

Hospital Statement of Cost

BHF Page 1

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information Preliminary

Name of Hospital: Saint Francis Medical Center		Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Avenue		Medicaid Provider Number: 16007
City: Peoria	State: Illinois	Zip: 61637-0001
Period Covered by Statement:	From: 10/01/2014	To: 09/30/2015

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☐ Church ☐	☐ Individual	☐ State ☐ Township
☐ Corporation	☐ Partnership	☐ City ☐ Hospital District
☐ Other (Specify)	☐ Corporation	☐ County ☐ Other (Specify)

Type of Hospital

☐ 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)

☐ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ 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)) Saint Francis Medical Center 16007 for the cost report beginning 10/01/2014 and ending 09/30/2015 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

BHF Page 2

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Rehabilitation	Period Covered by Statement:	From: 10/01/2014 To: 09/30/2015

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	447	163,155		117,948	72.29%		26,504	4.99
2.	Psych								
3.	Rehab	26	9,490		8,144	85.82%		513	15.88
4.	Other (Sub)								
5.	Intensive Care Unit	50	18,250		14,343	78.59%			
6.	Coronary Care Unit								
7.	Premature 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								
22.	Total	523	190,895		140,435	73.57%		27,017	5.20
23.	Observation Bed Days				8,980				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				1,169			468	2.50
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Premature 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								
22.	Total				1,169	0.83%		468	2.50

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

BHF Page 3

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Rehabilitation	Period Covered by Statement:	From: 10/01/2014 To: 09/30/2015

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	46,639,027	284,668,718	0.163836	9,599		1,573	
2.	Recovery Room	5,181,637	45,703,032	0.113376	2,432		276	
3.	Delivery and Labor Room	9,071,679	20,145,010	0.450319	48		22	
4.	Anesthesiology	3,778,488	158,833,135	0.023789	5,542		132	
5.	Radiology - Diagnostic	42,063,198	367,908,809	0.114330	77,370		8,846	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	37,036,173	496,982,583	0.074522	128,971		9,611	
9.	Blood							
10.	Blood - Administration	7,898,457	18,592,643	0.424816	782		332	
11.	Intravenous Therapy	1,900,364	2,447,349	0.776499				
12.	Respiratory Therapy	13,688,041	154,987,098	0.088317	56,568		4,996	
13.	Physical Therapy	16,007,984	42,573,291	0.376010	902,245		339,253	
14.	Occupational Therapy							
15.	Speech Pathology	1,508,429	4,725,326	0.319222	142,641		45,534	
16.	EKG	4,891,293	76,956,357	0.063559	8,288		527	
17.	EEG	1,335,865	14,448,280	0.092458	1,857		172	
18.	Med. / Surg. Supplies	46,922,215	339,726,414	0.138118	190,991		26,379	
19.	Drugs Charged to Patients	50,844,060	436,698,322	0.116428	402,314		46,841	
20.	Renal Dialysis	2,919,833	12,464,586	0.234250	1,279		300	
21.	Ambulance	61,741	8,085	7.636487				
22.	CT Scan	6,811,226	111,993,644	0.060818	21,858		1,329	
23.	MRI	7,802,016	60,088,274	0.129843	5,273		685	
24.	Cardiac Catheterization	5,311,984	207,707,628	0.025574				
25.								
26.	Implantable Devices	42,350,064	198,994,803	0.212820	32,615		6,941	
27.	Digestive Diseases	5,810,611	48,199,645	0.120553				
28.	Enterostomal	589,892	1,382,043	0.426826	3,907		1,668	
29.	Diabetic Service	1,471,805	208,375	7.063251				
30.	Wound Care	1,500,453	6,559,436	0.228747				
31.	Psychology	1,681,876	3,650,729	0.460696	28,860		13,296	
32.	Neuro Diagnostic Ctr.	2,051,613	236,993	8.656851				
33.								
34.	Urological	21,115	1,678,608	0.012579	3			
35.	Sleep Disorders	4,099,085	14,684,154	0.279150	22,848		6,378	
36.	Pain Program	1,891,549	7,979,187	0.237060				
37.	Comp Epilepsy	2,087,239	448,247	4.656448				
38.	Cardiac Rehab	821,766	1,897,905	0.432986				
39.	Lithotripsy	202,646	2,729,554	0.074241				
40.	Kidney Acquisition	2,971,359	3,381,127	0.878807				
41.	Pancreas Acquisition	141,623						
42.								
Outpatient Service Cost Centers								
43.	Clinic	5,010,428	4,076,592	1.229073				
44.	Emergency	26,040,541	111,127,149	0.234331	59,206		13,874	
45.	Observation	14,359,803	20,202,923	0.710778	184		131	
46.	Total				2,105,681		529,096	

* 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

BHF Page 4

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Rehabilitation	Period Covered by Statement: From: 10/01/2014 To: 09/30/2015

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)	128,552,809		6,014,453	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	126,928		8,144	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,012.80		738.51	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,169	
3.	Program general inpatient routine cost (Line 1c X Line 2)			863,318	
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)			863,318	

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	29,330,626	14,343	2,044.94		
9.	Coronary Care Unit					
10.	Premature ICU					
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					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					529,096
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,392,414

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

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Rehabilitation	Period Covered by Statement:	From: 10/01/2014 To: 09/30/2015

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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.	Premature 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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Rehabilitation	Period Covered by Statement:	From: 10/01/2014 To: 09/30/2015

