU							
54.	Medical ICU							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Computation of Lesser of Reasonable Cost or Customary Charge

PRELIMINARY

Medicare Provider Number: 14-0119		Medicaid Provider Number: 3048	
Program: Medicaid-Rehab		Period Covered by Statement: 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)	1,472,323	
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)		
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)	47,423	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,519,746	
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)	2,068,702	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	2,011,735	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Surgical ICU		
	H. Medical ICU		
	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)	4,080,437	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,560,691
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: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	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)	1,519,746	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,519,746	
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)	1,519,746	

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: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	2,560,691
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 (1)	to (2)	to (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.	Total (Sum of Lines 1 - 3)					

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

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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 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: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Line No.	Cost Centers	G M E Cost	Total Dept. Charges	Ratio of G M E Cost to Charges	Inpatient Program Charges	Outpatient Program Charges	Inpatient Program Expenses	Outpatient Program Expenses
		(CMS 2552-10, W/S B, Pt. 1, Col. 25)	(CMS 2552-10, W/S C, Pt. 1, Col. 8)*	(Col. 1 / Col. 2)	(BHF Page 3, Col. 4)	(BHF Page 3, Col. 5)	for G M E (Col. 3 X Col. 4)	for G M E (Col. 3 X Col. 5)
Inpatient Ancillary Centers		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	4,501,085	376,689,752	0.011949	16,100		192	
2.	Recovery Room							
3.	Delivery and Labor Room	437,026	21,346,365	0.020473				
4.	Anesthesiology	4,533,097	97,774,775	0.046363	3,967		184	
5.	Radiology - Diagnostic	4,665,318	291,139,697	0.016024	142,863		2,289	
6.	Radiology - Therapeutic	707,035	100,483,467	0.007036	58,648		413	
7.	Nuclear Medicine	398,055	26,323,075	0.015122				
8.	Laboratory	2,643,031	479,897,679	0.005507	253,648		1,397	
9.	Blood							
10.	Blood - Administration	357,692	58,590,829	0.006105	9,845		60	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	951,992	84,545,445	0.011260	20,546		231	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implant Devices							
23.	OP Renal Dialysis	719,561	2,563,943	0.280646				
24.	Day Hospital	2,842,058	8,548,311	0.332470				
25.	Heart Acquisitions							
26.	Kidney Acquisitions	139,180	8,190,000	0.016994				
27.	Liver Acquisitions							
28.	Pancreas Acquisitions							
29.	Other							
30.	Other							
31.	Other							
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	8,388,386	161,618,278	0.051902	1,618		84	
44.	Emergency	2,430,085	158,849,406	0.015298	86		1	
45.	Observation							
46.	Ancillary Total						4,851	

* 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: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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	12,890,211	106,058	121.54				
48.	Psych	954,776	14,607	65.36				
49.	Rehab	580,381	11,847	48.99	869		42,572	
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Surgical ICU	1,707,740	15,157	112.67				
54.	Medical ICU	3,238,721	15,535	208.48				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	111,908	3,135	35.70				
67.	Routine Total (lines 47-66)						42,572	
68.	Ancillary Total (from line 46)						4,851	
69.	Total (Lines 67-68)						47,423	

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

PRELIMINARY

Medicare Provider Number: 14-0119	Medicaid Provider Number: 3048
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	869		869
Newborn Days			
Total Inpatient Revenue	4,080,437		4,080,437
Ancillary Revenue	2,068,702		2,068,702
Routine Revenue	2,011,735		2,011,735
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

- Spread costs from W/S C, Col. 1 between Acute & Children's Hospital for Adults & Peds and Nursery. See worksheet.
- Observation Days were taken from filed S-3 & spread by same percentage as the split of A&P days between filed Acute & Children's Hospital reports.
- Total Hospital Discharges for Rehab & Psych were taken from filed Medicaid reports.
- Reclassified Blood as Blood-Admin.
- BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1. Filed report used W/S B, Column 24.
- BHF Page 3- Laboratory costs & charges in Cols. 1 and 2 include Laboratory-HLA.
- BHF Page 4 - Adults & Peds costs adjusted to worksheet and W/S C, Col 1 costs.
- Spread GME costs from W/S B, Column 25 between Acute & Children's Hospital for Adults & Peds and Nursery.