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)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	189,827	284,668,718	0.000667	9,599		6	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	12,605	158,833,135	0.000079	5,542			
5.	Radiology - Diagnostic	2,373,833	367,908,809	0.006452	77,370		499	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,134,991	496,982,583	0.002284	128,971		295	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	27,148	2,447,349	0.011093				
12.	Respiratory Therapy	45,510	154,987,098	0.000294	56,568		17	
13.	Physical Therapy	858,513	42,573,291	0.020166	902,245		18,195	
14.	Occupational Therapy							
15.	Speech Pathology	61	4,725,326	0.000013	142,641		2	
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance	1,427	8,085	0.176500				
22.	CT Scan							
23.	MRI	5,562	60,088,274	0.000093	5,273			
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology	18,536	3,650,729	0.005077	28,860		147	
32.	Neuro Diagnostic Ctr.	889,369	236,993	3.752723				
33.								
34.	Urological							
35.	Sleep Disorders	883,454	14,684,154	0.060164	22,848		1,375	
36.	Pain Program	489,205	7,979,187	0.061310				
37.	Comp Epilepsy	1,394,198	448,247	3.110334				
38.	Cardiac Rehab	104,970	1,897,905	0.055308				
39.	Lithotripsy							
40.	Kidney Acquisition	20,800	3,381,127	0.006152				
41.	Pancreas Acquisition							
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	1,148,597	4,076,592	0.281754				
44.	Emergency	14,926,836	111,127,149	0.134322	59,206		7,953	
45.	Observation	19,484	20,202,923	0.000964	184			
46.	Ancillary Total						28,489	

* 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Rehabilitation	Period Covered by Statement:	From: 10/01/2014 To: 09/30/2015

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	684,675	126,928	5.39				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	803,558	14,343	56.02				
52.	Coronary Care Unit							
53.	Premature 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)							
68.	Ancillary Total (from line 46)						28,489	
69.	Total (Lines 67-68)						28,489	

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0067		Medicaid Provider Number: 16007	
Program: Medicaid Rehabilitation		Period Covered by Statement: From: 10/01/2014 To: 09/30/2015	
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)	1,392,414	
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)	28,489	
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)	147,544	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,568,447	
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)	2,105,681	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	827,881	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Premature 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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	2,933,562	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,365,115
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

BHF Page 8

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Rehabilitation	Period Covered by Statement: From: 10/01/2014 To: 09/30/2015

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)	1,568,447	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,568,447	
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)	1,568,447	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Rehabilitation	Period Covered by Statement: From: 10/01/2014 To: 09/30/2015

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)	1,365,115
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Rehabilitation	Period Covered by Statement: From: 10/01/2014 To: 09/30/2015

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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Rehabilitation	Period Covered by Statement:	From: 10/01/2014 To: 09/30/2015

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	5,107,854	284,668,718	0.017943	9,599		172	
2.	Recovery Room							
3.	Delivery and Labor Room	1,998,634	20,145,010	0.099212	48		5	
4.	Anesthesiology	357,599	158,833,135	0.002251	5,542		12	
5.	Radiology - Diagnostic	5,441,659	367,908,809	0.014791	77,370		1,144	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	170,752	496,982,583	0.000344	128,971		44	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	343,603	76,956,357	0.004465	8,288		37	
17.	EEG	187,547	14,448,280	0.012981	1,857		24	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	247,030	111,993,644	0.002206	21,858		48	
23.	MRI	151,857	60,088,274	0.002527	5,273		13	
24.	Cardiac Catherization	1,973,441	207,707,628	0.009501				
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.							
33.								
34.	Urological							
35.	Sleep Disorders	98,672	14,684,154	0.006720	22,848		154	
36.	Pain Program							
37.	Comp Epilepsy							
38.	Cardiac Rehab							
39.	Lithotripsy							
40.	Kidney Acquisition							
41.	Pancreas Acquisition							
42.								
	Outpatient Ancillary Centers							
43.	Clinic	861,456	4,076,592	0.211318				
44.	Emergency	7,438,195	111,127,149	0.066934	59,206		3,963	
45.	Observation							
46.	Ancillary Total						5,616	

* 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:	14-0067	Medicaid Provider Number:	16007
Program:	Medicaid Rehabilitation	Period Covered by Statement:	From: 10/01/2014 To: 09/30/2015

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	17,235,647	126,928	135.79				
48.	Psych							
49.	Rehab	988,732	8,144	121.41	1,169		141,928	
50.	Other (Sub)							
51.	Intensive Care Unit	2,231,349	14,343	155.57				
52.	Coronary Care Unit							
53.	Premature 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)						141,928	
68.	Ancillary Total (from line 46)						5,616	
69.	Total (Lines 67-68)						147,544	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16007
Program: Medicaid Rehabilitation	Period Covered by Statement: From: 10/01/2014 To: 09/30/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,169		1,169
Newborn Days			
Total Inpatient Revenue	2,933,562		2,933,562
Ancillary Revenue	2,105,681		2,105,681
Routine Revenue	827,881		827,881
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Adjusted Adults & Peds Beds and Bed Days Available to agree with as filed W/S S-3, Cols. 2 and 3.

BHF Page 3 - Total costs & Charges agree with as filed W/S C Part 1, cols. 1 and 8.

BHF Page 3 - Clinic costs & charges include all Clinic data, W/S C lines 90.01-90.07.

BHF Page 6 - In Column 1 made adjustments to properly include figures from W/S A-8-2, Column 4.

BHF Page 7 - Moved the Routine charges from Adults & Peds line (10A) to Rehab line (10C).

Spread Adults & Peds and ICU costs between Acute and Children's Hospitals.